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A Report on Strengthening the System of Adult Behavioral Healthcare in San Luis Obispo County[1]

Prepared by Capstone Solutions Consulting Group, LLC

[1] Information was gathered from October 2022 – June 2023. The report does not reflect changes made since that time.

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Table of Contents

Introduction

This is a time of unprecedented challenge for behavioral health. The pandemic, economic struggles, rising rates of homelessness, a national opioid crisis, and the impacts of racism and political upheaval have had significant negative effects on the mental health and substance use status of many California residents, including those in San Luis Obispo County. Public service campaigns, the media and the recent pronouncement of a behavioral health crisis by United States Surgeon General Dr. Vivek Murthy, have raised public awareness and created increased demand for behavioral health services at a time when workforce shortages constrain the capacity to deliver what is needed.

In California, several major initiatives have established a foundation for the development of comprehensive mental health and substance use disorder services. While it is beyond the scope of this report to review them all, three highlights include:

- The 2004 passage of Proposition 63, The Mental Health Services Act, enabled Counties to develop a true continuum of mental health care, implementing prevention and early intervention services as well as intensive mental health programs designed to address the needs of the most vulnerable citizens of each County.
- The 2015 federal approval of the Drug Medi-Cal Organized Delivery System (and its subsequent extension) provided the platform for Counties' development of a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services.
- Currently, the State – and by extension the counties – are in the process of implementing California Advancing and Innovating Medi-Cal (CalAIM), a federally approved program designed to ensure vulnerable Californians (e.g., adults who are homeless, justice-involved or who experience frequent admissions to institutions) receive enhanced case management or community supports (e.g., housing navigation, respite care) to enable them to live successfully in their communities without the need for higher levels of care.

At the Federal and State level, there are also funding opportunities to support these behavioral health initiatives. Federal priorities are reflected in the Biden Administration's commitment of additional funding to the following:

- Block grants to support enhanced behavioral health services (MH/SUD) (Note: This funding flows to states and then to counties which determine local priorities).
- Funding for expansion of Certified Community Behavioral Health Clinics
- Mental health awareness training through Project Aware
- 988 Behavioral Health Crisis Services including mobile response teams
- Substance use disorder prevention and treatment of opioid addiction
- National Children's Stress Initiative

California has committed funding to expand behavioral health services including:

- CalAIM, which (as noted above) includes funding for enhanced care coordination and community supports such as finding housing and supporting the tenancy of vulnerable unhoused individuals with behavioral health disorders
- Peer service delivery as a Medi-Cal reimbursable intervention
- Medication Assisted Treatment (MAT), particularly for justice-involved individuals
- CARE Court for individuals who are homeless on the streets and unable or unwilling to receive treatment for mental illness
- Behavioral health interventions offered under the auspices of the managed care plans
- Medi-Cal reimbursement for in-reach into jails and prisons for up to 90 days prior to release, which received federal approval during the generation of this report.

Future components of CalAIM include a move toward payment reform. Beginning in July 2023, counties are transitioning from a cost reimbursement method of accounting for and drawing down funding to fee-for-service. Ultimately, the goal is to move to value-based purchasing (i.e., pay for performance). This will require California to establish strategies for assessing performance such as specifying measuring outcomes for various populations and creating performance dashboards.

Against this backdrop, the experience of the last two decades has resulted in:

1. An awareness that a stakeholder-driven process that supports new programs by identifying and embracing core values such as recovery, while ensuring broad ownership, is a necessary component of successful implementation.
2. Many counties having implemented intensive services – including residential treatment services – that are novel, recovery-oriented, and incorporate an integrated behavioral health approach.
3. An acknowledgement that it is important to consider intensive service programs within the context of the programs that feed into them, and those that will accept clients graduating from this level of care.
4. An understanding that it is possible and essential to prioritize investments to maximize both the continuum of services and funding.
5. Clarity that investment in prevention and early intervention activities reduces the demand for services in both mental health and substance use disorder treatment programs.

At the local level, the San Luis Obispo County Board of Supervisors has acknowledged the current crisis in developing its priorities for 2023 – 2024. Included in the plan are the following areas:

- Implementation of the Regional Homelessness Strategic Plan.
- Addressing the Behavioral Health services gaps.
- Housing (Transitional, low income and workforce).

While it is not yet clear how these priorities will be funded and / or implemented, this leadership, along with opportunities with CalAIM, provide San Luis Obispo County with an opportunity to reimagine the behavioral health continuum of care in its County.

In order to pursue the priorities of the SLO County Board of Supervisors, on October 1, 2022, Transitions-Mental Health Association (TMHA), partnering with the San Luis Obispo Behavioral Health Department (SLOBHD), signed an agreement with Capstone Solutions Consulting Group (CSCG) requesting their services in exploring strategic investments in program development and conducting a gap analysis of mental health and substance use disorder services. This report sets the stage for a future stakeholder process to be implemented in the County.

Our Approach

This report provides an analysis of the mental health and substance use disorder continuum of care in San Luis Obispo County based upon the model used in a report commissioned by the California Department of Health Care Services and performed by Manatt Health. Entitled "*Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications*"[2], the report catalogues services available in each County within a "Core Continuum of Care" (e.g., Prevention and Wellness, Outpatient, Peer and Recovery, Community Services and Supports, Intensive Outpatient Treatment, SUD Residential Treatment, Crisis Services, and Intensive Services) as reflected in the graphic below.

This framework applies equally to mental health and substance use disorder services and is used throughout this document as the structure for detailing types of services. In addition, the commonly recognized ASAM framework for levels of care for substance use disorder (SUD) services is introduced in the SUD services section of this report; it is aligned with and linked to the continuum of services above.

For each component of the continuum of services, this report offers the following:

- Description of services
- Review of the SLO System of Care
  - Catalogue of existing programs
  - Program Gaps
  - Processes governing access and/or transition of care

[2] Adapted from the Manatt Health (with support from Dr. Anton Nigusse Bland), "Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications.", January 10, 2022. Available at: https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

- Recommendations
    - New or enhanced programs
    - Potential new or revised processes

Methodology Used[3]:

In the first phase of the work with TMHA, CSCG first reviewed existing data, reports and frameworks at the state and federal levels. These are described further in the Background section. CSCG interviewed stakeholders (see Appendix A) within the Behavioral Health System (BH System) in San Luis Obispo County and reviewed data provided by the SLO County Behavioral Health Department (SLOBHD) staff and other stakeholders[4]. Interviews conducted with key informants included San Luis Obispo County and contract agency staff, hospital representatives, family members, peers and law enforcement officials. CSCG also spoke with leadership of programs located in other California counties to identify the key success factors in a good system or full continuum of care. Features of what is necessary to deliver these services were identified and are included in Appendix C. Information collected from all sources was used to analyze the system of care and to identify gaps and opportunities for the future.

[3] The focus of this work was on the adult system of care. The youth system of care was not in the scope for this contract.

[4] Note: We are distinguishing between the overall system of care that includes nonprofits, family members, clients (BH System in SLO) and the SLO County BH Department (SLOBHD).

Executive Summary

This report, *Strengthening the System of Adult Behavioral Healthcare in San Luis Obispo County*, describes and analyzes behavioral health services for adults that currently exist in San Luis Obispo County. This analysis represents the first step in a significant strategic planning effort with the expectation that a subsequent stakeholder process will determine action steps and priorities.

In order to conceptualize the elements of a continuum of behavioral health care, this analysis relied on work commissioned by the California Department of Health Care Services and performed by Manatt Health. Entitled "*Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications*"[5], the report catalogues services available in each County within a "Core Continuum of Care" (Figure 1).

Figure 1[6]

Prevention and Wellness Services	Outpatient Services	Peer and Recovery Services	Community Services and Supports	Intensive Outpatient Treatment Services	SUD Residential Treatment Services	Crisis Services	Intensive Treatment Services
Prevention and wellness services, including services, activities and assessments that educate and support individuals to maintain healthy lifestyles and prevent acute or chronic conditions, like wellness checks and health promotion activities	Outpatient services, including a variety of traditional clinical outpatient services like individuaal and group therapy, ambulatory detoxification services	Peer and recovery services delivered in the community that can be provided by indiviuals with lived experience, including young adults and family members	Community supports include flexible services that are designed to enable individuals to remain in their homes and participate in their communities, like support housing, case management, supported employment and supported education	Intensive outpatient treatment services including services such as ACT (Assertive Community Treatment) and substance use intensive outpatient services that are delivered using a multi-disciplinary approach to support individuals with higher acuity behavioral health needs	SUD residential treatment provided in short-term residential settings to divert individuals from or as a stepdown from intensive services	Crisis services include a range of services and supports, such as crisis call centers, mobile crisis services and crisis residential services that assess, stabilize and treat individuals experiencing acute distress	Intensive treatment services are provided in structured, facility-based settings to individuals who require constant medical monitoring

Adopting this framework enables this report to align with a recognized continuum of services for both mental health and substance abuse treatment. Through the utilization of data and key

[5] Manatt Health (with support from Dr. Anton Nigusse Bland), "Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications.", January 10, 2022. Available at: https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

[6] Manatt Health (with support from Dr. Anton Nigusse Bland), "Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications.", January 10, 2022. Available at: https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

informant interviews, CSCG consultants analyzed each element of the service continuum. The body of the report is organized into two chapters (mental health and substance abuse). Within each chapter, consultants provide:

- A description of the component of the continuum of services
- Observations and an analysis of the status of San Luis Obispo County with regard to the capacity of that component of the continuum of services
- Findings regarding processes that govern access to care and/or transition clients between levels of care/programs
- Recommendations

Descriptions of programs that demonstrate desirable characteristics are included in an Appendix to this report.

Before delving into specifics regarding service delivery capacity, it is necessary to highlight a significant challenge for San Luis Obispo County Behavioral Health Department (SLOBHD) as well as the BH System: the workforce shortage. The longstanding difficulties associated with attracting and retaining a behavioral health workforce in San Luis Obispo were exacerbated by the pandemic. Competition over the insufficient supply of mental health professionals, cost of living in SLO, opportunities for virtual work and reluctance to return to in-person settings have contributed to a problem that significantly affects the ability of SLO BH System to fulfill its mission. Key informants acknowledged this issue and the fact that, from their perspective, the SLO BH System is doing a commendable job delivering services under adverse conditions. Added to the serious workforce constraints is the issue of whether San Luis Obispo County has sufficient resources to develop a full continuum of care locally. Creative approaches to limitations in funding have been attempted through partnerships with neighboring counties and cross-county providers that accept residents of San Luis Obispo County. Nevertheless, as this report will show, workforce and resource shortages have impacted the full implementation of the continuum of care in the County.

General Observations: Strengths

There is much to recognize regarding the strengths of the behavioral health system in San Luis Obispo County. Consultants saw and heard reports of the following:

- Certain clinical programs, including Full Service Partnerships, are highly successful in meeting the full range of needs of highly vulnerable mental health clients.
- Forensic mental health programs, including integrated field response teams and post-release services, are effective and show exceptional collaboration between law enforcement and mental health professionals.
- The access protocols for obtaining substance use disorder services are relatively easy to understand and navigate.
- New substance use disorder programs (such as Sun Street Centers) show promise regarding their ability to successfully stabilize, treat and maintain clients with a history of substance use disorders.

- Peer and family support services are exceptional both for the knowledge and dedication of staff and for their comprehensive support for individuals attempting to enter and navigate the mental health system.
- The close personal connections among community leaders who all recognize the need for improvements create a strong matrix for action.

General Observations: Lack of Services/Limitations in System Capacity

There are capacity issues in parts of SLO's continuum of care for behavioral health services. It should be noted that in addition to considering capacity issues for the County as a whole, geographic distribution of services must be reevaluated. Multiple informants reflected the inadequacy of services in geographic areas of the county where transportation to services is inadequate or unavailable.

Certain elements of a comprehensive continuum do not exist including:

- Residential treatment programs such as Crisis Residential Services and Enriched Residential Programs[7].
- Partial Hospitalization for substance use disorders

Other elements of the continuum exist, but capacity is insufficient to address the needs of the residents of the County. These include:

- Acute inpatient care for clients in mental health crises.
- Housing options, including additional permanent supportive housing, adult residential facilities (e.g., board and care homes), and sober living programs.
- Higher levels of care in programs for substance use disorders (i.e. residential). These programs have significant waiting lists, a symptom of insufficient capacity.

