



# ASSESSING SERIOUS MENTAL ILLNESS LEVELS OF CARE IN CALIFORNIA

*Recommendations for*



**STEINBERG  
INSTITUTE**

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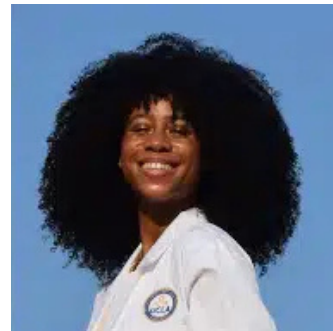
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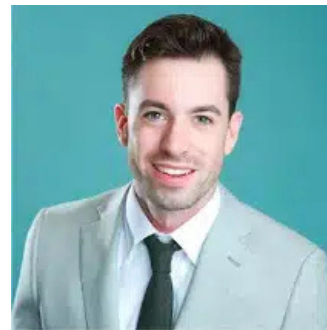
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# Glossary of Terms

*All terms are defined in the context of mental health.*

**Any Mental Illness (AMI)<sup>1</sup>:** A mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below).

**Serious Mental Illness (SMI):** A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.

**Serious Mental Illness (SMI) Prevalence:** The proportion of the overall population that has an SMI. It is calculated by multiplying national prevalence rates by population based on age, sex, county, and race/ethnicity.

**Serious Mental Illness (SMI) Treatment:** An individual who enrolled in a public mental health service designed for individuals with an SMI.

**Managed Care Plans (MCP):** Plan through which mental health services are provided for those with mild to moderate mental illnesses.

**Mental Health Plans (MHP):** Medi-Cal plans through which Specialty Mental Health Services (SMHS) are provided to individuals with SMIs.

**Specialty Mental Health Services (SMHS):** Services provided through county Mental Health Plans (MHPs) that provide more intensive and specialized treatments and supports. Services under SMHS encompass treatments for individuals with SMIs (e.g. crisis services, inpatient care, ACTs and FSPs), in addition to broader Mental Health Services (MHS).

**Full-Service Partnership (FSP) Programs:** Part of Specialty Mental Health Services, FSPs are one of the most intensive outpatient services for individuals with SMIs that takes a ‘whatever it takes’ approach to care and aims to serve people in the community rather than in facilities. By using evidence-based practices and recovery-oriented care approaches, FSPs are unique from other programs because they provide 24/7 crisis availability, multidisciplinary mental health teams, and low client to staff ratios.

**Assertive Community Treatment (ACT) Programs:** Part of Specialty Mental Health Services, ACTs provide the highest level of community-based outpatient care for adults who are experiencing or at risk of homelessness, have a serious mental illness, and/or have a substance use disorder. Similar to FSPs, ACT is an intensive case management treatment model that adopts a ‘whatever it takes’ approach to care, with in-person services provided several times per week including weekends and holidays, in addition to regular business hours. ACTs and FSPs can be interchangeable in some cases, as FSPs can adhere to the ACT model.

1. Baylor, K. (2014). Overview of Medi-Cal Mental Health Delivery Systems in California and Utilization of Specialty Mental Health Services by Child and Adolescent Medi-Cal Beneficiaries. California Department of Healthcare Services. <https://www.dhcs.ca.gov/services/Documents/073114DeenDiveTopicPresentation.pdf>

2. Contracts & Medicaid State Plan. (2025). Dhcs.ca.gov; California Department of Healthcare Services. <https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx>

3. Medi-Cal Specialty Mental Health Services. (2023). Dhcs.ca.gov; California Department of Healthcare Services. [https://www.dhcs.ca.gov/services/Pages/Medi-Cal\\_SMHS.aspx](https://www.dhcs.ca.gov/services/Pages/Medi-Cal_SMHS.aspx)

4. Full Service Partnerships. (2024, December 6). Bhsoac.ca.gov; Commission for Behavioral Health. <https://bhsoac.ca.gov/initiatives/full-service-partnerships/>

5. CalAIM Behavioral Health Workgroup. (2023). California Department of Healthcare Services. <https://www.dhcs.ca.gov/Documents/12-1-23-CalAIM-BH-Workgroup-MCBH-Presentation.pdf>



**Sub-Acute Mental Health Programs:** A bridge between acute care and independent living, sub-acute programs provide 24/7 psychiatric, nursing, and psychosocial rehabilitation services in a locked setting for individuals with serious mental illness.

**Mental Health Levels of Care:** Refers to a framework that categorizes different types and intensities of care based on an individual's needs. Levels of care guide practitioners in assessing the appropriate treatment, preventing both under-treatment and over-treatment.

**Adult Screening Tool for Medi-Cal Mental Health Services:** a worksheet, developed by DHCS, used by practitioners for every individual seeking public mental health services. Results are used to determine the type of services an individual needs (NMHS or SMHS).

**CalAIM Assessment:** A framework required by Department of Healthcare Services (DHCS) to assess individuals who have been deemed eligible for SMHS. The assessment aids practitioners in evaluating individuals, to be included in medical records.

**Serious Mental Illness (SMI) Level of Care Tools:** Frameworks/worksheets used to determine the appropriate Medi-Cal mental health delivery system to refer to an individual who has been identified as having an SMI. Each level of care is used to indicate a level of intensity or severity of a treatment or program. These tools are utilized by county practitioners for individuals deemed eligible for Specialty Mental Health Services.

# Executive Summary

California is facing a mental health crisis, with serious mental illness (SMI) affecting over 1.7 million adults annually. Despite various policy initiatives, significant treatment gaps remain.

This report, prepared for the Steinberg Institute, assesses how different counties define and assess levels of care for adult individuals with SMIs. Through a combination of quantitative data analysis and qualitative interviews with county officials, we estimate the prevalence and treatment rate of SMI throughout the state and examine the variation in assessment tools, processes, strengths, and challenges in service delivery. Our findings reveal that:

- **SMI prevalence disparities exist across counties:** SMI prevalence and public services treatment rates vary widely across counties, with many treatment rates below 30% for affected individuals.
- **Different Level of Care assessment tools can lead to inconsistencies:** Counties use a range of level of care assessment tools, including LOCUS, LIST, and ANSA, leading to inconsistencies in patient placement and care quality.
- **Outdated data infrastructure impedes data quality:** Antiquated systems can limit counties' ability to track and assess mental health service effectiveness.

## Policy Recommendations

Based on our findings, we developed four policy options and evaluated them using a Criteria Alternatives Matrix (CAM) based on four criteria: (1) equity, (2) effectiveness, (3) efficiency, and (4) feasibility. Based on this evaluation, we propose two recommendations:

- **Continue Research on Levels of Care:** We recommend that the Steinberg Institute continue investigating the role of level of care assessments in mental health service delivery. Future research could focus on how different assessment methods influence treatment engagement, resource allocation, and overall health outcomes for individuals with serious mental illness.
- **Strengthen Data Infrastructure for Level of Care Assessment:** Create standardized reporting across counties and require updated systems. This would allow policymakers to identify gaps in service delivery, assess the effectiveness of different levels of care tools, and allocate resources more equitably.

## Future Research

In addition to our policy recommendations, our findings show that future research is necessary to fully understand how standardization of assessment tools influences disparities in care, particularly among vulnerable populations such as young adults and racial minorities.

By adopting these recommendations and pursuing further research, California can work toward a more equitable, efficient, and effective mental health system that ensures adult individuals with SMI receive appropriate care.

