# CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

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

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

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California Behavioral Health Planning Council
Advocacy • Evaluation • Inclusion

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

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

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

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

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

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

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

## How the Data Notebook Project Helps You

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

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

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

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

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

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

## Adult Residential Care

**There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[5] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.**

**The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[6] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as an**

**occupancy or treatment slot for one person for one day.**
**One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.**

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

1. Please identify your County / Local Board or Commission.
   Mendocino
2. For how many individuals did your county behavioral health department pay some or all the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?
   29
3. What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?
   8145
4. Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?
   Not Available

5. Does your county have any "Institutions for Mental Disease" (IMDs)?

☒ No

☐Yes (If yes, how many IMDs?)

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

In-County

Out-of-County: 36

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

7774

## Homelessness: Programs and Services in California Counties

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

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

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

**Every year, the states, counties, and many cities perform a "Point-in-Time" count[7] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021.**

**Preliminary data for January 2021 had been posted in early February 2022, but those only contained data for the individuals in shelters or other temporary housing. There was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re- posting. The count for 2022 took place in many communities during the last week in February. The federal analysis and publication of that data will not be available for at least**

**six to twelve months. Therefore, we are presenting the previous year's data for January 2020 in Table 3 as a baseline reference for comparison to the most recent year's data for 2021 and/or 2022, whenever that data becomes available. (Please refer to your 2022 Data Notebook pdf document for Table 3.)**

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

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

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

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

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

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

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

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

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

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

9. Do you think your county is doing enough to serve the children/youth in group care?

☒Yes

☐No (If no, what is your recommendation? Please list or describe briefly)

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

10. Has your county received any children needing "group home" level of care from another county?

☐No

☒Yes (If yes, how many?)

4

11. Has your county placed any children needing "group home" level of care into another county?

☐ No

☒Yes (If yes, how many?)

13

## Background and Context

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

**The major themes are as follows:**

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

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

**In the strictest sense, we may not be able to establish that any of the changes in 2020-2021 were due to effects of the pandemic itself. Nonetheless, the continuing trends in 2020 and 2021 are cause for concern**

**and attention, regardless of the difficulty of distinguishing cause from correlation and mere chance. Note that in our questions and discussion we often use the shorthand of speaking about the effects of Covid-19 on clients' mental health or on a county system's ability to respond to the larger challenges of the pandemic. We are not speaking in the biologic sense of what this virus does to a person's body, but rather the totality of the pandemic experience as we face this ongoing public health emergency.**

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

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

Behavioral health challenges faced by children and youth have been presented in news stories and medical, pediatric, or psychology journal reports. Most recently, this urgency led the U.S. Surgeon General to issue a special health advisory[8]:

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

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

The pandemic added to the pre-existing challenges that America's youth faced. It disrupted the lives of children and adolescents, such as in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic's negative impacts most heavily affected those

who were vulnerable to begin with, such as youth with disabilities, racial and ethnic minorities, LGBTQ+ youth, low-income youth, youth in rural areas, youth in immigrant households, youth involved with the child welfare or juvenile justice systems, and homeless youth. This Fall, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

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

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

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

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

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

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

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

For example, during the pandemic, the hardest-hit communities for Covid-19 cases, hospitalizations, and deaths were Hispanic/Latino, African American, and Native-American people.[9] Some of these individuals were also the most difficult to reach by the public health Covid-19 teams. And

due to the prevalence of misinformation, significant numbers were hesitant to get vaccinations, even though many work in 'front-line' positions exposed to the public, and many live in multi-generational households. Thus, any exposure to Covid-19 put entire families at risk of Covid-19. There are those who distrust governmental agencies for health and social services. Data reported in early 2022 also found problems in access to specialized treatment for "long Covid"[10] symptoms for some African Americans and other persons of color when compared to white people. Numerous cross-cultural challenges affect access to services for both physical and mental health, including better adapting our outreach and messaging.

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

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

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

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

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

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

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

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

☐Decreased access/utilization of mental health services for youth. None of the above

☒Other (please specify)

Staffing shortages caused delays in care.

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

Top concerns for children and youth services

1. Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.
2. Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment.
3. Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit)

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

Telehealth for children and youth was ineffective for some clients. Providers were overworked and had limitations on support they were able to offer families due to COVID safety protocols. There was a significant shortage of providers during this period leading to delays in service. It was more difficult to access children as they were not in the school system and parents had difficulty connecting with services.

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

☐Increased numbers of adults presenting for services who report thoughts of suicide or other thoughts of self-harm.
☒Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.
☒Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.
☐Increased Emergency Department admissions for episodes of self-harm and suicide attempts among adults.
☒Increased Emergency Department visits related to misuse of alcohol and drugs among adults.
☒Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).
☒Decreased access/utilization of mental health services for adults.
☐None of the above
☒Other (please specify)
Telehealth worked better for adults than children and overall adults seemed to have better access during the pandemic. The exception was access to med-management due to psych provider access. There was also a notable increase in substance use including overdoses.

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

- Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.
- Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.
- Increased Emergency Department visits related to misuse of alcohol and drugs among adults.

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

Behavioral Health Staff and Contracted Providers are to be commended for continuing to provide services, adapt quickly, and put themselves on the front lives to help people during this difficult time.

18. Since 2020, has your county increased the use of telehealth for all adult behavioral health therapy and supportive services?

☒ Yes ☐ No

19. Since 2020, has your county increased the use of telehealth for psychiatric medication management for all adults?

☒ Yes ☐ No

20. Does your county have tele-health appointments for evaluation and prescription of medication-assisted treatment (MAT) for substance use disorders?

☒ Yes ☐ No

Not applicable (if your board does not oversee SUD along with mental health)

21. Many or most MAT programs rely on in-person visits by necessity in order to get certified to provide these services. [Some of these medications include buprenorphine, methadone, suboxone, emergency use Narcan]. As part of SUD treatment services, are you able to coordinate routine drug testing with clinics near the client?

☐ Yes ☒ No

Not Applicable (if your board does not oversee SUD along with mental health)

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

Drug testing is done onsite

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

☒Increase in funding for crisis services
☐Decrease in funding for crisis services
☒Issues with staffing and/or scheduling
☐Difficulty providing services via telehealth
☐Difficulty implementing Covid safety protocols

☐None of the above
☐Other (please specify)

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

Staff out to quarantine for self: 1

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

Staff re-directed or re-assigned to support the COVID-19 teams: 3

Staff unable to obtain daycare or childcare: 4

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

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

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

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

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

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

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

☐Difficulty with or inability to utilize telehealth services

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

☒Inadequate staffing to provide services for all clients

☒Lack of transportation to and from services

☒Client or family member illness due to Covid-19

☒Client disability impairs or prevents access

☒Mistrust of medical and/or government services

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

☐None of the above

☐Other (please specify)

**Post-Survey Questionnaire**

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

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

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

☐MH Board completed majority of the Data Notebook

☒Data Notebook placed on Agenda and discussed at Board meeting.

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

☒MH board partnered with county or Director.

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

☐Other (please specify

29. Does your board have designated staff to support your activities?

☐No

☒Yes (if yes, please provide their job classification)

Department Analyst II

30. Please provide contact information for this staff member or board liaison.
**Name** Rosanna Santos
**County** Mendocino
**Email Address** santosr@mendocinocounty.org
**Phone Number** (707) 472-2706

31. Please provide contact information for your Board's presiding officer (Chair, etc.)
**Name** Flinda Behringer
**County** Mendocino
**Email Address** mhboard@mendocino.com
**Phone Number** (707) 472-2310

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

Questions seemed on point this year. Please make the font bigger on the form. It was very hard to read/work with.