General Observations: Underutilized Services/Opportunities to Enhance the Existing System of Care

Although capacity is a concern throughout the network of services in SLO, there are several areas in which existing programs or processes could be modified to enhance care.

- While SLO has a Crisis Stabilization Unit, utilization is low.
- Opportunities within the San Luis Obispo Behavioral Health Department (SLOBHD) exist to enhance processes to ensure better access to and utilization of services.

Recommendations:

Challenges in the current system and recommendations for remediation are summarized below. They are detailed in the report that follows, but grouped here according to the anticipated ease and timing of implementation as follows:

[7] For the sake of this analysis, Enriched Residential Programs are defined as licensed adult residential facilities with intensive mental health services and augmented supervision in a home like environment. Some of these facilities also have services for co-occurring substance use and mental health disorders.

- Level 1: Solutions that can be implemented in the near-term with existing or limited additional resources
- Level 2: Mid-term Solutions that may be implemented with some additional dedicated resources
- Level 3: Long-term solutions requiring extended planning, funding and implementation timelines

Challenge	Potential Solution
Inadequate capacity to serve those in mental health crisis	Level 1 • Redesign the Crisis Stabilization Unit as an Urgent Care Center • Evaluate service priorities currently addressed by the Mental Health Evaluation Team.
Limited outpatient capacity for most at-risk/vulnerable mental health clients	Level 2 • Expand Full Service Partnership slots • Implement an FSP-lite program
Limited available capacity and timely access; waiting lists reduce flow through the system and increase risk to clients	Level 1 • Within the mental health system, add a centralized access and service tracking function; staff appropriately • Use standardized tools to determine readiness for transition of care for mental health services • Within the SUD system, monitor access to care by implementing a data collection system that records time from first walk-in contact to enrollment in treatment
Care is not fully integrated (mental health-substance use-physical health)	Level 1 • Consider using screeners who assess for behavioral health and primary care issues regardless of the system to which the client presents • Expand integrated care through formal and informal partnerships with local providers to ensure all elements of care are provided • Promote opportunities for communication and case conferencing Level 2 • Augment fully integrated agencies and/or programs that represent the full continuum of care • Explore and invest in technology / data platforms for improved connectivity and integration between programs and systems

Workforce capacity is constrained; recovery orientation could be enhanced (particularly in the mental health programs)	Level 1 • Expand opportunities for peers, community health workers and other "nontraditional" providers such as mentors, members of the faith community and others to address the needs of clients • Capitalize on new Peer certification by adding new job classifications • Integrate peers as navigators in outpatient programs where they do not currently work • Operationalize the recovery model within every program and level of care
Lack of capacity to stabilize clients exiting hospital services or who are at risk for a higher level of care	Level 1 • Ensure residential treatment programs are rich in programming and offer food and environments that are welcoming to deter clients from leaving before achieving full benefit Level 2 • Augment staffing at adult residential facilities to enhance mental health services by adding peer support services and augmented supervision for clients leaving a higher level of care Level 3 • Invest in a crisis residential treatment program • Develop an enriched residential treatment program • Expand substance use services by developing a partial hospitalization program in existing outpatient programs; collaborate with sober living homes
Lack of residential alternatives, including adult residential facilities	Level 2 • Consider opportunities to expand availability both in and outside of the county (consider specialized populations, i.e. programming for female clients) • Explore supplemental rate programs to expand programming in adult residential facilities
Lack of adult inpatient beds	Level 1 • Conduct a study on length of stay in the SLO Psychiatric Health Facility (PHF); optimize the balance between stay and client outcomes Level 3 • Add an additional Psychiatric Health Facility (PHF) that should accept private insurance as well as Medi-Cal

The Report - Continuum of Care

Before evaluating existing programs and the service delivery system, it is important to define the behavioral health continuum of care. In its January 10, 2022, assessment of the continuum of behavioral health services in California, Manatt Health identified core elements that are necessary in a behavioral health system[8]. The identified principles include:

- Person-centered and culturally responsive approaches
- A full array of services, including prevention and a wide range of community-based care
- Focus on equity
- Evidence-based and community-defined best practices.

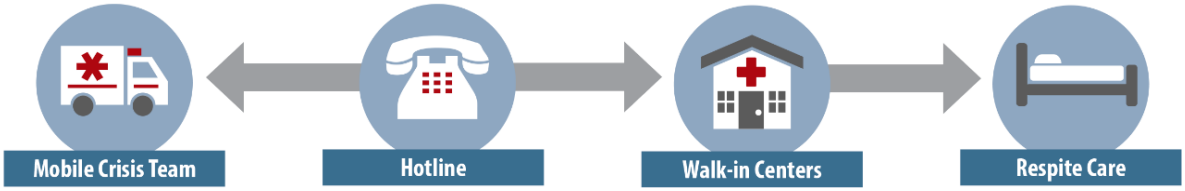
The report further identified eight, major categories of services included in the continuum that are illustrated further in the table (Figure 1) referenced earlier in this report. A key assumption in their report is an understanding that the individuals may be engaged in more than one type of service at any given time. Further, services should include a variety of community supports that address the social determinants of health and other factors, such as housing, employment, education, primary care, and community connection, among others. Finally, all programs should be capable of treating individuals with co-occurring disorders regardless of where they enter treatment.

Since the publication of the Manatt report, rising deaths from suicide and opiate abuse have focused national attention on the need to develop comprehensive crisis services. In response to this behavioral health crisis, the Substance Abuse and Mental Health Services Administration (SAMSHA) also established national guidelines[9] for behavioral health crisis care. Included in these are recommendations for:

- Regional Crisis Call Hub Services that provide “Someone To Talk To”
- Mobile Crisis Team Services that provide “Someone To Respond”
- Crisis Receiving and Stabilization Services that provide “A Place to Go”. [Noted specifically are the need for Short-term Residential and Peer-Operated Respite.]

[8] Manatt Health (with support from Dr. Anton Nigusse Bland), “Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications.”, page 7, January 10, 2022. Available at: https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

[9] “National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.” 2020, SAMSHA. Available at: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf



Mobile Crisis Team	Hotline	Walk-in Centers	Respite Care
Trained professionals arrive at location to provide face to face care	Call 988	Available 24/7/365 Crisis Stabilization Units Connection to resources	Referrals from walk-in centers Transitional help, therapy and medication management 14 day stay

To achieve success, these services require coordination between various systems, including public providers, private providers, managed care organizations, hospital systems, law enforcement, first responders, schools, and others. This includes the need to consider ways of sharing of information. While mentioned on the continuum of care in Figure 1, the operational considerations (including use of technology) are important to call out separately.

Finally, strategies for integrating primary care with mental health and substance use services have been a focus of national and local discussions for years. A successful continuum of care with a "no wrong door" philosophy needs to consider ways in which behavioral health needs are assessed and addressed during primary care and emergency room visits. Likewise, effective behavioral health systems and providers should also consider the primary care needs of those entering their systems. The use of technology to coordinate care and track outcomes across systems is highly recommended. Examples of treatment models from other counties are detailed in Appendix C.

San Luis Obispo County Behavioral Health Department (SLOBHD)

In San Luis Obispo County, the San Luis Obispo County Behavioral Health Department (SLOBHD) is responsible for both mental health and substance use. While the county is mandated to provide services for Medi-Cal beneficiaries and indigent individuals, additional individuals are also served through funding sources such as grants, Mental Health Service Act (MHSA), etc. The focus of this assessment was on the continuum of care starting with Prevention and Wellness Services through to Intensive Treatment Services for both mental health services and substance use disorder services as shown in Figure 1. The analysis was done separately as that is how the two systems appear to operate today. For this analysis, CSCG interviewed individual staff (Appendix A) and analyzed data provided by County and other behavioral health staff. The capacity of the current system and processes governing access to and transitioning between various levels of care are reviewed. A set of recommendations is provided for the future. While the focus of this analysis was the adult behavioral health system, it is important to note that

there are opportunities to better coordinate with primary care to provide a true "no wrong door" approach.

Mental Health Delivery System in SLO

CSCG completed an inventory of the system of care for mental health disorders overseen by SLOBHD that revealed a continuum of services through directly operated and contracted providers.

Prevention and Wellness Services

Mental Health Prevention and Wellness Services: Prevention and Early Intervention (PEI) programs are designed to increase protective factors and diminish an individual's risk factors for developing mental illness. In FY 2021-2022 the County's PEI Program included the following work plans: 1. Prevention, 2. Early Intervention, 3. Outreach for Increasing Recognition of Early Signs of Mental Illness, 4. Access and Linkage to Treatment Programs, 5. Stigma and Discrimination Reduction, 6. Improve Timely Access to Services to Underserved Populations, and 7. Suicide Prevention. [10] The PEI and Wellness programs are described in the table below.

Program Name	Provider	Program Description	Outcomes
Family Education, Training, & Support Program (MHSA funded)	Center for Family Strengthening Transitions-Mental Health Association (TMHA)	The program uses a multi-level approach to reduce risk factors and increase protective factors for all parents and other caregivers raising children.	Resources or education provided to 700+ parents annually. Coaching services for parents/caregivers are provided to 500+ families annually.
Community Based Therapeutic Services Program (MHSA funded)	Community Counseling Center	Community Based Therapeutic Services (CBTS) maximizes the opportunity for many diverse individuals to access prevention.	The program provided 2,000+ hours of counseling to 495 uninsured and underinsured clients from at-risk populations in FY 21-22.

[10] 2022-2023 San Luis Obispo County Annual Update to the Three-Year Plan

Integrated Community Wellness Resources Specialists (MHSA funded)	Transitions-Mental Health Association (TMHA)	TMHA provides Family Support Specialists (FSS) and Behavioral Health Navigators (BHN) — individuals with lived experience as either a participant or family member— who collaborate with other PEI providers to deliver system navigation services towards securing basic needs such as food, clothing, housing, healthcare, employment, and education and wellness supports.	During 2021–2022, T-MHA provided 6,031 community contacts with BHNs; 844 of those contacts became participants in the form of assistance and referrals to services. Of those participants, 252 received intensive services. Four clients were referred to County outpatient mental health services.
Older Adult Mental Health Initiative (MHSA funded)	Wilshire Community Services	The program provides an intensive continuum of mental health prevention and early intervention services for Older Adults.	The program screened 749 unique clients for depression in FY 21-22. 329 enrolled in outpatient mental health programs. 51 clients in need of a higher level of care received 276 hours of transitional therapy services to address issues of grief, loss, anxiety, and other mental health illness related to aging.
In-Home Parent Educator (MHSA funded)	CAPSLO	The Community Action Partnership of San Luis Obispo (CAPSLO). The program provides to build parenting skills,	Not available.

		improve knowledge of appropriate behaviors, increase positive discipline skills, and increase attachment through positive parent/child interactions.	
Veteran Outreach Program (Grant funded)	San Luis Obispo Behavioral Health Department	The program provides a Behavioral Health Clinician embedded within local rehabilitative activities for veterans and their families.	In FY 21-22, the program-initiated screenings and referrals for 11 veterans and more than 100 veterans and family members participated in activities.
First Episode Psychosis (SAMHSA Mental Health Block Grant funded)	San Luis Obispo Behavioral Health Department	With SAMHSA Mental Health Block Grant funding, the County provides an early intervention First Episode Psychosis program for California Polytechnic State University (Cal Poly) and its on-campus residential community	In FY 21-22 approximately 53 students were diverted from Health Center caseloads by being seen and treated within the residential community.

Recommendations:

- SLOBHD should consider adding additional resources to hire individuals with lived experience within prevention programs for both contracted and directly operated programs. Adding this job classification would allow SLOBHD to bill for these services.

Outpatient Services

SLOBHD Outpatient Mental Health Clinics: SLOBHD operates 3 adult outpatient mental health clinics. Individuals are encouraged to contact the access line at 1 (800) 838-1381 to schedule an appointment.

Provided services include:

- Screening, Assessment and Treatment Recommendations
- Treatment Planning
- Individual and Group Psychotherapy
- Medication Services
- Psychiatry
- Case Management
- Rehabilitation Services

SLOBHD's "No Wrong Door" approach ensures that Medi-Cal beneficiaries receive timely mental health services without delay, regardless of the delivery system where they seek care, and that individuals are able to maintain treatment relationships with trusted providers without interruption. Individuals without Medi-Cal receive services based on medical necessity to the extent resources are available.