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## SECTION ONE



# INTRODUCTION

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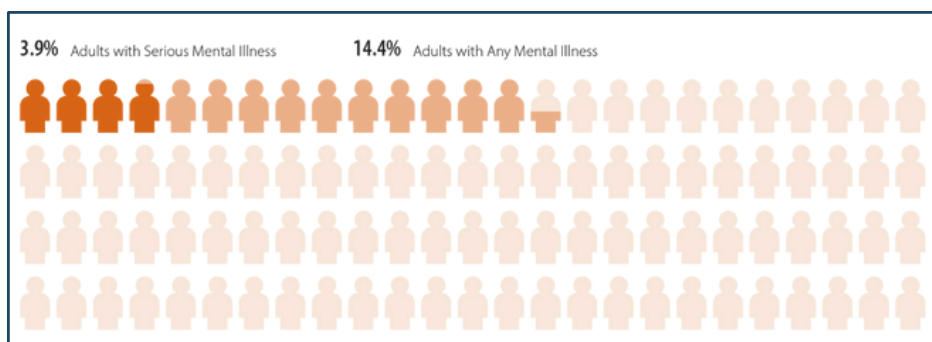
# Introduction

## California's Mental Health Crisis

Mental illness is a serious public health concern that has lasting effects on a person's ability to function successfully in society. It is typically defined as a health disorder that involves significant changes in emotion, thinking and/or behavior, and problems functioning in social, professional or family scenarios.<sup>9</sup> Untreated mental illness can have devastating costs, not only to individuals, but their friends, family, and society as a whole – researchers estimate that mental illness costs the U.S. economy \$282 billion annually.<sup>10</sup>

Serious mental illness (SMI) is a more severe subset of any mental illness (AMI)<sup>11</sup> due to its significant and prolonged impact on functional impairment.<sup>12</sup> Untreated serious mental illness can result in substance abuse, homelessness, incarceration, or suicide.<sup>13</sup> Examples of commonly diagnosed serious mental illnesses include schizophrenia, bipolar disorder, severe major depressive disorder, and other psychotic disorders.<sup>14</sup> In California, the California Health Care Foundation estimates that as of 2019 (Figure 1), 1 in 26 adults experience a serious mental illness, impacting approximately 1 million adults each year.<sup>15</sup>

**FIGURE 1. MENTAL HEALTH IN CALIFORNIA: WAITING FOR CARE – INCIDENCE OF MENTAL ILLNESS AMONG ADULTS, CALIFORNIA 2019**



Source: California Health Foundation

California has made several improvements to its mental health system to address this crisis. Federal and state laws now require equal commercial insurance coverage for mental and physical health, and the Affordable Care Act and California Advancing and Innovating Medi-Cal (CalAIM) have expanded Medi-Cal eligibility and mental health services. Public and private efforts have also worked to increase access to care, integrate mental and physical health services, and reduce stigma. To address serious mental illness specifically, the state has passed several landmark pieces of legislation, including the Mental Health Services Act of 2004 (MHSA), the 988 Suicide and Crisis Lifeline (AB-988), and the Behavioral Health Services Act of 2024 (BHSA). These policies provided frameworks and funding for counties to prioritize individuals with SMIs who are in need of immediate treatment outside of private care facilities.

9. Njoku, I. (2022). What is mental illness? American Psychiatric Association. <https://www.psychiatry.org/patients-families/what-is-mental-illness>

10. Boaz, A., Job, B., & Aleh, T. (2024, April). Macroeconomics of Mental Health. NBER.org; National Bureau of Economic Research. [https://www.nber.org/system/files/working\\_papers/w32354/w32354.pdf](https://www.nber.org/system/files/working_papers/w32354/w32354.pdf)

11. NIMH defines Any mental illness (AMI) as a mental, behavioral, or emotional disorder that can vary in impact, from no impairment to mild, moderate, and severe. Serious mental illness (SMI) is a subset of AMI and has a severe impact on daily functioning.

12. National Institute of Mental Health. (2024). Mental Illness. <https://www.nimh.nih.gov/health/statistics/mental-illness>

13. Njoku, I. (2022). What is mental illness? American Psychiatric Association. <https://www.psychiatry.org/patients-families/what-is-mental-illness>

14. Managing Life with Serious Mental Illness. (2023). Samhsa.gov; Substance Abuse & Mental Health Services Administration. <https://www.samhsa.gov/mental-health/serious-mental-illness/managing-life>

15. Mental Health in California: California Healthcare Almanac Quick Reference Guide. (2022, July). Chcf.org; California Healthcare Foundation. <https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022ORG.pdf>

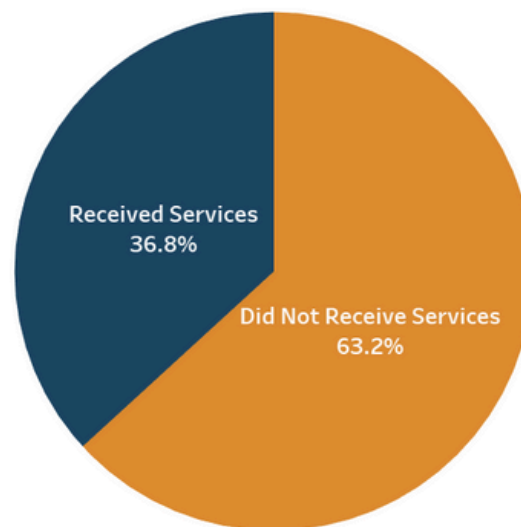


Despite these investments, most Californians who need mental health care still do not receive it. For instance, only 37% of California adults with any mental illness (AMI) receive mental health services across the public and private healthcare system (Figure 2). Although individuals with SMIs are more likely to receive treatment compared to individuals with AMIs, approximately 40% of California adults with SMIs did not receive treatment in 2019.<sup>16</sup>

This gap in mental health care is especially concerning given its connection to California's growing homelessness crisis, as many individuals experiencing homelessness struggle with untreated mental illness, making it even harder for them to access stable housing and support services. Mental illness and homelessness in California has grown over the last decade, and was further exacerbated by the COVID-19 pandemic.<sup>17</sup> Over 181,000 Californians experienced homelessness in 2023, and research suggests the trauma of experiencing homelessness can cause more significant mental health problems, including substance use disorder (SUD) (Figure 3).<sup>18</sup> This challenge increases from lack of access to adequate care; one survey found that nearly 4 in 5 unhoused

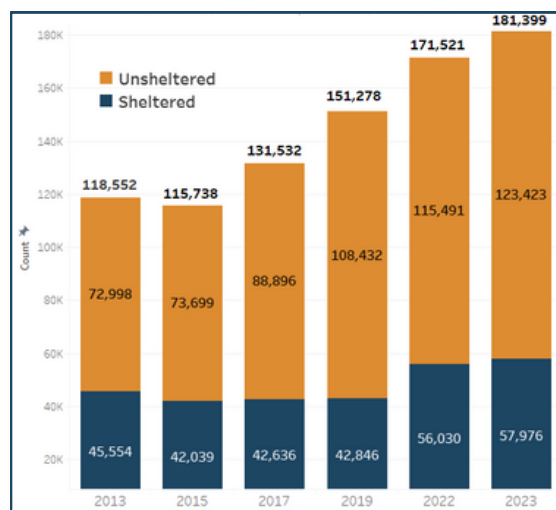
Californians reported experiencing a serious mental health condition at some point in life, and reported limited access to treatment. The study also found that 1 in 5 unhoused Californians who reported regular substance use and wanted treatment were not able to receive it.<sup>19</sup>

**FIGURE 2. MENTAL HEALTH SERVICE USE AMONG ADULTS WITH ANY MENTAL ILLNESS, 2017 - 2019**



Source: California Health Foundation

**FIGURE 3. CALIFORNIA'S POPULATION OF PEOPLE EXPERIENCING HOMELESSNESS, 2013-2023**



Source: The U.S. Department of Health & Urban Development (HUD) point-in-time (PIT) counts, Annual Homeless Assessment Report, and HUD memorandum.