The following data was provided to determine the access timeliness to outpatient clinic services. The data refers to the time between an individual's request for services and the first offered service, first delivered service, and first availability of psychiatrist time. [11]

First Offered Appointment for SLO Mental Health (SLOBHD)*

	Adult Services
Business days from first request for service to first offered appointment	18 Average 10 Median Range 0 to 67 days
DHCS standard	10 business days
Count of first service requests	1168
Count of first offered appointments	870
Count of first offered appointments that met DHCS standard	310
Percent of first offered appointments that met DHCS standard	36%

*Data reported in represents County-Operated Services

[11] SLOBH Policy 3.23 Availability_Timeliness_Network Adequacy_Array of Services/BH/Pg.4.

First Delivered Service*

	Adult Services
Business days from first request for service to first delivered service	21.3 Average 20 Median Range 0 to 92 Days
Mental Health Plan (MHP) standard (in business days)	10 days (offered**)
Count of first service requests	289
Count of first delivered services	289
Count of first delivered services that met MHP standard	33%
Percent of first delivered services that met MHP standard	33%

*Data reported in represents County-Operated Services
** The first appointment is offered; and, it may or may not be accepted by the client

First Offered Non-Urgent Psychiatry Appointment*

	Adult Services
Business days to *first offered psychiatry appointment*	20 Average 12 Median Range 0 to 98 days
DHCS standard	15 business days
Count of initial psychiatry service requests	1396
Count of offered psychiatry appointments	1393
Count of offered appointments that met DHCS standard	498
Percent of offered appointments that met DHCS standard	36%

*Data reported represents County-Operated Services. [12]

Feedback from key informants show that client entry into the mental health treatment system is a challenging multi-step process that is difficult to navigate. For example, it was reported that new clients must telephone the access line and request a return telephone screening call which is often received one or two weeks later. If clients miss this return call, they must recontact the access line and start over. Following a telephone screening to determine whether the client is in crisis, a telephone intake is scheduled. Finally, an appointment is made with the assigned

[12] CalEQRO Site Review/Assessment of Timely Access MH FY 2022-2023v2

medication manager who will determine the services needed by the client and make follow-up appointments with the assigned psychiatrist or therapist as needed. In addition, key informants report that County staff seem more like gatekeepers and less like providers in a welcoming system. While SLOBHD engages in staffing meetings to coordinate client care within the clinic, the current staffing shortfalls have made it difficult to coordinate care across programs.

The need for additional behavioral health staff was identified by several key informants. It was reported that clinicians carry large caseloads that are not viewed as optimal. The most recent California External Quality Review Organization (EQRO) validates this, indicating that caseloads of 250 were not uncommon[13]. While the SLOBHD-operated clinics are managing what comes in, the system is strained and not sustainable. Hiring and retention of staff is challenging due to costs of housing and living in SLO, retirements, and lack of availability of qualified or interested staff.

Recommendations:

- Develop strategies for streamlining steps for new clients seeking mental health services. A workgroup that includes both those involved in the intake process and stakeholders who view the current system from the outside can identify essential steps and where redundancies or inefficiencies exist.
- SLOBHD should commit to developing a more welcoming experience for persons requesting mental health treatment. The Department may want to consider conducting stakeholder focus groups for input into how persons requesting mental health treatment experience the entry processes into the system of care, and how they think it can be improved. Management and staff focus groups can help to formulate strategies for developing a more welcoming entry into services, while continuing to make appropriate level-of-care placement decisions.
- Consider the use of peer navigators to enhance supports for individuals coming into the system.
- Given the expansion of opportunities for peer specialists, SLOBHD would benefit from a team approach in which certain responsibilities currently carried by licensed staff could be assumed by credentialed peers, thereby preserving the time of licensed professionals to work in their scope of practice.

Peer and Recovery Services

Mental Health Peer and Recovery Services: Offered by individuals with lived experience, peer and recovery services provide support to individuals and families affected by mental illness. These services can be delivered through the 1) development of specialized peer-run or peer-driven programs and/or 2) through integration of peer staff into traditional mental health programs. In San Luis Obispo County, specialized family and peer services are delivered primarily by Transitions-Mental Health Association (TMHA) and include:

[13] https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Quality-Support-Team/EQRO-Reports/San-Luis-Obispo-MHP-EQR-Final-Report-FY-2021-22-v5.pdf

Behavioral Health (BH) Navigators	•BH Navigation and support while connecting to services •Transition Assistance and Relapse Prevention (TARP) for those graduating from FSP programs •Service Enhancement: integration of peers into South County behavioral health center to assist with appointments, paperwork
Behavioral Health Engagement and Education Team	•Assisting Individuals with Mild to Moderate mental health conditions to link with managed care (CenCal)
Peer Advisory and Advocacy Team	•Advocate for those with mental illness •Provide education for the community regarding mental health issues
Central Coast Hotline	•a 24/7 call center offering confidential assistance addressing mental health crises including suicide prevention, linkage to services

As evident from the foregoing chart, peer services in SLOBHD are intentionally focused on assisting those who qualify for both specialty and non-specialty mental health services navigate and connect with the appropriate treatment program. TMHA also offers an extensive array of family support programs, including training, education and support services.

Recommendations:
While San Luis Obispo County is notable for the extensive and excellent peer and recovery services in place, a review suggests the following:

- Peer service enhancement should be expanded. Currently, this service is provided by stationing TMHA peer navigators in the SLOBHD South County clinic only. Expansion to the other SLOBHD clinics would be important at the time of entry into the behavioral health system; additional assistance could be offered with appointments, communication with care providers, etc. In addition to supporting clients of the system, an expansion would aid the SLOBHD staff. Enhancing this navigation function might also ensure better utilization of appointments by reducing no-shows.
- Training and funding for peer support and recovery services should be expanded. California's implementation of the peer support specialist certification provides a road forward for training of a new cadre of peers and family members that can augment the current workforce, drawing down Medi-Cal funding to offset the additional cost.
- The option of adding programs to serve other areas of SLO County should be considered. Areas of North County and the North Coast lack services. Distance and limited existing transportation options preclude access to services that do exist in other parts of the County.

- SLOBHD should capitalize on opportunities to involve peer navigators in behavioral health planning. Interviews with TMHA peer staff demonstrated their keen knowledge of how the system works, as well as their desire to contribute to making the system better.
- Communication and care coordination can be enhanced. Involving peer navigators in discussions around the specific needs of shared clients might ensure effective linkage to and utilization of resources while preventing duplication of efforts.

Community Services and Supports

Mental Health Community Services and Supports: Community supports are flexible services designed to enable individuals to remain in their homes and participate in their communities. Community Services and Supports are provided in various settings to support individuals to live full lives in the communities of their choice. These services include supportive housing, such as housing navigation, support for maintaining housing and other housing related interventions (for example, addressing landlord tenant issues). This category also includes case management, behavioral management, culturally tailored services, consumer/family education, consultation to caregivers, supported employment, and supportive education.

SLOBHD and its contractors provide Community Navigators who link and refer community members to the services and support they need; hold free trainings to community members and organizations that cover a variety of mental health and wellness topics; provide small grants and technical assistance to help local communities improve their capacity to support the wellbeing of their members and provide resources, events, trainings and other free programming to reduce the stigma associated with mental illness and seeking help.

Supportive Housing Options: TMHA Community Residential Program (CRP) provides housing for 127 individuals with an open case with SLOBHD. The housing is situated in residential settings. Care coordination meetings take place monthly between TMHA and SLOBHD to coordinate admissions and discharges. Permanent supportive housing is limited in SLO County; and some individuals have been in the program for as long as 20 years. This represents a backlog in the system as it is hard for new clients to enter. Another current challenge is the fact that some individuals are aging out of the program but are not appropriate for Assisted Living or Skilled Nursing Facilities. This is a growing gap in the system of care.

TMHA also operates 121 County Permanent Supportive Housing units dedicated to homeless individuals located in SLO County. Admissions are authorized through the Coordinated Entry System. Key informants report the waitlist to be several years long. For individuals who receive permanent supportive housing, there are still gaps, including limited available transportation for individuals with disabilities. While bus passes are free, there is only one transportation company that does door-to-door transportation which makes it difficult for disabled individuals to get to appointments.

While there are limited board and care options in SLO, SLOBHD staff reported that the County contracts for some licensed adult residential facilities in various locations outside of SLO. These facilities provide a housing option for individuals who desire a homelike setting coupled with care and supervision. These include Davis Guest Home; C&D Guest Homes (New Horizons); Marian Homes Front St. (Drake House/Opal House); Marian Homes; and Psynergy in Northern California.

In addition to supported housing, opportunities for supported employment exist in San Luis Obispo. Growing Grounds Downtown Store and Farm & Nursery, are social enterprises operated by TMHA that offer employment and job skills training for individuals with serious mental illness.

Recommendations:
San Luis Obispo County is not alone in experiencing a serious lack of housing options for individuals with mental illness. While efforts should be made to increase the supply of new housing, additional areas of focus must be on preserving the housing that currently exists and enhancing services to foster recovery. Specific suggestions include:

- SLOBHD should seek opportunities to expand housing options with additional partnerships inside and outside of SLO.
- SLOBHD should explore enhanced staffing, programming and the environment of existing residential options such as adult residential care facilities in order to support the providers while creating a recovery climate for clients

Intensive Outpatient Treatment Services

Mental Health Intensive Outpatient Treatment Services: Full Service Partnerships (FSPs) provide a comprehensive community-based treatment program for persons with severe and persistent mental illnesses. These programs are designed to reduce hospitalization and facilitate successful community living and psychosocial rehabilitation. Supportive FSP housing is available through TMHA that includes 35 intensive residential beds, 4 beds for Homeless Outreach Team (HOT) FSP and 5 beds for Assisted Outpatient Treatment (AOT) FSP. These programs are certified by DHCS as outpatient mental health programs and are Medi-Cal eligible. Key informants reported lengthy waitlists for these supportive housing beds.

TMHA operates the adult FSP services for SLOBHD. Currently there are 3 adult FSP teams (North and South County) and 2 Homeless Outreach Teams (HOT FSP). One Older Adult FSP team is operated by Wilshire Community Services. One Transition Age Youth (TAY) FSP is operated by Family Care Network.

Data regarding program capacity and average length of stay is reflected in the table below:

Program	Slots	Average Length of Stay
Adult FSP	53	851 days
TAY FSP	36	336 days
Older Adult FSP	23	363 days
Homeless Outreach FSP	38	1004 days

Recommendations:

- SLOBHD should consider expansion of FSPs in all age groups to increase flow through the various levels of care. The size and length of time clients remain on a waiting list should be monitored to identify and validate trends. This information can be used to quantify any future expansion. In addition, consideration of the second recommendation below must be factored into the level of future need.
- SLOBHD should consider implementing a Full-Service Partnership stepdown level of care for individuals transitioning from FSP to the outpatient clinics (FSP-lite). The concern is that individuals often fall through the cracks during this process and end up returning to their FSP teams.

Crisis Services

Crisis Services: Services can include crisis lines, mobile response teams and crisis residential programs.

Crisis Line and Mobile Response Teams: 24/7 access to a crisis telephone line is provided SLO County-wide via TMHA's Central Coast Hotline. Callers can phone or text a person and get a response immediately, unless there are two calls taking place. The Central Coast Hotline (CCHotline) has been in operation since 1970 and is toll-free. In 2022-23, staff fielded almost 9000 calls or texts (texting was introduced halfway through the year). Of those calls, 95% were handled or de-escalated by CCHotline call handlers, 138 (1.5%) were referred to 911, and 305 (3.5%) needed MHET mobile crisis services dispatched. The national crisis line 988 is being rolled out across the country, including California. This will give people a 911-alternative to call if someone appears to be having a behavioral health emergency. In SLO, there is not a local 988 system set up, and 988 calls are routed to one of the regional centers in California. Central Coast Hotline has re-applied to be a 988 call center in order to support the Central Coast community.