16. Mental Health in California: California Healthcare Almanac Quick Reference Guide. (2022, July). Chcf.org; California Healthcare Foundation. <https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022ORG.pdf>

17. Mental Health in California. (2021, February). Nami.org; National Alliance on Mental Illness. <https://www.nami.org/wp-content/uploads/2023/07/CaliforniaStateFactSheet.pdf>

18. Grant, P. (2024). Homelessness in California. California State Auditor. <https://information.auditor.ca.gov/pdfs/reports/2023-102.1.pdf>

19. Kushel, M., & Moore, T. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. University of California San Francisco. [https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH\\_Report\\_62023.pdf](https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf)

## ***Our Focus***

Recognizing the severity of the mental health crisis, the State of California and some local governments are taking steps to expand mental health services and access to care. In 2020, the Steinberg Institute co-sponsored Senate Bill (SB) 855 (Wiener)<sup>20</sup>, which, among other provisions, requires that healthcare service plans use treatment criteria developed by the relevant non-profit, clinical professional association when determining coverage for the appropriate level of care. Level of care in mental health refers to a framework that categorizes different types and intensities of care based on an individual's needs. It guides practitioners in assessing the appropriate treatment, preventing both under-treatment and over-treatment.<sup>21</sup>

Our client, the Steinberg Institute, has been at the forefront leveraging their expertise and resources to address mental health disparities in California. While the Steinberg Institute has raised the importance of serious mental illness (SMI) level of care assessments in creating equitable access to appropriate levels of care, more information is needed to understand the different processes for assessing levels of care across the state. We partnered with them to explore how counties define SMI levels of care and their processes for assessing patients with serious mental illness. Our client indicated that, without standardized processes, we could expect to see significant variations in how different California counties approach these level of care assessments, which may contribute to inconsistencies in how patients are assigned to specific levels of care. With this information, the institute will then examine how these variations affect the quality of care and whether the current system has the capacity to meet the often complex and high-intensity needs of individuals with serious mental illness.

Ultimately, the Institute is focused on ensuring that SMI level of care tools meet the evolving needs of clinicians and adults dealing with mental illnesses, enabling more precise, effective, and accessible mental health care. By improving SMI level of care frameworks, it can expand access to mental health resources by ensuring individuals receive the right care at the right time, reducing delays and unnecessary hospitalizations. Addressing these issues is critical to creating a more equitable and effective mental health care system across California. By continuing to push for improvements in both policy and practice informed through research, the Steinberg Institute aims to create a mental health system that better serves the needs of all Californians, particularly those with the most serious and complex mental health conditions.

## ***Steinberg Institute***

The Steinberg Institute is a leading nonprofit organization dedicated to improving California's mental health and substance use care systems through policy, advocacy, and research. Founded in 2015 by then Sacramento Mayor and former State Senate President pro Tempore Darrell Steinberg, the institute has been instrumental in passing key legislation that advances mental health rights for Californians. The No Place Like Home Program<sup>22</sup>, passed in 2018, provides over seven thousand supportive housing units for unhoused individuals with serious mental illness, helping to address the intersection of homelessness and mental health issues. Steinberg was also involved in the passing of SB 855, which made California the first state to require comprehensive insurance coverage for mental health, ensuring that people with mental health needs are treated on par with those with physical health conditions. More

20. Bill Text - SB-855 Health coverage: mental health or substance use disorders. (2020, September 29). Leginfo.legislature.ca.gov; California Legislative Information. [https://leginfo.ca.gov/faces/billNavClient.xhtml?bill\\_id=2019202005855](https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=2019202005855)

21. Sowers, W., George, C., & Thompson, K. (1999). Level of care utilization system for psychiatric and addiction services (LOCUS): a preliminary assessment of reliability and validity. *Community Mental Health Journal*, 35(6), 545-563. <https://doi.org/10.1023/a:1018767403107>

22. Proposition 2 AB 1827. (2018, November 6). Lao.ca.gov; The California Legislature's Nonpartisan Fiscal and Policy Advisor. <https://lao.ca.gov/BallotAnalysis/Proposition?number=2&year=2018>

recently, the institute helped pass Assembly Bill (AB) 988 (Bauer-Kahan)<sup>23</sup> in 2022, securing \$20 million to launch California’s 988 hotline for mental health crisis calls and ongoing funding through a fee on telephone lines, creating a direct and accessible resource for individuals in immediate need of mental health support. The organization’s focus remains on improving mental health outcomes across the state by connecting cutting-edge research with real-world policy-making decisions.

In addition to its policy advocacy efforts, the Steinberg Institute launched its Vision 2030 research initiative<sup>24</sup>, which aims to conduct innovative research to help California better understand and address the mental health challenges facing the state. This initiative focuses on identifying systemic issues and implementing long-term solutions to improve mental health care accessibility, quality, and affordability.

## ***Policy Questions***

This report provides research and recommendations to inform Steinberg Institute’s efforts to assess and analyze how SMI level of care tools are being used across California. Given that California counties use different methods to assess SMI level of care, it may create inconsistent ways to diagnose and assign care for patients with serious mental illnesses. To explore this issue, we will be focusing on the following three questions:

### **QUESTION ONE**

**How does the prevalence and treatment of serious mental illness (SMI) vary across California counties?**

### **QUESTION TWO**

**How are serious mental illness level of care assessment tools being used in California counties?**

### **QUESTION THREE**

**What are the best practices and challenges in assessing the level of care for an individual living with SMI in California?**

Our client started exploring the use of various SMI levels of care tools in California and is committed to enhancing their efficiency and effectiveness to improve equitable outcomes and better meet the needs of counties across the state. Through this research, we hope to answer these questions and add to a body of research that is largely unexplored.

23. Bill Text - AB-988 Mental health: 988 Suicide and Crisis Lifeline. (n.d.). Leginfo.legislature.ca.gov; California Legislative Information. [https://leginfo.ca.gov/faces/billNavClient.xhtml?bill\\_id=202120220AB988](https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB988)

24. Vision 2030 - Steinberg Institute. (2023, September 21). Steinberg Institute. <https://steinberginstitute.org/vision-2030/>



# METHODOLOGY

CITY HALL

# Methodology

## ***Overview***

To answer our policy question, we utilized quantitative and qualitative research. This included reviewing 43 articles, a quantitative data analysis of SMI prevalence rates, and interviewing eight California county officials.

We conducted a comprehensive review of literature that pertained to the mental illness and serious mental illness landscape in California, definitions of levels of care across California counties, and level of care tools available. The literature review was used to map the programs available to individuals with SMIs to their respective levels of care, as defined by the state of California and its recommended level of care tiers. We also reviewed literature to understand how level of care assessments for SMI can impact gaps in treatment, particularly for vulnerable populations. Second, we conducted quantitative data analysis to determine the number of predicted individuals with SMIs in each of California's 58 counties. This methodology was used to help us better understand treatment gaps for individuals with SMIs across California. We mapped those numbers to data that tracks what individuals with SMIs were treated in California to determine gaps in treatment by age and race/ethnicity.

Finally, we conducted qualitative interviews with county officials from eight different counties to determine how they defined the level of care for individuals with SMIs, what tool they used for these assessments, and strengths and challenges associated with their tool and processes. These decisions are grounded in the experience of those closest to administering level of care frameworks which guided our decision in choosing our qualitative methods. Our interviews and our analysis helped our research team learn about county perspectives regarding level of care assessment processes which directly informed our policy options. A key priority for the client was exploring how counties are determining which level of care a patient should be placed in including what level of care tools counties are using and how. We planned our methodologies in collaboration with our client and with guidance from our UCLA advisor.

## ***Literature Review***

The initial step of our research was a comprehensive literature review to better understand SMI level of care assessments, what tools are available, and ways they are used in practice.