In addition to the Central Coast Hotline, SLOBHD has a 24/7 Behavioral Health Crisis Dispatch Center that is run by Sierra Mental Wellness Group (SMWG). This group provides dispatch of primarily unlicensed staff with consultation from licensed clinicians. They also provide assessments, evaluations, and transportation via two Mental Health Evaluation Teams (MHET) for SLOBHD (one for adults and one for youth). The MHETs travel to an individual's home or location in the community (e.g., a homeless shelter or street location) or an emergency department (ED) to de-escalate a situation and assess the type of care an individual requires. The MHET links individuals who require further treatment to crisis stabilization services, crisis respite services, sobering centers, or other behavioral health treatment. If necessary, they can

transport individuals to Emergency Departments (EDs) for more in-depth assessment and stabilization. Over the course of a year, data show that most requests for MHET calls came from hospitals (1,942) with the remainder coming from clinics, law enforcement, schools, Crisis Stabilization Unit, and field/walk-ins for annual total of 2,160 episodes[14]. SMWG also stations a MHET crisis worker at Arroyo Grande Hospital. This individual is funded by the hospitals and not through SLOBHD.

Interviews revealed that some local hospitals station crisis workers in their EDs, while others do not. These differences may be attributable to workforce challenges. Nevertheless, lengths of stay in the ED and reliance on the MHET teams appear to be affected by the availability of these crisis workers. Hospital utilization of the MHET teams can limit MHET availability to address other community-based needs.

Recommendations:

- SLOBHD would benefit from reviewing the service priorities addressed by MHET.
- State funding could support the positioning of dedicated staff in hospitals for the purpose of transition and discharge planning.
- MHET teams might be utilized in the field to de-escalate clients and prevent the need for a higher level of care and/or transport to the crisis stabilization unit/hospitals for individuals determined not eligible for community-based care.
- SLOBHD should explore opportunities to expand their mobile crisis teams through CalAIM.

Crisis Stabilization Unit (CSU): The CSU operates 24/7 and provides up to 23-hours and 59 minutes of voluntary care. Interventions include crisis intervention, assessment, evaluation, collateral supports, therapy, and peer support. While medication services are not available at the CSU, clients can go to the outpatient client and on-site pharmacy or medication services. The goal of the CSU is to avoid unnecessary hospitalization and incarceration while improving wellness for individuals with mental health disorders and their families. The CSU provides the following:

- A step down from the PHFs and acute hospitals for patients to access community resources.
- Immediate evaluation for individuals in crisis who are willing to sign in voluntarily.
- Medication walk-in services.
- A gateway to on-going community mental health services.

The CSU is operated by Sierra Mental Wellness Group (SMWG) through a contract with SLOBHD. The program has 4 chairs and can add 4 chairs if warranted. Utilization was 452 visits with an average length of stay of 1.07 days. During this timeframe (as reported by SLOBHD), the program received 266 referrals and admissions from hospitals and 186 field/walk-in admissions.

[14] Data provided by County staff.

Projected utilization for FY 2022-23 is 365 according to the SLOBHD 3 Year Mental Health Services Annual Plan. Key informants reported that the CSU uses overly restrictive admission criteria that excludes too many people in acute mental health crisis. The CSU has a consistently low census which is incongruent with high demands for more accessibility from clients in mental health crises. To further complicate matters, the leadership of the CSU has experienced a high turnover rate with an average tenure of about one year. According to data provided by SLOBHD staff, the CSU has four chairs but is seeing an average of 1 client per day, which is lower than what was expected. This could be a function of the lack of Lanterman-Petris-Short (LPS) designation. If the CSU was operating at 75% capacity, the programs could easily see 1,095 individuals/visits per year. Walk-in hours are from 10 a.m. to 9 p.m., with access to on-call providers after hours.

Recommendations:

- SLOBHD should develop a vision and strategies to reposition the CSU so it is able to admit more clients in crisis and effectively serve them in a transitional "staging" facility for stabilization and refer them to stepdown treatment at appropriate levels. It is recognized that this recommendation requires a significant change in treatment philosophy and program design.

Crisis Residential Treatment Programs (CRTPs): CRTPs are designed to prevent hospitalization or to facilitate early discharge from hospitals when admission has been unavoidable. These programs stabilize individuals in a psychiatric crisis that do not require acute care. Adults CRTPs serve individuals over the age of 18, providing short-term intensive and supportive services in a homelike environment. They offer self-help skills, peer support, individual and group interventions, social skills and community reintegration services, medication support, co-occurring disorder services, pre-vocational and educational support, and discharge planning. SLOBHD has no crisis residential beds; therefore, this represents an opportunity for future expansion of services to enhance the continuum of care.

Recommendations:

- SLOBHD should consider adding a crisis residential treatment program to their continuum of care to increase flow from the CSU and PHF as well as to ensure successful community reintegration for individuals who require additional supports prior to returning to their living situation.

Intensive Treatment Services

Mental Health Intensive Treatment Services: The services in this category include facility-based care for individuals requiring 24/7 monitoring.

State Hospitals: State Hospitals treat Lanterman-Petris-Short (LPS) conserved individuals from SLOBHD who are diagnosed with the most severe symptoms of mental illness. These individuals have engaged in behaviors that are dangerous to themselves or others or are so gravely disabled by their mental illness that they require a highly structured treatment environment in order to prepare for community-based placements. State Hospital inpatient

units can place clients in seclusions and restraints and give intramuscular medications, as necessary. At the time of this report, there were 2 residents of SLO in the State Hospitals: one individual has been at Metropolitan State Hospital for 4 years and another individual has been hospitalized at Atascadero State Hospital for 3 years and 10 months. Currently, State Hospitals are not admitting patients on LPS conservatorships as the State is in the process of transitioning general beds for those with psychiatric disorders qualifying under the LPS Act to beds for the forensic population with mental health disorders. However, individuals who are on forensic commitments may be conserved and subsequently be transferred to a County bed in the State Hospital. This may ultimately impact SLOBHD.

Recommendations:

- This an area on which SLOBHD should focus its strategic planning efforts, considering what type of resources they will need for the future. It should be noted that the severely limited access to LPS beds in the State Hospital is an issue that affects all California counties. One option is to partner with California Behavioral Health Directors Association (CBHDA) and California Mental Health Services Authority (CalMHSA) regarding an effort made previously to identify an alternative to State hospitals.
- SLOBHD could also explore new funding opportunities with DSH for forensic populations.

Acute Hospitals: Acute psychiatric hospitals and / or acute hospitals with psychiatric units stabilize individuals in medical or psychiatric crisis. The objectives are to stabilize symptoms through medication intervention, to enhance social rehabilitation skills, and to facilitate community reintegration through discharge planning and linkages to community mental health services. These facilities are licensed, regulated, and inspected and/or certified by the California Department of Public Health (CDPH) Licensing and Certification Program and by the Center for Medicare & Medicaid Services (CMS) where applicable for facilities accepting Medicare and Medi-Cal.

There are four acute hospitals in SLO: French Hospital Medical Center in San Luis Obispo and Arroyo Grande Community Hospital in Arroyo Grande operated by Dignity Health, and Sierra Vista Regional Medical Center in San Luis Obispo, and Twin Cities Community Hospital in Templeton operated by Tenet Healthcare Corporation. While none of these hospitals have acute inpatient psychiatric units on-site, they do have patients in psychiatric crisis who are being seen in their emergency departments and on their medical floors. It should be noted that these hospitals have limited psychiatric consultation, behavioral health navigator and in-house behavioral health staff support. These services would allow the hospitals to be more adept at behavioral health screenings, short-term interventions, and referrals. As a result of workforce shortages and other factors, hospitals reported that they feel adversely impacted when 5150 holds come to their door and especially when people come into the ER who are not in immediate crisis.

The hospitals report shortages of MHET staff to conduct mental health evaluations and re-evaluations of 5150 holds. Arroyo Grande Hospital took the step of obtaining funds to support an additional onsite MHET staff person who can routinely and pro-actively do re-evaluations. In contrast, French Hospital in central SLO, must make special requests that can involve considerable wait times for re-evaluations. Key informants said that ideally they would like to conduct re-evaluations within 24 hours since most patients get stabilized within that time frame. The four hospitals have relationships with out-of-county hospitals to transfer individuals on involuntary holds in need of acute psychiatric services if the SLOBHD inpatient unit is unable to admit their patients.

Hospital key informants have the impression that the County processes for receiving referrals, conducting assessments, and facilitating referrals into treatment need streamlining. In their eagerness to quickly refer, the hospital social workers and other navigators will often bypass the SLOBHD Access Line and refer directly to assessing staff at the outpatient clinic sites. While this accomplishes a quicker referral process, the assessors do not record some of the data for later analysis that is needed for the Access Line. Hospital staff also have the impression that the more intensive levels of care for both MH and SU lack sufficient capacity due to wait lists. The combined impacts of these problems on patients are longer wait times resulting in relapses and recidivism. This is especially the case for youth who, at times wait in the emergency department for up to a week before being triaged to non-hospital treatment. Increasing timeliness for assessments and admission into treatment are key challenges in SLO for serving those who experience serious mental illnesses and addictions.

The hospitals do not have reporting mechanisms to track the timing of processes from initial encounter to assessment to admission and / or transfer / referral / discharge. The lack of these mechanisms compromises efforts throughout the entire health and behavioral health care systems to evaluate and improve the efficiency and effectiveness of their entryways to care. This is particularly the case for identification, screening and effective referral of hospital ER patients with behavioral health conditions to post-discharge treatment for those conditions. Hospital staff estimated that only a small percentage of those in the ED with behavioral health conditions are further screened and referred to SLOBHD or other providers.

Recommendations:

- CSCG recommends that SLOBHD establish treatment goals, with hospitals becoming more involved in the identification, further screening and referral of patients from the ED and inpatient units to County behavioral health (SLOBHD) and FQHCs upon discharge. SLOBHD should explore what it would take to fund and hire more behavioral health staff to work in the hospitals as screeners and referrers, and explore possibilities for increasing funding to hire more MHET staff to conduct mental health evaluations and re-evaluations for 5150 holds.
- The behavioral health workforce shortages in the hospitals need to be addressed.

- Increase awareness and training for hospital staff in how to screen and refer for behavioral health conditions. Although hospital EDs routinely conduct initial evaluations and insert problem lists into the patient's EHR, these lists are not being used subsequently for indications of the prevalence of behavioral health disorders among patients, nor are they used routinely to prompt behavioral health screenings. It is recommended that the problem lists generated in each hospital are used to prompt follow-up screenings and referrals of patients initially identified as having a mental health and/or substance use problem. An analysis and reporting on timeliness for each step in the process will provide additional information.
- The processes referred to in the previous paragraph are a key focus of the recent CalAIM initiatives, especially the CalAIM Behavioral Health Quality Improvement Programs (BHQIP). Surprisingly few key informants were familiar with the BHQIP requirements for Counties and with SLO-specific findings, plans and current efforts. It appears that SLOBHD hopes to improve how they address coordination of care with the upcoming implementation of a new EHR, SmartCare, which will roll out on July 1, 2023. SmartCare is being used elsewhere in California, such as Santa Barbara County
- Use the findings from the reports mentioned in the paragraphs above to improve the screening, referral, assessment and admission processes. Make adjustments in the processes as needed and measure changes in percentages and in timeliness. Depending upon the results, make adjustments to capacity at specific levels of care as needed.
- SLOBHD should communicate the vision of CalAIM's BHQIP and related performance improvement efforts more broadly so that each participating agency or organization (e.g. hospitals, FQHCs and BHD providers) understand the value of the undertaking to the client they share, the role they each must play for the undertaking to succeed, and how they can each help each other in the implementation. This overriding shared vision and commitment to achieving it will be especially important as SLOBHD undertakes the implementation of a new EHR. While a successful EHR implementation is essential to support these broader aims, early stages inevitably focus attention on fine details and can result in the proverbial "losing the forest for the trees".

Despite the challenges SLOBHD currently faces concerning linkage to County services from hospitals, the County provided the following data on patients referred and seen in the mental health system of care following psychiatric hospitalization.

Follow-up Services After Psychiatric Hospitalization*

	Adult Services
Days from discharge to first follow-up service	3 Average 3 Median
MHP standard or goal (HEDIS Standard is 7-Days)	7 Days
Total number of hospital admissions	506
Total number of hospital discharges	506
Total number of follow-up services delivered *within 7-days of discharge*	480
Percent of services delivered *within 7-days of discharge*	73%
Total number of follow-up services delivered *within 30-days of discharge*	26
Percent of services delivered *within 30-days of discharge*	96%

*Data reported represents the County-operated services for Medi-Cal population only.[15]

Psychiatric Health Facilities (PHF): The PHF in SLO provides acute inpatient care in a free-standing, 16-bed facility, 24/7, for individuals in acute psychiatric crisis including individuals on conservatorships with the Public Guardian. The SLO PHF provides intensive mental health services to clients who may enter the program voluntarily or through 5150 or 5250 involuntary detention. To gain access to the facility, initial calls are screened by the Sierra Mental Wellness dispatch center. Ultimately, admission decisions are made by the SLOBHD psychiatrist within the PHF. One bed within the PHF is designated for individuals that have been placed on an involuntary hold in the SLO Jail. The PHF provides medication evaluation, monitoring, nursing services, and coordination of services with community agencies. Discharge planning is tailored to the needs of each client to determine the best possible outcome; this process is initiated at admission. PHFs are licensed by the Department of Health Care Services and must be affiliated with a hospital or outpatient clinic. They are generally certified by CMS and LPS designated. Beginning July 1, 2023, the 16-bed PHF will transition from being a SLO County BHD-operated facility to a contracted provider, Crestwood Behavioral Health.

[15] CalEQRO Site Review/Assessment of Timely Access/MH/FY 2022-2023v2.

The average length of stay (LOS) is 6 days[16] in SLO. This LOS was compared with PHFs in several other Counties, revealing the following differences:

County	Length of Stay for individuals on conservatorship	Length of Stay for individuals NOT on conservatorship
Los Angeles	36	18.4
Fresno	25.6	20.8

County	Average Length of Stay for all individuals
Sutter	14-21 days
Merced	11.2 days
Santa Cruz	13.4 days
Statewide Average	8.6 days

Recommendations:

- While there may be County-level issues that contribute to differences in length of stay, it is our recommendation that SLOBHD explore the reasons for these differences.
- A focus on readmission rates and ED visits might provide important information regarding optimal length of stay for this level of care. SLOBHD could conduct stakeholder focus groups with former PHF clients, with ED referrers, and with PHF staff to identify performance issues and work with the new contract provider to learn from that input and plan how to operate differently. Deploying quality improvement mechanisms with feedback loops may set a new tone for the program.

IMD/Subacute Beds: Institutions for Mental Diseases (IMDs) are long-term care psychiatric facilities that provide care for individuals who no longer meet the criteria for acute care but are not clinically ready to live in board and care facilities. This level of care is for individuals who require additional intensive services and supports or specialized populations such as those who have a hearing impairment or are involved with the forensic system. SLOBHD currently contracts with 6 IMD facilities located out of the county for 27 individuals in need of this level of care. These are 7th Avenue, Crestwood, Golden Living (Inspire), Merced Behavioral Health, Sylmar Health and Rehabilitation (no individuals currently), and Vista Pacifica. SLOBHD case managers review the status and progress of individuals with the IMD staff on a quarterly basis to determine the need for continuing care. Individuals are transferred back to SLO when they meet their treatment goals and appropriate placement is located. Generally, individuals are placed in board and care facilities and enrolled in Full-Service Partnership (FSP) Programs upon discharge from IMDs.

[16] This includes individuals on conservatorships. Interviews revealed there are 1-5 individuals in the PHF on conservatorships at any given time.

Recommendations:

- SLOBHD should consider the development of IMD/Subacute resources within the County with an experienced IMD provider. This provides more continuity with families and communities and enhances aftercare.

Enriched Residential Services: These supportive residential programs serve individuals ready for discharge from IMDs and acute inpatient units. These programs provide intensive support required to successfully transition individuals from higher levels of care to community-based services. They offer housing, specialized programming and capacity to handle emergencies on a 24/7 basis. These housing sites are licensed by Community Care Licensing (CCL), and meet the definition of Adult Residential Facilities with mental health services provided from a certified offsite mental health outpatient program. Many of these programs partner with Federally Qualified Health Care Centers (FQHCs) to provide physical health care.

While SLO does not have Enriched Residential Services, they offer several options that may be enhanced or expanded within the county. TMHA operates the Adult Transitional Program (ATP) for 12 men and women that serves as step-down from enhanced board and cares like Psynergy (in Northern California) which is contracted with SLOBHD. ATP is licensed as a transitional residential program by the State and has an average length of stay of 12-18 months. In addition, SLOBHD staff provide a case manager and a psychiatrist at a 40-bed board and care, American Care Home, one day per week.

Recommendations:

- To the extent resources permit, SLOBHD should consider developing at least one enriched residential treatment facility.
- SLOBHD could consider adding staffing at the board and care to enhance mental health services including peer support services and augmented supervision for individuals being discharged from higher levels of care.

Other Services and Processes

Justice Services: Justice Services include Community Action Teams (CAT), Crisis Intervention Training (CIT) both in-custody and for community agencies, Outreach, Assisted Outpatient Treatment (AOT); Court Screening Diversion; Pre-trial Treatment; Jail Release (Forensic Re-entry Services); and Outpatient Treatment: Post -Trial treatment. Referrals to Justice Services come from the court, jail, or probation. The CAT referrals come from law enforcement and jail. There are no waitlists.

The Justice Programs include Forensic FSP and treatment courts. Forensic FSP team referrals come from mental health, law enforcement and the AOT FSP team. The AOT FSP team and a Forensic FSP team are SLOBHD-operated programs. In addition, there are treatment courts that provide individuals with an opportunity to receive treatment through the court system. The current and average census of the Justice Programs provided by SLOBHD staff is as follows:

Program	Clients Served/Year	Average Client Utilization at Any Given Time
Mental Health Treatment Courts	40	12-15
Drug and Alcohol Treatment Co-occurring Treatment Court (ASAM level 2.1 with mild to moderate mental health)	15-20	12
Forensic FSP (includes housing for 4 clients	15	15
Co-occurring Mental Health Treatment Courts	48	12-15

Communication and Treatment Admission Authorization: SLOBHD does not have a centralized system for authorizing admissions for individuals to higher levels of care. Various staff provide authorization for admissions to the PHF, IMDs, FSPs, and contracted board and cares. There are six to eight staff who coordinate these activities, but screening, triage, and authorization to various levels of care is only a small part of their duties. Several key informants reported the impression that client entry into the mental health treatment system is challenging and that the County staff seem more like gatekeepers and less like a welcoming care system. CSCG recognizes the pressures on County mental health staff to be selective in how limited public funds are used that were intended primarily for people with serious mental illnesses. It is challenging but important to present a welcoming no wrong door approach.

Programs in the mental health system of care have regular meetings with SLOBHD staff to share information and review clients. FSPs meet weekly with the County while housing meets one time per month. Case managers for the State Hospital and IMD clients communicate with these facilities quarterly along with the Public Guardian.

SLOBHD currently utilizes Anazasi for its Information Technology Electronic Health Record (EHR). Providers have access to the County EHR to communicate between programs and provide documentation of services. That data is used to track client access to outpatient care. As mentioned, beginning July 1, 2023, SLOBHD will transition to SmartCare through CalMHSA as its County EHR.

SLOBHD does not currently use clinical tools for determining levels of care or for utilization review and management. SLOBHD has policies and procedures for utilizing transition of care tools (3.05 Adult and Youth Screening and Transition of Care Tools), but these tools do not replace requirements for urgent or emergency needs, protocols that address clinically appropriate, timely and equitable access to care, mental health clinical assessments, level of care determinations, and service recommendations. Rather, these tools are designed to capture information necessary for identification of initial indicators of mental health needs for the purpose of determining whether the Mental Health Plan (MHP) must refer to CenCal, or to

an MHP provider (County or County-contracted) to receive an assessment. The screening tools focus on safety, clinical experiences, life circumstances, and risk. SLOBHD will be utilizing State developed tools in the next fiscal year when they are available.

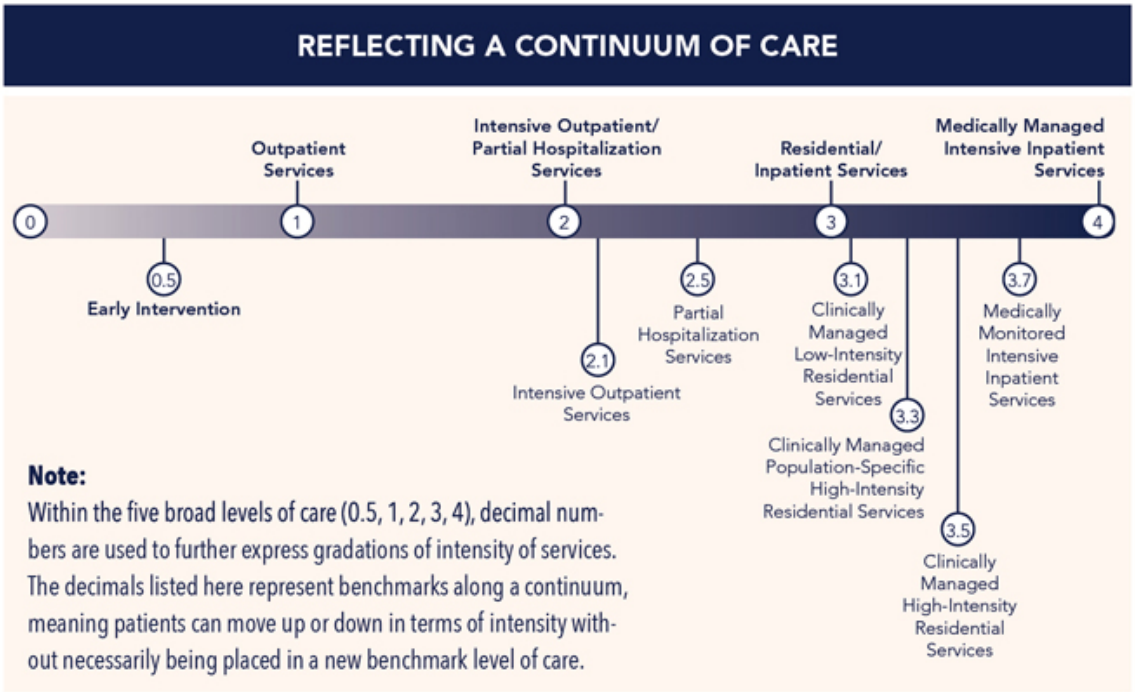
Recommendations:

- There is an opportunity for enhanced case management, sharing of information / data, and use of evidence-based tools to manage care within SLOBHD.

Substance Use Disorder (SUD) Delivery System in SLO

A review of the system of care for substance use disorders (SUD) in SLO revealed a full continuum of services through directly operated and contracted providers. This includes the services identified in Figure 1 and the American Society of Addiction Medicine (ASAM) levels of care (Figure 2). A strength in the SLOBHD system of care for substance use disorder is the coordination of access and treatment needs being centralized at the County level, including a multi-disciplinary treatment team that guides the screening and assessment process. The teams also use ASAM criteria to drive clinical decisions; and, there is a focus on recovery throughout the system.