### ***Defining & Categorizing Level of Care for Serious Mental Illness***

A comprehensive qualitative literature review enabled us to better understand SMI level of care assessments, what tools are available, and ways they are used in practice. This included:

- National Institute of Mental Health (NIMH), Substance Abuse & Mental Health Services Administration (SAMHSA), and other federal agency documentation defining and describing Serious Mental Illness (SMI) in the United States
-



- User manuals and official documents of level of care tools used across CA counties: Level of Care Utilization System (LOCUS)<sup>25</sup>, Level of Intensity Screening Tool (LIST)<sup>26</sup>, Milestones of Recovery Scale (MORS) Assessment<sup>27</sup>, and Adult Needs and Strengths Assessment (ANSA)<sup>28</sup>
- Studies that evaluate effectiveness of different level of care tools<sup>29</sup>
- State and county documentation outlining how they use level of care tools for individuals with SMIs<sup>30</sup>

### ***Identify Programs & Processes for SMI Assessments and Treatment Across California***

To understand how levels of care assessments assign treatments to individuals, we analyzed state and county documentation that outline programs they offer for individuals with SMIs and their respective outcomes. This included:

- State policies and frameworks that provide guidance for assessing and treating individuals with SMIs: SB-855, AB-988, Proposition 1, CalAIM, Laura's Law, and CARE Act
- Official county documentation that outlines programs they offer for individuals with SMIs across eight counties: Los Angeles, Mono, Orange, Placer, Sacramento, San Diego, San Mateo, and Yolo
- MHSA Annual Reports from the eight counties specified above, which provided information on SMI-specific programs (e.g. Full Service Partnership (FSP) programs)<sup>31</sup> and the outcomes and challenges the county faced in effectively treating individuals with SMIs
- County documents from departments responsible for mental health services that describe services and programs offered to individuals with SMIs

For counties with incomplete information on their processes, we sent post-interview emails requesting documentation pertaining to their framework and processes for level of care assessments. We received such information from San Diego County, Los Angeles County and Sacramento County.

### ***Data Analysis: Prevalence of Serious Mental Illness Across California Counties***

We then conducted quantitative analysis to determine predicted prevalence of SMI across California counties and key demographics. This analysis was used to identify populations who are vulnerable to SMI, and compare prevalence numbers to the number of individuals treated with SMIs by county and key demographics.

#### ***California County-level Population data***

To conduct this analysis, we leveraged 5-Year American Community Survey (ACS) Estimates county-level population data for California for the years 2021, 2022, and 2023.<sup>32</sup> We included population data by key demographics: age, sex, and race/ethnicity. Appendix A outlines the specific variables and their subcategories used in this data collection.

25. American Association for Community Psychiatry - LOCUS. (2014). American Association for Community Psychiatry. <https://www.communitypsychiatry.org/locus>  
 26. Level of Intensity Screening Tool (LIST). (2023). Sacramento County Department of Health Services. <https://dhs.sacounty.gov/BHS/SiteAssets/Pages/GI-Provider-Resources-Forms/Level%20of%20Intensity%20Screening%20Tool%20-%20Updated%203-22-23.pdf>  
 27. Fisher, Dennis & Pilon, David & Hershberger, Scott & Reynolds, Grace & LaMaster, Stephen & Davis, Monica. (2009). Psychometric Properties of an Assessment for Mental Health Recovery Programs. Community mental health journal. 45. 246-50. 10.1007/s10597-009-9213-8  
 28. The Adult Needs and Strengths Assessment (ANSA) - Praed Foundation. (2023). Praedfoundation.org; The John Praed Foundation. <https://praedfoundation.org/tcom/tcom-tools/the-adult-needs-and-strengths-assessment-ansa/>  
 29. Sowers, W., Pumariega, A., Huffine, C., & Fallon, T. (2003). Best Practices: Level-of-Care Decision Making in Behavioral Health Services: The LOCUS and the CALOCUS. Psychiatric Services, 54(11), 1461-1463. <https://doi.org/10.1176/appi.ps.54.11.1461>  
 30. MHSA County Plans and Updates. (n.d.). [www.dhcs.ca.gov/services/MH/Pages/MHSA-County-Plans-and-Updates.aspx](https://www.dhcs.ca.gov/services/MH/Pages/MHSA-County-Plans-and-Updates.aspx)  
 31. Full-Service Partnership (FSP) Programs are one of the most intensive outpatient services for individuals with SMIs. FSPs aim to serve people in the community rather than in facilities, using evidence-based practices and recovery-oriented care approaches to improve outcomes. Services include 24/7 crisis availability, multidisciplinary mental health teams, and low staff to client ratios.  
 32. U.S. Census Bureau, "American Community Survey 5-Year Data (2009-2023)," <https://www.census.gov/data/developers/data-sets/acs-5year.html>

### ***SMI Prevalence data***

The National Institute of Mental Health (NIMH) uses The National Survey on Drug Use and Health (NSDUH), an annual survey conducted by The Substance Abuse and Mental Health Services Administration (SAMHSA)<sup>33</sup>, for determining SMI prevalence across the United States. This survey provides nationally representative data on issues, treatment, and status of individuals aged 12 or over around the topics of substance use and mental health.<sup>34</sup> Mental health topics covered in NSDUH include major depressive episodes, suicidal ideation and attempts, general mental illness, and mental health care. They use specific variables from their survey in a logistic regression model that predicts the likelihood of an individual having a Serious Mental Illness (SMI): Serious thoughts of suicide in the past year, Past year major depressive episodes, Past Year Kessler-6 (K6) Score, and Past Year World Health Organization Disability Assessment Schedule (WHODAS) Score. The output of this model provides the “estimated probability an adult had a Serious Mental Illness (SMI).”<sup>35</sup> Appendix B outlines specific details on the NSDUH SMI model.

The 2023 survey produced Detailed Tables that provide 2022 and 2023 real numbers and percentages of individuals with predicted SMIs across age, sex, poverty level, race/ethnicity and educational attainment.<sup>36</sup> The 2021 survey also produced detailed tables providing the same information for 2021 only.<sup>37</sup> Appendix C outlines each detailed table utilized in our county-level analysis of SMI prevalence.

### ***Sensitivity Considerations***

While multiple national surveys, including the Behavioral Risk Factor Surveillance System (BRFSS), the National Health Interview Survey (NHIS), and the Medical Expenditure Panel Survey (MEPS)<sup>38</sup>, measure the prevalence of SMI using the Kessler-6 (K6) screening tool, our analysis relies on data from the National Survey on Drug Use and Health (NSDUH). We selected the NSDUH because, unlike the other surveys, it uses additional predictor variables beyond the K6 scoring, which reduces bias and error.

Lack of public data prevented us from accessing recent SMI prevalence rates from NHIS, MEPS, and BRFSS, but NSDUH conducted several rounds of experiments over the course of several years to optimize their model for bias and error. NSDUH has used extensive methodological testing, including a 2004 split-sample experiment, which concluded that using K6 scores alone introduced bias in prevalence rate for SMIs. They built and revised a model with additional predictor variables (mentioned above) that reduces bias and error, with their most recent model in use since 2012.<sup>39</sup>

### ***SMI Prevalence across California counties***

To get a total count of adults likely to experience a serious mental illness across California’s 58 counties, we applied SMI prevalence rates from NSDUH Tables 6.5B and 6.6B to the 2021-2023 5-Year ACS Estimates county-level population data. For instance, 2023 NSUDH found a 13.3%

33. The Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency within the United States Department of Health and Human Services that conducts research and leads efforts to improve treatment of behavioral health across the United States.