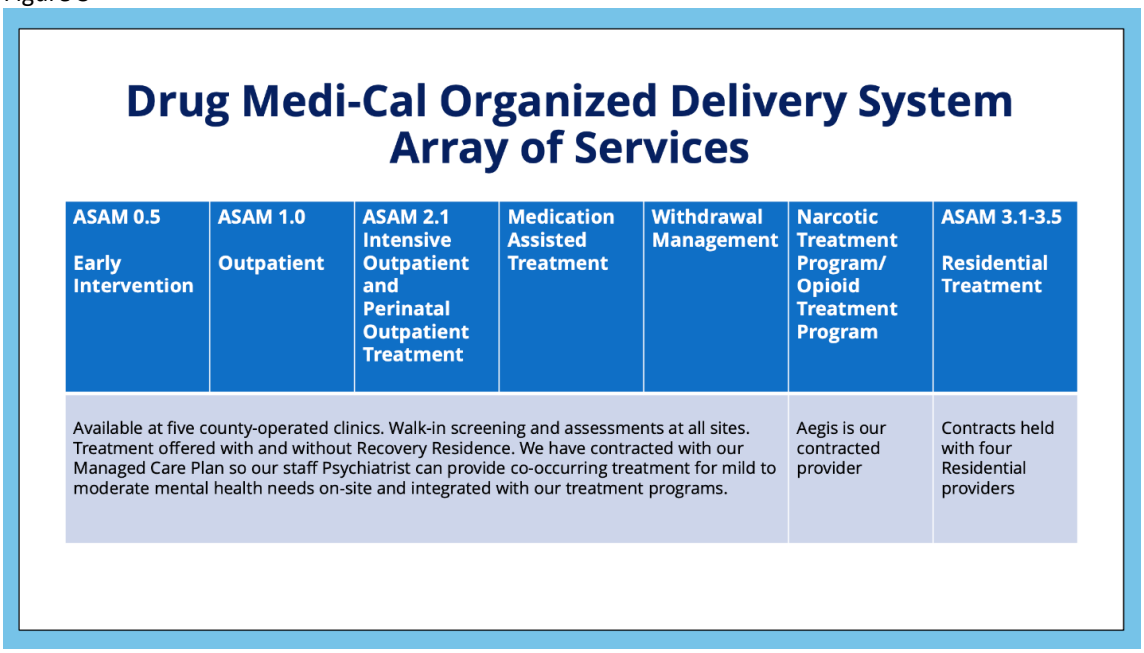
Figure 2[17],[18]



A review of the continuums of care in Figures 1 and 2 reveal the following services currently in the SLOBHD continuum of care (Figure 3):

[17] Asam.org
[18] DMC ODS does not provide level 4

Figure 3[19]



Prevention and Wellness Services | Peer and Recovery Services

SUD Prevention and Wellness Services / Peer & Recovery Services

Early Intervention (0.5) / Prevention: Recovery Services are provided at various points along the continuum. Through partnerships with local nonprofit organizations, recovery services are provided at the end of treatment to support clients and reduce risk for relapse. Key informants reported that more could be done related to aftercare services to prevent relapse. It was also noted that peers are used at various points in the continuum of care. The recent CalEQRO report on SLOBHD's DMC-ODS several strengths related to Early Intervention (0.5) / Prevention were noted. These include:

- Strong collaboration with the community, especially the school system, that includes education and related activities to prevent drug abuse.
- Naloxone training and community-wide distribution of overdose prevention kits with an added guide for local SUD treatment resources.
- Counselor training for early intervention techniques with clients showing signs of relapse to help them remain in treatment (this was the focus of one of their Performance Improvement Projects).

Recommendations:

- Consider opportunities to further expand prevention and peer / recovery services to those entering the system who do not meet medical necessity for higher levels of care.

[19] Provided by County of San Luis Obispo Behavioral Health Department

- Further examination of Aftercare Services to strengthen those services and prevent relapse.

SUD Outpatient and Intensive Outpatient Services

Outpatient Services (1.0) / Intensive Outpatient and Perinatal Outpatient Treatment (2.1): Outpatient services are those with less than 9 hours per week. This appears to be most of the services provided on an outpatient basis with an average of 9,550 units billed per month. Intensive outpatient services are those with more than 9 hours per week. SLOBHD provides an average of 1,900 units per month. All outpatient services are provided by the 5 directly operated SLOBHD clinics. The most recent CalEQRO report reveals that SLOBHD served 1,540 unduplicated, Drug Medi-Cal covered clients in 2021.

Medication Assisted Treatment (MAT): SLOBHD embeds MAT services (non-Narcotic Treatment Program (NTP)) in their directly operated facilities and has an excellent history with outpatient non-methadone MAT program for more than ten years. SLOBHD requires that other treatment services be provided alongside MAT services which is a best practice. Clients are monitored for compliance with treatment plan and levels of care. SLOBHD utilizes a licensed psychiatric technician (LPT) as part of the assessment process. If MAT services (non-NTP) are medically necessary, the LPT can begin the medication process. Due to regulatory changes, it appears as though this position may no longer be supported. Additionally, SLOBHD utilizes a contracted provider (Aegis) for NPT / Opioid Treatment Programs (OTP) through two of their facilities located in the county.

Partial Hospitalization (2.5): These services (outpatient services offered for 20 hours or more per week) are not currently offered by SLOBHD. With partial hospitalization programs, there is an opportunity to enhance the outpatient continuum for those with safe housing (i.e. sober living, family, etc.) and/or for those who could access safe housing. SLOBHD could couple this level of care with the sober living beds they are providing through their “room & board” day rates.

Recommendations:

- SLOBHD is already considering how to manage the loss of the LPT position as part of the assessment process. If the position cannot be replaced in the SUD programs, it is recommended that SLOBHD consider partnerships with FQHCs or other organizations so that this important process does not get lost.
- SLOBHD should consider adding the Partial Hospitalization level of care to its continuum for those requiring more than what is offered in intensive outpatient but who do not meet criteria for residential (or require a step-down from higher levels of care). This should be considered in conjunction with expansion of residential beds (see next section).

SUD Residential Treatment Services

SUD Residential Treatment Services

Residential Services (3.1 – 3.5): SLOBHD has 104 Recovery Residence beds, which is a strong showing for the size county and size of other services that SLO provides. These services are provided through 4 contracted providers at 9 locations. Utilization data show an average of 400 bed days per month at the 3.1 ASAM level of care (clinically managed, low intensity level of care); 0 bed days at the 3.3 ASAM level of care (clinically managed, high intensity level of care); and an average of 250 bed days per month at the 3.5 ASAM level of care (clinically managed, high intensity level of care). It is important to note that the 3.5 level of care is only available at out-of-county facilities. Within SLO, Bryan's House offers 3.1 ASAM Residential Level of Care for women and their children (6 beds for females who can have up to 2 children with them). SLOBHD has contracts with other providers for residential level of care (3.1 ASAM), including Sun Street Centers, operating 16 beds for males in SLO, (with programs in Monterey and San Benito counties), Good Samaritan (northern Santa Barbara County), and Tarzana Treatment Centers (Los Angeles County). Women without dependent children, must go to an out-of-county facility for treatment as there are no beds in SLO for females. There are wait list issues with this level of care. Discussions with the Director of Drug and Alcohol Services reveal the average wait list has 15 individuals awaiting this level of care, with wait times of 2-3 weeks. SLOBHD has engagement groups and case management services offered during this period which represents an opportunity for the future, including expanding services in the SLOBHD clinics to allow partial hospitalization along with sober living for this high-risk group. Given that SLOBHD is contracting these services to out-of-county providers, it may be worth exploring additional out-of-county contracts. Interviews with key informants revealed there may not be sufficient capacity to meet the needs of the community and admit new clients without unduly long wait lists (even with the additional beds added in August 2022). Anecdotes from hospital staff interviews suggest that SLO admission processes into the residential facility can be erratic and cumbersome, and waiting lists are unnecessarily lengthy. Outcomes are unclear. Finally, SLOBHD has done a good job putting together residential treatment options using out-of-county contracts. That said, this limits the amount of family work that can be done, which is an important part of the treatment plan for substance use disorders.

Recommendations:

- Develop and implement feedback channels to learn what the experience is like for prospective clients awaiting admission to this level of care. Develop and implement statistical mechanisms for determining the timeliness from first request to admission in that facility. Use the findings to determine if there are timeliness issues and, if so, whether they are rooted in cumbersome procedures that can be streamlined or in capacity issues that can only be addressed by expansion of bed capacity.
- SLOBHD should consider adding additional in-county beds for females so that clients who identify as female (who do not have children) do not have to be transferred out of county for care. The addition of Partial Hospitalization (noted in the prior section) might also be helpful in meeting this need.

Intensive Treatment Services

SUD Intensive Treatment Services

Withdrawal Management (W/M): Outpatient W/M is provided by SLOBHD for opiate and alcohol related disorders that can be safely managed on an outpatient basis. ASAM Level 3.7 (Medically Monitored, High Intensity Inpatient Services) are provided in partnership with local hospitals (through the Dignity Health System). Of note, SLOBHD has a clinician follow these individuals while in the hospital setting to ensure coordination of care to the next appropriate level of care. In addition, SLOBHD uses peer volunteers to help transition patients from the hospital level of care to other levels of care. These coordinating / navigating roles are important as this is a place where patients / clients can often get lost to follow up.

Recommendations:

- The recommendations listed in the prior section will be beneficial to consider here as well. This is an important time for SLOBHD to obtain systematic feedback so they can ensure the programs are accessible and effective which is important as individuals leave a detoxification level of care. Some opportunities to consider include:
    - Conduct focus groups and/or surveys of current and former clients of the ASAM levels of 3.2WM, 3.1 and 3.5 (residential care) regarding their experiences with trying to access admission.
    - Develop tracking systems with consistent data entry of dates for first request for residential withdrawal management and/or residential treatment followed by first screening, first assessment, and first day of admission. Analyze the data, produce reports on the timeliness results and present them at least monthly to management.
    - Ensure that discharge planning from ASAM level of 3.2WM begins quickly with sufficient staffing and is accompanied by case management follow-up to ensure that planned linkages with other services are made.
    - Track outcomes for ASAM level of 3.2WM, including readmissions to 3.2WM within 30 days and within 60 days of discharge.

Community Services and Supports | Peer and Recovery Services

SUD Community Services and Supports / Peer and Recovery Services

Peer and Recovery Services is a strength in the SUD system of care. SLOBHD utilizes volunteers and staff with lived experience throughout its continuum. Through their own staff or contracted providers, SLOBHD provides screening / assessments for clients in jails (via zoom or in-real life) and in the social services / welfare system of care. SLOBHD manages transportation for these clients. For those clients currently in jail who need a residential level of care, SLOBHD coordinates to ensure clients go directly from jail to the residential setting. Mental health services are embedded within the SLOBHD directly operated SUD programs. There is a psychiatrist available to see clients with mild to moderate mental health symptoms who coordinates care directly with the other treatment providers. The screening team and screening processes within SLOBHD's SUD system are also strengths. The County uses a walk-in system so all clients get seen same day for their screening. The team includes 2 clinicians, one Licensed Psych Tech, 1 case manager, and one clerical person.

While SLOBHD has many elements that are considered best practices, there are opportunities for the future. In terms of best practices, SLOBHD utilizes ASAM criteria to inform their level of care for each client; though, the recent EQRO[20] indicates moderate congruence between indicated level of care and referred level of care. They have a centralized intake function and same day / walk-in assessments available. This is critical in the treatment of SUD. Having said that, data was not provided on the time from that initial assessment to enrollment in care. There is evidence to suggest that this could be an area for improvement as clients may get "lost" while waiting to begin treatment. The most recent EQRO report on the DMC-ODS system of care for SLOBHD also suggests there are opportunities for improvement in how data is collected.

Recommendations:

- SLOBHD should develop and utilize data to examine its true wait times. This includes understanding the time from initial assessment to enrollment in care.

Recommendations for Mental Health Care and Substance Use Disorder Services

While useful to use the various levels of care to analyze the system of care, it is important to recognize that individual clients often require multiple levels of care and are receiving services in more than one place. While recommendations are described above by the various levels of care, the recommendations that follow are consolidated to address developing a more fully integrated system of care. Several recommendations were identified that fall into the following categories discussed in the section that follows:

1. Capacity: The capacity required to build out a more comprehensive system of behavioral health care for SLO
2. Processes: The processes needed to ensure the successful utilization of services
3. Programmatic: The critical components that should be included in program levels of care

Capacity required to build out a system of intensive behavioral services

Two factors related to capacity are critical. First, the system should ensure that services exist at all points along the continuum of care (i.e., there are no levels of care unrepresented). Second, there must be sufficient capacity within the programs that exist. Related to this is the need to consider geographic distribution of critical services to ensure accessibility to those in need.

- Based on reports, SLO appears to need more than the existing 16 beds of acute inpatient care found in their one PHF. It is recommended that SLOBHD and the hospitals develop a system to track how many individuals are being transferred out-of-county with the results of this tracking effort tempered by client outcome data related to

[20] https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Quality-Support-Team/EQRO-Reports/San-Luis-Obispo-DMC-ODS-EQRO-FY-2021-22-Final-Repo.pdf

optimal length of stay. This will help inform whether SLOBHD should purse an additional Psychiatric Health Facility (PHF) or create the acute hospital bed capacity to address the mental health needs of a county the size of SLO.

- Urgent Care Centers (UCCs) are clearly seen as a successful model for managing behavioral health crises. This is an area that CSCG highly recommends that SLOBHD explore further. While SLO has a small Crisis Stabilization Unit (CSU), utilization is low - even based on the current number of beds (4). It would be beneficial to consider full utilization of the existing CSU, with possible future expansion to another part of the county to address the anticipated expansion of demand associated with implementation of 988 and additional crisis teams. Further, experience in counties such as Los Angeles, Fresno, San Diego, and Orange suggests that most successful CSUs are LPS-designated in order to receive and treat individuals who are detained involuntarily. There are two recommendations here. First, CSCG recommends revisiting the model of services provided at this level of care. More specifically, it is recommended that SLOBHD explore LPS designation status for the CSU with the understanding that a change in treatment philosophy would be required. Second, should the change in treatment philosophy result in additional utilization of the current CSU, SLOBHD could consider adding capacity in the existing CSU location as well as in a second location, perhaps North County.
- Given the anticipated increase in demand for crisis services, and the challenge of finding stabilization services for individuals discharged from the PHF and CSU, CSCG recommends the creation of one or more Crisis Residential Treatment Programs. Each Crisis Residential Treatment Program should be between 10-16 beds in order to optimize economies of scale while preserving a welcoming and home-like environment. In addition, adding Enriched Residential Programs would enable longer-term stabilization with significant supports for individuals with serious mental illness. As SLO currently has no programs of this type within the county, prioritizing establishment of this type of facility may be beneficial. We recommend that SLOBHD consider adding the CRTP level of care to its continuum of care.
- As noted elsewhere in this report, there are differences in the lengths of stay in Psychiatric Health Facilities (PHFs), with SLOBHD's PHF having a much shorter length of stay compared to other County PHFs. While there may be county-level issues contributing to these differences, CSCG recommends that SLOBHD explore the reasons for these differences. Further analysis on readmission rates and ED visits might provide important information regarding optimal length of stay for this level of care.
- SLOBHD could benefit from further review of the service priorities currently addressed by the Mental Health Evaluation Team (MHET). For example, currently individuals in mental health crisis are served largely in hospitals, including emergency departments (EDs). The lack of psychiatric inpatient units in SLO results in the need for MHETs to respond to EDs to evaluate clients. Mental Health Urgent Care Centers (UCCs) could stabilize many clients in crisis thereby preventing the need for psychiatric hospitalization and freeing up some of the time of MHET for other purposes.

- While data was not obtained regarding FSP waiting lists, it is important to note that ensuring flow through the system to lower levels of appropriate care is predicated on having enough FSP slots without a delay in accepting new clients. Further, the successful transition of clients placed in out-of-county IMDs to residential placement hinges upon the immediate engagement with an intensive outpatient treatment program. Thus, CSCG recommends that SLOBHD consider the expansion of FSPs in all groups to increase flow through the various levels of care. In addition, key informants recommended that SLOBHD consider implementing an FSP-lite level of care for individuals transitioning from FSP to the outpatient clinics to prevent clients from "falling through the cracks" and returning to their FSP teams.
- Given the limited availability of board and care beds in SLO, we recommend that SLOBHD consider opportunities to expand availability both in and outside of the county.
- Within the substance use disorder system of care, there are capacity issues and wait lists for the more intensive services. Even with contracts for out-of-county beds, SLOBHD has an average wait list of 2-3 weeks for an average of 15 clients. SLOBHD may want to consider adding the partial hospitalization level of care to its system. This would provide an option for those not yet ready to be discharged to intensive outpatient but no longer requiring the residential level of care. As mentioned previously in this report, coupling the partial level of care with housing (in sober living or other safe, supported living environments) could help to ease the wait list and move individuals through the system more quickly. An alternative approach would be to explore additional contracts outside of the county. However, as stated earlier, this has disadvantages related to family work.
- There are a lack of SUD Residential Treatment beds for women without children in the county. Currently, clients who identify as female who do not have children must receive care outside of the county. It is recommended that SLOBHD explore ways to build capacity for this population within the county.
- There is a strong need to ensure geographic distribution of services – particularly crisis services – across the county. This is essential to ensure that no residents are disadvantaged by having to travel to locations that are inaccessible to receive treatment when they are in crisis. CSCG recommends further evaluation of how services are distributed between north and south County locations.
- FQHCs appear to be a relatively unused resource for treating the mental health and substance use needs of the County. Years ago, many counties with their health plans supported development of an integrated behavioral health capability within primary care teams. This proved to be an invaluable resource for clients and a great partnership strength for County behavioral health departments. With many lessons learns from other counties about how to best accomplish this, the questions for SLO County's BH System, CenCal and the FQHCs are: What are the perceived costs and risks versus value and benefits? If a decision is made to embark on such a venture, what would the stakeholders involved identify as the first steps? How would they work together to make it successful? This is something that could be consider during the stakeholder process.

The processes needed to ensure the successful utilization of services

- While SLOBHD makes intentional efforts to coordinate services (particularly in substance use disorder treatment), we did not find formal gatekeeping in place (especially in mental health services). CSCG recommends that SLOBHD explore adding a centralized access function which is staffed appropriately (staff are dedicated to this function). This would support full utilization of high-intensity services while also enabling tracking of waiting lists and identification of real-time system demands including where clients may be encountering difficulty in transitioning to an appropriate level of care.
- While SLOBHD does not currently have standardized clinical tools for evaluating clients' readiness for transition to alternative levels of care for mental health, CSCG noted that the County will begin using State tools for this purpose when they are available in July. SLOBHD is already utilizing ASAM criteria for SUD clients; however, there may be opportunities to improve the congruence between indicated level of care and referred level of care.
- Within the SUD system, individuals are encouraged to walk in to be seen. This suggests that waiting lists do not exist. However, it appears that there may be a longer wait time from that initial assessment to the first appointment for treatment. To promote an accurate picture of the length of waiting times and potential dropouts, a data collection system that records time to from first walk in contact to enrollment in treatment is recommended. (Of note, the SLOBHD staff suggested this information does exist; however, CSCG did not receive reports on this information.).
- To promote co-occurring services and coordination of care between mental health, SUD, and primary care systems, SLOBHD should consider the use of screeners who assess for a variety of behavioral health and primary care issues regardless of the system in which the client enters. Critical to the success of these efforts is having a place to refer the clients following the screener / assessment. Beyond these initial micro-level interventions, SLOBHD can consider how to share information across systems through written consents from the client(s) and technology-based solutions.
- Develop and implement feedback channels to learn what the experience is like for clients awaiting admission to higher levels of care, particularly for the recently launched residential treatment and detox center operated by Sun Street Centers. Develop and implement statistical mechanisms to determine timeliness from first request to admission in that facility. Use the findings to determine if there are timeliness issues and, if so, whether they are rooted in cumbersome procedures that can be streamlined or in capacity issues that can only be addressed by expansion of bed capacity.

Programmatic: Critical components of programs

Based on the input received from model mental health, substance use disorder and co-occurring disorders programs, several consistent themes and recommendations regarding program elements that contribute to high quality care emerged.

- SLOBHD should focus on fully integrated agencies and / or programs that represent the complete continuum of care. In the absence of this, SLOBHD can focus on the establishment of formal and informal partnerships with other local providers to ensure all elements of the continuum are represented. It is recommended that these partnerships be formalized with MOUs or other agreements. Primary care organizations such as FQHCs should be included in the array.
- SLOBHD and providers should ensure the continued or expanded use of peers, community health workers and other "nontraditional" providers such as mentors, members of the faith community and others to address the needs of clients while also responding to the current workforce crisis. This may include the ongoing operation of training programs for individuals with lived experience of a mental illness, substance use disorder and / or homelessness, the development of a clergy academy, use of interns, and other options.
- SLOBHD and providers should operationalize the recovery model at all levels of care. For example, clients in residential placements such as CRTPs and SUD treatment can – and should – be involved in the governance of and participation in community activities to ensure successful community reintegration.
- SLOBHD and providers should ensure that all programs – particularly residential treatment facilities – are rich in programming and offer food and environments that are pleasant and welcoming to deter clients from leaving prior to achieving full benefit of the program. It is critically important to consider and include trauma informed services and environments.
- SLOBHD and providers should consider augmenting staffing at adult residential facilities (board and care homes) to enhance mental health services including peer support services and augmented supervision for individuals being discharged from higher levels of care.
- With the current workforce crisis, ensuring behavioral health staff represent the clients being served is more challenging. That said, it is critical that programs are representative of the diverse needs of the communities served (age, race, language, religion, gender identification, etc.). The Behavioral Health System must address disparities in pay for staff that keep people from electing to work in the field.

We wish to thank the many staff of Transitions-Mental Health Association, the San Luis Obispo Behavioral Health Department, and community partners and hospitals who contributed information for this report. Their dedication, time and knowledge were invaluable in informing this assessment of behavioral health services for adults in San Luis Obispo County.

Appendices

Appendix A – Acknowledgements

Capstone Solutions Consulting Group would like to thank the following individuals and departments for their time and engagement on this project.

Name	Title	Department
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Trista Ochoa	Director of Peer Support	Transitions-Mental Health Association
Vince Pierucci	EMS Director & MHOAC	County of San Luis Obispo Health Agency

Appendix B – SLO Data[21]

Level of Care	Facilities / Individuals in SLO Providing this level of care	Capacity
Assertive Community Treatment	0	n/a[22]
Sobering Centers	0	0
Psychiatric units within general acute care hospitals	0	0
Psychiatric Acute Care Hospitals	0	0
Psychiatric Health Facilities	1	16 beds
Number of Psychiatrists	91	n/a
Psychiatrists per 100,000 individuals	32.3	n/a
Permanent Supportive Housing	n/a	357 total year round beds
Other Permanent Housing	n/a	4 total year round beds
Transitional Housing	n/a	31 total year round beds
Rapid Rehousing	n/a	404 total year round beds
Short-term Residential Therapeutic Programs	2	18 beds
Community Treatment Facilities	0	0
Crisis Stabilization Units	1	24 slots
Jail-based Competency Treatment Program	n/a	5
Crisis Intervention Teams	1	n/a
Pre-Trial Diversion Program Petitions Received	n/a	0 Petitions Received in Q1 2020
Prison Community Reentry Programs	6	42
Community Based Restoration Program Capacity	n/a	0

Level of Care	Beds / Slots Available	Number of Beds / Slots Needed	Gap between available and needed beds / slots
Acute Psychiatric Inpatient Beds	16	22	6
Crisis Stabilization Units and PHF	24	13	11
Mobile Crisis Teams (number of teams)	2	2	0

[21] Adapted to show SLO only data from the Manatt Health (with support from Dr. Anton Nigusse Bland), "Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives and Implications.", January 10, 2022. Available at: https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

[22] Not applicable or not include in the report

Appendix C – Review of programs from other counties

As background information, interviews were conducted with key informants outside of SLO County to identify elements that have been critical to their success in providing intensive services. These have been described below as Successful Models and specific Program Examples from other counties.

Successful Models

Crisis Services

There are several models for providing crisis services, including mobile crisis response teams, urgent care centers and crisis residential services. Starting with mental health urgent care centers (UCCs), a model was examined to better understand the key elements that are necessary for successful implementation. The key services include assessment, stabilization services, and medication evaluation and management. Hospitalization is arranged for individuals who require inpatient care. Of note is the very low rate of hospitalization (10%) for individuals served by the urgent care center reviewed. UCCs can be open and available 24 hours per day, 365 days per year. Certification is required to operate. The UCCs are certified as Crisis Stabilization Units and are Lanterman-Petris-Short (LPS) designated. The UCCs coordinate with law enforcement and other first responders, taking ambulance and law enforcement drop offs and providing a medication walk-in clinic on site.

Another level of care for crisis stabilization are crisis residential services. These programs provide crisis stabilization and support for individuals who have persistent or acute mental illness through structured, intensive programs that clients can attend for up to 28 days (longer lengths of stay can be arranged through authorization by the county mental health department). These programs help to decrease hospitalization and / or re-hospitalization of clients who may already engaged in other levels of treatment. For example, clients in intensive outpatient programs can be admitted for stabilization in a crisis residential program. Crisis Residential Treatment Programs can also serve as a step down from higher levels of care, such as acute psychiatric hospitalization. Licensure is required by the Department of Social Services and certification is required by the Department of Health Care Services.