34. About NSDUH | CBHSQ Data. (2025). Samhsa.gov; Substance Abuse & Mental Health Services Administration. <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/about>

35. 2012 National Survey on Drug Use and Health Methodological Resource Book Section 16a: 2012 Mental Health Surveillance Study Design and Estimation Report. (2014). <https://www.samhsa.gov/data/sites/default/files/NSDUH2012MRB-Ammended/NSDUHmrB/MHSS-DesignEst2012.pdf>

36. SAMHSA. (2024, July 30). 2023 NSDUH Detailed Tables | CBHSQ Data. Ww.samhsa.gov; Substance Abuse & Mental Health Services Administration. <https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables>

37. SAMHSA. (2021). 2021 NSDUH Detailed Tables | CBHSQ Data. Ww.samhsa.gov; Substance Abuse & Mental Health Services Administration. <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>

38. Comparisons of SMI and AMI National Estimates between NSDUH and Other Data Sources. (2015, September). Nih.gov; Substance Abuse and Mental Health Services Administration (US). <https://www.ncbi.nlm.nih.gov/books/NBK531557/>

39. Kott, P., Hedden, S., Aldworth, J., Bose, J., Chromy, J., Groer, J., & Liao, D. (2013). 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH A REVISED STRATEGY FOR ESTIMATING THE PREVALENCE OF MENTAL ILLNESS. In <https://www.samhsa.gov/RTI>

International. <https://www.samhsa.gov/data/sites/default/files/NSDUHrevisedMImethods2012/NSDUHrevisedMImethods2012.pdf>

predicted SMI prevalence for women ages 18-25 nationally. Los Angeles County has 562,354 women ages 18-25, according to ACS data. By multiplying 13.3% (0.133) to this number, we predict that approximately 74,793 Los Angeles County women ages 18-25 are at risk of having an SMI:

$$\text{SMI prevalence count} = \text{population count} * \text{prevalence percentage number}$$

## ***Data Analysis: Assessing Treatment Gap for Serious Mental Illness Across California Counties***

After assessing SMI prevalence across counties and key demographics, we analyzed how many individuals with SMIs were treated across California counties. To do this, we compiled data from the California Commission for Behavioral Health's Client Services Information (CSI) Dashboard. The California Commission for Behavioral Health, also called the Mental Health Services Oversight and Accountability Commission, is responsible for overseeing the implementation of the Mental Health Services Act, with the main goal of ensuring people who need mental health services are getting treated.<sup>40</sup> They published the Client Services Information Dashboard to show the number of individuals with SMIs who were treated in California's public mental health system. Data shown in this dashboard was provided by the Department of Health Care Services.<sup>41</sup>

We leveraged several views of the CSI Dashboard to uncover how many individuals were treated with an SMI by county and key demographics:

- County-level numbers across all demographics for FY 20-21, FY 21-22, FY 22-23
- County-level numbers by race/ethnicity for FY 20-21, FY 21-22, FY 22-23
- County-level numbers by age ranges for FY 20-21, FY 21-22, FY 22-23

We used this data to compare annual SMI prevalence to those treated across California counties, specifically looking at discrepancies between race/ethnicity, age, and sex.

Using total SMI prevalence numbers across counties by specific demographics, we utilized three different calculations to get a comprehensive understanding of treatment gaps and their relativity across counties: a normalized difference ratio, a simple ratio, and a percentile calculation.

### ***Normalized difference ratio***

We calculated a normalized difference ratio to measure the gap between predicted prevalence and actual treatment counts, allowing us to compare unmet needs across counties and demographics group. This metric compares the prevalence of SMI within a demographic group to the number of individuals who received treatment, and standardizes this difference relative to the size of both populations combined. This produces a value between -1 and 1, allowing for consistent interpretation across counties and population groups.

40. About BHSOAC - Behavioral Health Services Oversight & Accountability Commission. (2025, March 12). BHSOAC. <https://bhsoac.ca.gov/about/>

41. Client Services - Transparency Suite - BHSOAC. (2025, January 10). BHSOAC, Behavioral Health Services Oversight & Accountability Commission. <https://bhsoac.ca.gov/transparency-suite/client-services/>

A ratio of zero indicates that treatment delivery is exactly aligned with SMI prevalence. Positive values indicate under-treatment—where prevalence exceeds the number of individuals treated—while negative values suggest over-treatment relative to the estimated population in need. Because the denominator incorporates both treated and prevalent cases, the normalized difference ratio adjusts for variation in scale, making it suitable for cross-county and cross-group comparisons.

For example, two counties may have vastly different population sizes, but a normalized difference ratio of 0.20 in both reflects a similar proportional treatment gap. As a standardized measure, it ensures that differences in treatment access reflect true service disparities rather than variations in population. This ratio was primarily used to compare treatment gaps between counties.

The below formula demonstrates how we calculated normalized ratios across counties and demographics:

$$\text{normalized ratio} = (\text{prevalence ct} - \text{treatment ct}) / (\text{prevalence ct} + \text{treatment ct})$$

### **Simple ratio calculation**

A simple ratio calculation was used to understand direct treatment rates within each county. It measures the share of the SMI population that received services, calculated as the number treated divided by the number with SMI. For example, if 700 out of 1,000 individuals with SMI received care, the simple ratio is 0.70, indicating a 70% treatment rate. While intuitive, this metric can be unstable in groups with low prevalence. This ratio was primarily used to describe statewide trends in treatment gaps and direct treatment rates for populations.

$$\text{simple ratio} = \text{treatment count} / \text{prevalence count}$$

### **Percentile calculation**

Percentile rank was calculated to support further analysis by contextualizing each county's level of unmet SMI treatment relative to others, based on their normalized difference ratio. This measure positions each county within the distribution of normalized difference ratios across all counties for a given demographic group. A higher percentile indicates a higher level of unmet need compared to peer counties. For example, a percentile of 0.85 means the county's normalized difference ratio is higher than 85 percent of counties in the analysis.

The percentile for each county demographic was calculated as:

$$\text{percentile} = (\text{normalized difference ratio} - \text{minimum normalized difference ratio}) / (\text{maximum normalized difference ratio} - \text{minimum normalized difference ratio})$$



## ***Semi-Structured Interviews with County Officials***

To better understand the level of care assessment process across different kinds of counties, we conducted 30-minute interviews with county officials from eight counties: Los Angeles, Mono, Orange, Placer, Sacramento, San Diego, San Mateo, and Yolo.

These eight counties provide a representative sample of the state of California, representing almost half of California's adult population. We selected these counties because of their range in diversity, size, and landscape. Los Angeles, for instance, is California's largest and most diverse county. Mono, on the other hand, is a rural county with an adult population of 10,750, making it the fourth-least populous county in California. Table A provides the full breakdown of counties by size and type. For county size, we assigned counties with an adult population of less than 500,000 as small, counties with between 501,000 and 999,999 as medium, and counties with greater than 1 million adults as large. We used the California State Association of Counties to classify counties as urban, rural, or suburban.<sup>42</sup> This classification allowed us to compare counties' SMI level of care assessment processes in a more systematic manner.

**TABLE A. CASE STUDY COUNTY CLASSIFICATIONS**

| County             | 2023 Population (18+) | Classifications: Size / Type |
|--------------------|-----------------------|------------------------------|
| <b>LOS ANGELES</b> | 7,790,870             | Large / Urban                |
| <b>MONO</b>        | 10,750                | Small / Rural                |
| <b>ORANGE</b>      | 2,489,230             | Large / Urban                |
| <b>PLACER</b>      | 321,825               | Small / Suburban             |
| <b>SACRAMENTO</b>  | 1,218,380             | Medium / Urban               |
| <b>SAN DIEGO</b>   | 2,588,613             | Large / Urban                |
| <b>SAN MATEO</b>   | 597,036               | Medium / Urban               |
| <b>YOLO</b>        | 173,144               | Medium / Suburban            |

To recruit interviewees, our client leveraged their relationships with county officials across several counties to identify the best person to talk to regarding SMI level of care. All eight counties responded with interest, and interviews were conducted between February 14 and March 18, 2025.

We developed an interview protocol to guide our conversation. The guide included questions around the different SMI levels of care counties have, tools they use, challenges and strengths with their current level of care assessment process, and how they treat priority populations. Some sample questions are below, and the full interview protocol is in Appendix G.

42. California County Caucuses. (2020, June 3). Counties.org; California State Association of Counties. <https://www.counties.org/sites/main/files/file-attachments/2020-june3-countycaucusesinfographic-4-final.pdf>

- Could you speak to how your county assesses what level of care a client living with SMI should enroll in?
- How does the County determine when clients are ready to step down to a lower level of care?
- Are you satisfied with how your county is currently assessing the level of care for a client living with an SMI? What strengths or challenges have you noticed?
- How do you prioritize who is enrolled in services if there is greater need than slots available?

### ***Semi-structured interview codebook***

To define the landscape as related to SMI level of care assessments, we developed a codebook using a hybrid approach incorporating four phases of derivation. These codes were validated by at least two independent reviewers to ensure relevance, clarity, and accuracy. Iterative analysis of the codebook led to some codes being added, merged, and deleted. The final codebook can be found in Appendix H.