Critical elements of successful crisis services include:

- Comprehensive care is provided by an interdisciplinary team of MDs, nurse practitioners, R.N.'s, and therapists (including licensed mental health staff), practitioners with lived experience and non-licensed treatment staff. Services include mental health assessment, medication evaluation and management, therapeutic interventions, social services, referrals to community programs and other resources, and discharge planning that ranges from home to hospital.
- Coordination with other services and levels of care, including primary care clinics, shelter beds, outpatient services, full-service partnerships, hospitals and other providers and services.

- Co-occurring capable: Staff are cross-trained, and assessments include questions related to a client's mental health, substance use, trauma history, and medical issues.
- Seamless transitions for clients: These programs either provide multiple levels of care for clients or have strong partnerships with other programs that do to ensure that clients can move from one level of care to another without delay.
- A focus on recovery and community reintegration: Those in residential treatment fully participate in the running and governance of the residence.

Barriers:

- Workforce issues include hiring according to discipline and retention.
- Bed resources and community placements are limited resulting in longer lengths of stay.
- Longer-term length of stays for mental health may be needed.
- Limited community housing options and outpatient mental health services create barriers to linkage upon discharge.

Intensive Treatment Services

Another level of intensive treatment is Adult Residential Facilities (ARF). These programs serve individuals who are ready for discharge from Institutions for Mental Diseases (IMDs), Acute Psychiatric Inpatient Units, or Crisis Residential Facilities, and who need a safe place to live, require augmented supervision in housing, intensive mental health and / or substance use treatment services and medical care. Treatment for mental health disorders, substance use disorders and primary care can be provided on-site or through partnership with other community partners. These partnerships are critical and should be formalized through memorandums of understanding (MOUs) or other agreements to ensure access to the services for clients at this level of care. Program goals are to meet the need for intensive mental health and substance use treatment services and to assist clients to transition successfully to community living.

Critical elements to the successful programs include:

- Peer support staff.
- Recovery-oriented and community re-integration activities.
- Linkage to on-going community-based treatment services.

Barriers:

- Workforce issues including staff hiring and retention.
- Lack of housing including supportive housing, board and cares and available outpatient services on discharge.

Full Continuum of Services

Some programs interviewed provide a full continuum of services, including primary medical care, dental care, and behavioral health care, representing a true, "no wrong door" approach. While these programs have grown over many years to provide the range of services they

provide today, there are opportunities to replicate this approach through MOUs, data sharing and other care coordination.

Critical success elements in programs offering a full continuum include:

- All patients are screened and assessed for medical and behavioral health conditions and receive whole person care guided by an integrated treatment plan.
- Treatment is integrated for mental health, substance use, and primary medical issues with access to detox, inpatient, residential and outpatient treatment levels of care.
- Program environments are responsive to issues of diversity, equity and inclusion and include trauma responsive and trauma informed approaches.
- Peer Support Services are integrated throughout the continuum. Peer Navigators ensure that clients have someone who they can call for questions. This combination of empathy and personal success can have a strong impact on clients struggling in their journey.
- Treatment is guided by population-health metrics and patient-centered care standards to ensure integrated services that are coordinated, comprehensive, and team-based.
- These programs live a no wrong door philosophy. Given the variety of services provided, all clients / patients are screened and provided the care they need at the right level. For example, someone coming in for dental care is also assessed for behavioral health concerns and can also receive those services (and vice versa). This is done through integrated assessments and / or screeners.
- There is a low barrier to entry for problematic drug use that creates a true safety net. This means that even if someone is still using, they can get services that they want / need. One day, it may mean that they need food. The goal is to begin the trust building process so that they come back when they want other services as well.
- Treatment begins when clients enter detoxification. In the past, detoxification was often focused only on the medical management of care. It is now considered part of the treatment plan and process.
- Co-occurring Capable Staff and Programs are present throughout these organizations. Staff throughout these organizations are cross trained on assessments and screeners that include questions for mental health, substance use and medical issues. When someone has a mental health diagnosis and is in residential treatment for substance use, their mental health needs are also addressed (and vice versa).
- Long-term Transitional Housing is available. Key elements of success in these programs include peer coaches, 24-hour awake staff, outpatient treatment, medical care, and dental care.
- Systems that help keep people connected. Outreach and community-based teams know how to keep people connected. They find out where they sleep. They do not lose track of them. The meet the clients where they are.
- Engagement is based on social determinants of health. This drives the engagement and interactions with clients. This requires highly skilled staff that understand the complex

interactions between how an individual is housed or unhoused, their mental health needs, use of substances, primary care, etc.

Barriers:

- Workforce issues, including hiring and retention, make it harder to maintain the integration of services. It was also notes that it is harder to recruit for mentors / peers for communities of color.
- Lack of bed resources and community-based services that are critical to successful discharge planning and successful community reintegration.
- Longer-term length of stays for mental health needs are needed.
- The Drug Medi-Cal Organized Delivery System (DMC-ODS) and managed care systems are designed for large facilities. System does not support smaller programs financially.

Program Examples

Exodus Recovery delivers urgent care services in four Mental Health UCCs contracted with the Los Angeles Department of Mental Health. The UCCs provide a welcoming environment where individuals 12 years of age or older who are in crisis can be assessed and provided with stabilization services and medication evaluation and management. Hospitalization is arranged if necessary. The UCCs overall rate of hospitalization for individuals admitted to the program is 10 percent. The UCCs are open and available 24 hours per day, 365 days per year. The UCCs are certified as a Crisis Stabilization Units and are LPS designated. The UCCs take ambulance and law enforcement drop offs and provide a medication walk-in clinic on site.

Critical elements of their successful programs include:

- Comprehensive care by an interdisciplinary team of MDs, Nurse Practitioners, R.N.'s, and Therapists who provide mental health assessments, medication evaluation and management, therapeutic interventions, social services, referrals to community programs and resources, discharge planning that ranges from home to hospital.
- Access to primary care clinics and dedicated shelter beds.
- Medi-Cal certified and LPS designated.
- Integrated treatment for co-occurring substance use disorders through co-located providers of the Department of Public Health Substance Abuse Prevention and Control program (SAPC) or directly through Exodus which is also a certified substance use treatment provider for SAPC in Los Angeles County.
- The operation of programs that represent a continuum of care, ensuring seamless transitions for clients.

Barriers:

- Workforce issues include hiring according to discipline and retention.

- Bed resources and community placements are limited for individuals on discharge resulting in overstays.

The Didi Hirsch Community Mental Health Center (Didi Hirsch) runs several crisis residential treatment programs in Los Angeles County. One example is Jump Street, a crisis residential treatment program that provides crisis stabilization and support for individuals who have persistent or acute mental illness. Jump Street's crisis services are provided through a structured, intensive program that clients can attend for up to 28 days. Longer lengths of stay must be authorized by the mental health department. Clients can be admitted from outpatient intensive programs to avoid hospitalization or directly from hospitals to continue crisis stabilization. With capacity for 10 clients, Jump Street creates a welcoming, home-like environment where clients can regain the dignity and sense of responsibility that are critical to hope and wellness. Staff works with residents to foster self-care, improve coping skills, and stabilize psychiatric medication. Clients are linked with community services prior to discharge.

Elements critical to their successful program include:

- Licensed mental health staff, paraprofessional staff, and psychiatrists for medication management.
- Co-occurring capable. Staff are cross trained on providing mental health, substance use and medical assessments.
- Linkages to a variety of community-based resources, including but not limited to, Full-Service Partnerships and outpatient clinics on discharge from the program.
- A focus on recovery and community reintegration, evidenced by the expectation that residents will fully participate in the running and governance of the residence.

Barriers:

- Longer-term length of stays for mental health may be needed.
- Limited community housing options and outpatient mental health service capacity create barriers to linkage upon discharge.

Gateways-Percy Village is an Adult Residential Facility (ARF) located in the Boyle Heights area of Los Angeles that provides housing for adults ages 18 and above. The program serves individuals, who are ready for discharge from Institutions for Mental Diseases (IMDs), Acute Psychiatric Inpatient Units, or Crisis Residential Facilities, and who need a safe place to live, require augmented supervision in housing, and intensive mental health and substance abuse treatment services from an

off-site Medi-Cal certified mental health clinic. The program partners with an established Federally Qualified Healthcare Center to provide medical care at the housing site. The program's goal is to meet the need for intensive mental health and substance use treatment services to assist clients in successfully transitioning from intensive placements to community living.

Critical elements to the successful program include:

- Housing in a licensed adult residential facility (ARF).
- Intensive mental health and substance use treatment for co-occurring disorders from an outpatient Medi-Cal certified clinic mental health outpatient clinic nearby.
- Primary care services and access to specialty medical services, if required.
- Augmented supervision 24/7 seven days per week at the ARF.
- Peer support staff.
- Recovery-oriented and community re-integration activities.
- Linkage to on-going community-based treatment services.

Barriers:

- Workforce issues including staff hiring and retention.
- Lack of housing including board and cares and available outpatient services capacity on discharge.

Tarzana Treatment Centers (TTC) is a non-profit, full-service integrated healthcare organization, provides high quality, cost-effective Substance Use Disorder and Mental Health (SUD/MH) treatment, primary medical and HIV/AIDS services for adults and youth in an integrated and community- based model of care. TTC is accredited by The Joint Commission and certified by them as a Behavioral Health and Patient Centered Medical Home. TTC is also licensed by the State of California and certified by the County of Los Angeles.

Critical elements to the TTC successful programs include:

- All patients are screened and assessed for medical and behavioral health conditions and receive whole person care guided by an integrated treatment plan.
- Integrated mental health, substance abuse treatment, and primary care with access to detox, inpatient, residential and outpatient treatment levels of care.
- Housing and Peer Support Services.
- Treatment guided by population-health metrics and patient-centered care standards to ensure integrated services that are coordinated, comprehensive, and team-based.

Barriers:

- Workforce issues including hiring and retention.

- Lack of bed resources and community-based services that are critical to successful discharge planning and successful community re-integration.

HealthRight 360 has programs located in 11 counties throughout the state of California. Services provided include medical care, dental care, behavioral health outpatient and residential treatment, re-entry services and a mobile medical van.

Critical elements to their successful programs include:

- No wrong door philosophy. Given the variety of services provided, someone coming in for dental care is also assessed for behavioral health and can also receive those services (and vice versa).
- Low barrier to entry for problematic drug use to create a true safety net. This means that even if someone is still using, they can get services that they want / need. One day, it may mean that they need food. If they get it from HealthRight 360, they know where to go when they want other services, including behavioral health services.
- Detoxification is where treatment starts. In the past, detoxification was often focused only on the medical management of care. It is now considered part of the treatment plan and process.
- Co-occurring Capable. Services throughout their organization are cross-trained and include mental health, substance use and medical assessments. When someone has a mental health diagnosis and is in residential treatment for substance use, their mental health needs are also addressed.
- Long-term Transitional Housing. Key elements of success in these programs include peer coaches, 24-hour awake staff, outpatient treatment, medical care, and dental care.
- System that keeps people connected. Outreach and community-based teams that know how to keep people connected. They find out where they sleep. They do not lose track of them. Meet them where they are.

Barriers to success:

- Longer-term length of stays for mental health needs are needed.
- The DMC-ODS and managed care systems are designed for large facilities. System does not support smaller programs financially.

Turning Point Community Programs (TPCP) has programs located in 10 counties throughout the state of California. Services provided include mental health residential, crisis residential, emergency response, peer run services, housing supports, outpatient services, mental health urgent care clinics and substance use treatment.

Critical elements to their successful programs include:

- Engagement is based on social determinants of health. This drives their engagement and interactions with clients. This requires highly skilled staff that understand the complex interactions between how an individual is housed or unhoused, their mental health needs, use of substances, primary care, etc.
- System of care. The public sector system of care in Sacramento is strong and more integrated (than the private sector).
- Peer Navigators. This role is critical in ensuring that clients have someone who they can call upon when they have questions. This helps to show how someone can flourish in life.

Barriers to success:

- Workforce issues. These include staffing shortages, generally; and, staffing of staff with specific expertise. For example, finding case managers who are trained to understand co-morbid conditions (substance use, mental health, and medical issues). Many employees get burned out on the volume of paperwork and are leaving for private sector roles (i.e. Kaiser is one employer who is paying substantially higher salaries).
- Lack of mentors / peers for communities of color.
- Transition from urgent care. Beds are limited but critical to a successful discharge.