- **Phase 1 – Developing Preliminary Thematic Framework:** We used the WHO Mental Health Action Plan objectives<sup>43</sup> to develop major themes to guide our initial round of coding. The four objectives from the WHO Action Plan<sup>44</sup> were distilled to their thematic components and informed our subthemes.
- **Phase 2 – Development of Deductive Codes (from Literature Review):** See Appendix H for list of sub-thematic codes derived from literature review.
- **Phase 3 – Development of Inductive Codes (from Interviews):** Performed county interviews and utilized an iterative approach to refine our major themes and incorporate further subthemes.
- **Phase 4 – Finalization of Hybrid Codebook and Definitions:** Refined codebook, including but not limited to addition/deletion of codes, examples, and definitions based on at least three passes of the interview data by at least two independent reviewers.

### ***Coding protocol***

Coding of the eight interviews was divided between primary and secondary coders utilizing the free platform Taguette to perform coding. The primary coder cleaned the interview data and uploaded it to the platform. The Phase 2 codebook was subsequently uploaded to the platform. The first pass of coding extracted additional sub-themes. Interviews were then evaluated by coder(s) for themes and subthemes, which were tagged and extracted. Throughout the coding process, coders discussed discrepancies and redundancies to ensure consensus over how codes were implemented during analysis. Both interview data and literature review findings informed the final codebook.

43. The WHO Mental Health Action Plan objectives (2013-2030) is a global standard aiming to "increase commitment by governments to enhance the priority given to mental health within their health and public policy" across diverse governments and communities.

44. Saxena S, Funk M, Chisholm D. WHO's Mental Health Action Plan 2013-2020: what can psychiatrists do to facilitate its implementation? *World Psychiatry*. 2014 Jun;13(2):107-9. doi: 10.1002/wps.20141. PMID: 24890053; PMCID: PMC4102273.

## **Research Limitations**

A major limitation of our quantitative methodology stems from the use of national-level SMI prevalence rates applied to California counties. While this method allows for a broad analysis of SMI prevalence across different demographics, it does not account for potential regional variations in mental health conditions that may be influenced by access to healthcare or environmental influences. As a result, the estimated prevalence of SMI in certain counties may not fully reflect the actual number of individuals experiencing serious mental illness. For example, in small rural counties like Mono county, access to mental health services may be more limited. Populations are small but may contain higher proportions of individuals with SMI. So, our model could underestimate SMI prevalence due to unaccounted barriers to care. On the other hand, large urban counties like Los Angeles could have stronger public mental health infrastructure and higher Medi-Cal enrollment rates, resulting in our model overestimating unmet needs for individuals with SMI that are receiving treatment outside of the public healthcare system (e.g. private insurance).

Another limitation of this study's quantitative methodology stems from inconsistencies in how demographic information is reported across data sources. The NSDUH survey provides SMI prevalence estimates using age categories that do not align directly with those used in the ACS population data. Similarly, the CSI treatment data uses different age groupings than the other two sources. To enable consistent comparisons, we constructed synthetic age groups (18–25, 26–59, and 60+) by estimating proportional distributions from overlapping categories in the ACS. These transformations were necessary to align population, prevalence, and treatment data, but relied on assumptions of uniform distribution within each group, which introduced potential error, particularly at the lower and upper ends of the age spectrum (Appendix I).

In addition to age alignment, differences in the reporting timeline required adjustments. While ACS and NSDUH data are structured by calendar year, the CSI treatment data is reported by fiscal year. To produce comparable annual estimates, we converted fiscal year data into calendar year values by averaging adjacent fiscal years (e.g., FY 20–21 and FY 21–22 to represent 2021). This rolling average approach allows for temporal alignment across datasets but may smooth over meaningful year-to-year variation in treatment trends (Appendix J).

There were also inconsistencies in how gender was reported. The CSI dataset includes additional gender categories, such as “other” and “unknown”, that are not present in the ACS or NSDUH, which report only binary sex. To reconcile these differences, we redistributed treatment counts from the “other” and “unknown” groups proportionally to male and female within each age group and year. This approach preserved total counts and allowed for consistent comparison across datasets, though it simplifies the gender landscape and may obscure variation in service access across nonbinary populations (Appendix K).

Race categories presented a similar challenge. Labels in the CSI dataset did not always match those used in the ACS, and categories such as “Asian/Pacific Islander” and “Latino/a” were recoded for consistency. In addition, treatment counts labeled as “other” or “unknown” were redistributed proportionally across six standard race and ethnicity groups. These adjustments enabled alignment between data sources, but relied on assumptions about how individuals in

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ambiguous categories would be distributed, which may affect the accuracy of subgroup estimates, particularly for smaller or racially diverse populations (Appendix L).

Additionally, despite including eight counties that represent 50% of California's adult population, a major limitation for our interviews is our eight-county sample size. Although we selected counties that represent diverse demographics, our findings are based on interviews from 8 of 58 counties in California. The perspectives shared by interview participants may not be fully representative of how all counties assess and manage levels of care for individuals with SMIs, especially given the significant variation in county mental health programs across the state. Furthermore, because interview participants were identified through existing relationships with our client, there is a risk of selection bias, with responses potentially reflecting counties that are more engaged or resourced in mental health service provision.

Lastly, while our findings suggest gaps in treatment based on race/ethnicity, age, and geographic location, we were unable to fully explore other systemic barriers that may influence treatment access. Factors such as stigma, workforce shortages, insurance limitations, and variations in service availability at the county level likely play a significant role in shaping the observed disparities. Future research should investigate these structural barriers in greater depth to develop more targeted policy recommendations that address inequities in mental health care across California.

## **Ethics**

Ensuring ethical integrity was a central priority in our research, particularly given the sensitivity of studying serious mental illness (SMI) and access to care. All participants in our qualitative interviews provided informed consent electronically before their interviews, acknowledging that their participation was voluntary, that they could withdraw at any time, and that their responses would remain anonymous unless disclosure was necessary to prevent harm. To ensure accuracy and ethical integrity in our qualitative research, we followed up with the counties we interviewed and provided them with the written summaries of their interviews. This process allowed county officials to review our descriptions, clarify any potential misinterpretations, and ensure that our reporting accurately captured their perspectives.

One ethical challenge in our study was the reliance on self-reported information from county officials regarding SMI assessment and treatment processes. This could have introduced a level of bias in their classification of strengths and weaknesses of their county processes and systems. Additionally, the nature of our recruitment process by leveraging pre-existing relationships between our client and county officials may have influenced who agreed to participate, potentially skewing our findings toward counties more engaged in mental health policy and assessment practices.

Another ethical consideration involved our approach to estimating SMI prevalence and treatment gaps. Because we applied national-level prevalence rates to California's counties, our estimates are based on statistical modeling rather than direct individual diagnoses. While this method is widely used in public health research, it carries inherent ethical concerns about representation and accuracy, particularly when making policy recommendations that may

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influence resource allocation.

Despite these limitations, we believe our research was conducted with a high standard of ethics, and we hope it contributes to a more equitable and evidence-based approach to SMI care in California.

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SECTION THREE



# PROBLEM IDENTIFICATION

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# Problem Identification

Our findings are derived from interviews with eight county officials, national, state, and county-level data analysis, and our literature review of the level of care frameworks in assessing mental health. The following predominant themes were found.

## ***Serious Mental Illness (SMI) Prevalence & Treatment Rates***

Our analysis found that over 1.7 million Californian adults had a Serious Mental Illness (SMI) in 2023, but only 403,667 were treated, indicating that 78.8% of Californians did not receive needed treatment.<sup>45</sup> Below outlines detailed analyses of trends in prevalence and treatment rates across counties and demographics.

### ***SMI prevalence in California***

SMI prevalence rates show the percentage of individuals who are likely to have a serious mental illness (SMI). In 2023, 2+ races individuals and women between the ages of 18-25 had the highest SMI prevalence; 14% and 13.6%, respectively. Still, the data suggests that sex and age are the strongest characteristics of serious mental illness (SMI).

2023 SMI prevalence rates indicate that sex had a larger impact on SMI likelihood compared to age; adult women had a 7% SMI prevalence rate, compared to 4.3% of adult men. Although younger ages had higher prevalence across both men and women, women across all ages had higher prevalence rates compared to every age group of men.

Despite having higher prevalence rates, women saw an overall decrease in prevalence from 2021 to 2023. Men, on the other hand, saw an increase in prevalence, with even more significant increases across specific age groups. Men ages 60-64 saw the highest increase in prevalence (+125%), with the largest increase occurring from 2021 to 2022 (+158.3%). Men ages 26-34 also saw a significant increase in prevalence (+35.7%) from 2021 to 2023, men ages 35-49 saw on average a 11.2% decrease in prevalence in the same timeframe.

Although adult women saw a slight decrease in prevalence (-1.4%) from 2021 to 2023, there were several variations across age groups. Women ages 26-34, 40-49, and 65+ all saw increases in prevalence from 2021-2023, with women ages 40-44 experiencing the largest change (+42%) across age groups. The largest decrease in prevalence occurred for women ages 60-64 (-33.3%). Table B provides an overview of prevalence rates by age and sex from the years 2021-2023.

When examining SMI prevalence across race/ethnicity demographics, 2023 rates show that 2+ races individuals have a prevalence rate over two times higher compared to all other races.<sup>46</sup> This finding is consistent with other studies examining AMIs and SMIs among multi-racial populations.<sup>47,48</sup> Data from the American Psychological Association, for instance, shows that individuals identifying as two or more races had the highest prevalence of SMI at 7.5% in

45. Developed by authors using quantitative analysis of publicly available data, as outlined in our Methodology chapter.

46. To avoid double-counting individuals who identify with more than one racial group, surveys such as NSDUH categorize multiracial individuals under a distinct 'two or more races' category.

47. Coleman, K. J., Stewart, C., Waltzfelder, B. E., Zeber, J. E., Morales, L. S., Ahmed, A. T., Ahmedani, B. K., Beck, A., Copeland, L. A., Cummings, J. R., Hunkeler, E. M., Lindberg, N. M., Lynch, F., Lu, C. Y., Owen-Smith, A. A., Trinacty, C. M., Whitebird, R. R., & Simon, G. E. (2016). Racial-Ethnic Differences in Psychiatric Diagnoses and Treatment Across 11 Health Care Systems in the Mental Health Research Network. *Psychiatric Services*, 67(7), 749-757. <https://doi.org/10.1176/appi.ps.201500217>

48. American Psychiatric Association. (2017). *Mental Health Disparities: Diverse Populations*. <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf>

2016, significantly higher than other racial and ethnic groups.<sup>49</sup> Although White (6.1%) and Hispanic or Latino (5.5%) individuals have the next highest prevalence rates, they are significantly lower compared to 2+ races individuals.

**TABLE B. 2021-2023 CALIFORNIA PREVALENCE RATES BY AGE AND SEX**

|              | 2023 |       | 2022 |       | 2021 |       |
|--------------|------|-------|------|-------|------|-------|
| Age          | Men  | Women | Men  | Women | Men  | Women |
| <b>18+</b>   | 4.3% | 6.9%  | 4.8% | 7.1%  | 4.0% | 7.0%  |
| <b>18-20</b> | 6.1% | 12.5% | 7.8% | 14.3% | 5.8% | 16.9% |
| <b>21-25</b> | 7.7% | 14.1% | 9.0% | 14.9% | 7.5% | 15.4% |
| <b>26-29</b> | 8.4% | 13.7% | 7.2% | 11.4% | 6.2% | 12.8% |
| <b>30-34</b> | 8.7% | 11.8% | 8.4% | 11.2% | 6.4% | 9.5%  |
| <b>35-39</b> | 5.5% | 8.4%  | 6.7% | 7.6%  | 6.2% | 9.1%  |
| <b>40-44</b> | 4.2% | 7.8%  | 5.4% | 6.6%  | 4.3% | 5.3%  |
| <b>45-49</b> | 4.0% | 7.1%  | 4.1% | 7.4%  | 5%   | 6.3%  |
| <b>50-54</b> | 3.4% | 5.5%  | 3.0% | 7.4%  | 3.1% | 6.3%  |
| <b>55-59</b> | 2.2% | 3.8%  | 4.6% | 3.7%  | 2.8% | 4.8%  |
| <b>60-64</b> | 2.7% | 2.6%  | 3.1% | 4.0%  | 1.2% | 3.9%  |
| <b>65+</b>   | 0.8% | 1.9%  | 0.5% | 2.2%  | 0.7% | 1.7%  |

*Source: Computed by authors using ACS 2021-2023 Surveys & 2021, 2023 National Survey Drug on Drug Use & Health SMI prevalence data*

Prevalence rate trends from 2021 to 2023 show significant changes in prevalence, especially for AIAN (-64.5%), 2+ races (+70.7%), and Black or African American (-14%) individuals. SMI prevalence rates for White individuals, on the other hand, remained steady, with Asian and Hispanic or Latino individuals experiencing slight increases in prevalence.

Annual trends vary across race/ethnicity, as well. Asian individuals, for instance, saw a 49% increase in prevalence between 2021 and 2022, but a 29.3% decrease from 2022 to 2023. Black or African American individuals saw similar patterns; after having a 9% increase in prevalence from 2021 to 2022, treatment rates decreased by 21.3% from 2022 to 2023. Table C shows California SMI prevalence rates for adults by race/ethnicity 2021, 2022, and 2023.

49. American Psychological Association. (n.d.). Mental health disparities: Diverse populations. <https://www.apa.org/pi/disability/resources/mental-health-disparities>

**TABLE C. 2021-2023 CALIFORNIA PREVALENCE RATES BY RACE/ETHNICITY**

| Race/ethnicity (18+)                                       | 2023   | 2022   | 2021  |
|------------------------------------------------------------|--------|--------|-------|
| Hispanic or Latino                                         | 5.50%  | 5.30%  | 5.10% |
| American Indian and Alaskan Native (AIAN)                  | 3.30%  | 7.30%  | 9.30% |
| Asian                                                      | 2.90%  | 4.10%  | 2.80% |
| Black or African American                                  | 3.70%  | 4.70%  | 4.30% |
| Native Hawaiian and Pacific Islander (NHOPI) <sup>50</sup> | -%     | 3.5%   | -%    |
| Two+ Races                                                 | 14.00% | 11.80% | 8.20% |
| White                                                      | 6.10%  | 6.50%  | 6.10% |

Source: Computed by authors using ACS 2021-2023 Surveys & 2021, 2023 National Survey Drug on Drug Use & Health SMI prevalence data

### SMI treatment rates

Across age, sex, and race demographics, 60+ year old men had the highest treatment rates, despite having lower SMI prevalence rates compared to women. From a race/ethnicity perspective, AIAN and Black or African American individuals had the highest rates of care. Although AIAN treatment rates align with SMI prevalence rates in this demographic, Black or African American demographic had higher treatment rates compared to prevalence. Tables D and E show 2021, 2022, and 2023 treatment rates by age, sex, and race/ethnicity.

Although treatment rates for men remain higher across age groups, women saw a larger increase in treatment rates (+23%) between 2021 and 2023 compared to men (+6%). However, certain age groups for men and women had more fluctuation. For instance, men ages 60+ saw a 29.1% decrease in treatment rates, whereas men ages 18-25 had a 21.2% increase. Women ages 26-59, on the other hand, saw a 12% decrease in treatment, compared to a 16% increase in treatment rates for women ages 18-25.

**TABLE D. 2021-2023 CALIFORNIA SMI TREATMENT RATES BY AGE AND SEX**

| Age   | 2023   |        | 2022   |        | 2021   |        |
|-------|--------|--------|--------|--------|--------|--------|
|       | Men    | Women  | Men    | Women  | Men    | Women  |
| 18+   | 37.73% | 25.98% | 28.84% | 20.33% | 35.59% | 21.12% |
| 18-25 | 31.40% | 21.02% | 25.94% | 19.18% | 25.94% | 18.03% |
| 26-59 | 34.98% | 21.63% | 31.06% | 22.59% | 36.74% | 24.57% |
| 60+   | 46.79% | 35.28% | 50.71% | 28.06% | 76.79% | 33.61% |

Source: Computed by authors based on SMI count analysis and CSI treatment counts.

50. NSUDH did not provide NHOPI prevalence rates for 2021 or 2023 due to "low precision" estimates.



From 2021 to 2022, every age group across men and women saw a decrease in treatment rates, except for women ages 18-25, who experienced a 6.4% increase in treatment rates. Men's treatment rates from 2022 to 2023 recovered, with treatment rates increasing in every age group except for men ages 60+ (-7.7%). Women, however, continued to experience lower treatment rates across every age group except for 26-59 (+4.3%).

When looking at changes in treatment rates across race/ethnicity, several themes emerged. Asian/NHOPI, Hispanic or Latino, and 2+ races all experienced a decrease in treatment rates from 2021 to 2023, with 2+ races having the largest decrease at -52%. White (+27.8%), Black or African American (+15.3%), and AIAN individuals, on the other hand, saw increased treatment rates from 2021 to 2023, with AIAN having the largest increase at 204.6%. The drop in SMI prevalence rates for this demographic from 2022 to 2023 for this group could explain this drastic change.

Similar to age and sex demographics, significant changes in treatment rates occurred across race/ethnicity demographics. From 2021 to 2022, treatment rates decreased across every race/ethnicity demographic except for AIAN individuals, which saw a 32.7% increase in treatment rates. Despite this dip in treatment rate for Black or African American individuals during this timeframe, they saw a 26.7% increase from 2022 to 2023. Similarly, Asian/NHOPI individuals saw a 27.7% increase in treatment rates from 2022 to 2023, but a 31.3% decrease in treatment from 2021 to 2022.

**TABLE E. 2021-2023 CALIFORNIA SMI TREATMENT RATES BY RACE/ETHNICITY**

| Demographic                      | 2023    | 2022    | 2021    |
|----------------------------------|---------|---------|---------|
| <b>White</b>                     | 24.59%  | 17.57%  | 19.24%  |
| <b>Asian/NHOPI</b>               | 17.78%  | 12.84%  | 18.70%  |
| <b>Black or African American</b> | 107.18% | 84.60%  | 92.97%  |
| <b>AIAN</b>                      | 398.14% | 173.51% | 130.72% |
| <b>2+ races</b>                  | 9.92%   | 13.02%  | 20.66%  |
| <b>Hispanic/Latino</b>           | 33.81%  | 35.70%  | 37.92%  |

*Source: Computed by authors based on SMI count analysis and CSI treatment counts.*

AIAN and Black or African American treatment rates are above 100%, indicating that there may be individuals who identify as one of these ethnicities who are getting treated for an SMI even if they may not have one. There are several explanations for these treatment numbers. First, this could mean that our SMI prevalence model underestimates SMI prevalence with these populations. Furthermore, the treatment data only accounts for individuals who enrolled in public mental health services, suggesting that Medi-Cal could play a role in connecting underserved populations such as Black or African American and AIAN individuals to mental health services. However, the elevated treatment rates for these groups may also reflect systemic inequities, such as over-diagnosis or over-reliance on inpatient care.



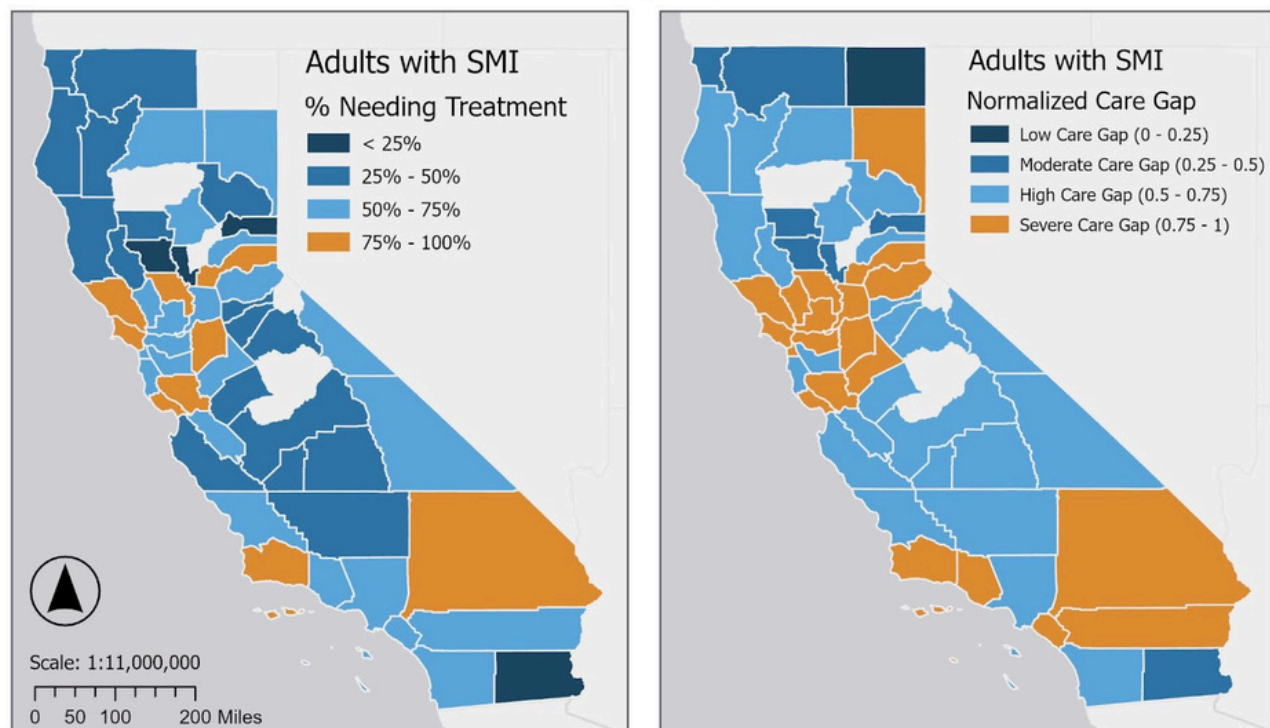
This explanation is supported by previous research, which shows that Black individuals, especially Black men, are overrepresented within inpatient psychiatric settings.<sup>51</sup> California Department of Healthcare Services' dashboard, which tracks annual Medi-Cal Mental Health Program (MHP) utilization rates for specialty and non-specialty services, shows similar inequities.<sup>52</sup> 2022 utilization rates, for instance, show a higher percentage of White individuals accessing non-specialty services compared to Black individuals. However, a higher percentage of Black individuals use specialty mental health services compared to White individuals (Appendix M). Although this offers some context to explain our analysis, these findings have no causal implications. More research needs to be conducted to determine if treatment levels align with actual need or suggest disparities in diagnosis and care.

### ***SMI prevalence and treatment across California counties***

Over half of California counties (31) had treatment rates below 30% in 2023. However, our analysis shows significant differences in treatment rates across counties and demographics (Figure 4).

The normalized difference ratio calculations identify counties with treatment gaps, regardless of population. 2023 analysis shows significant differences in treatment rates across counties and demographics. Counties with the lowest treatment rates (i.e. highest normalized ratios) for all adults included San Bernardino, Santa Cruz, Marin, and Sonoma. Counties with the highest treatment rates (i.e. lowest normalized ratios) included Modoc, Sierra, Sutter, and Imperial. Appendix N outlines the 2021, 2022, and 2023 normalized treatment ratios for each county.

**FIGURE 4. GAPS IN SERIOUS MENTAL ILLNESS TREATMENT, 2023**



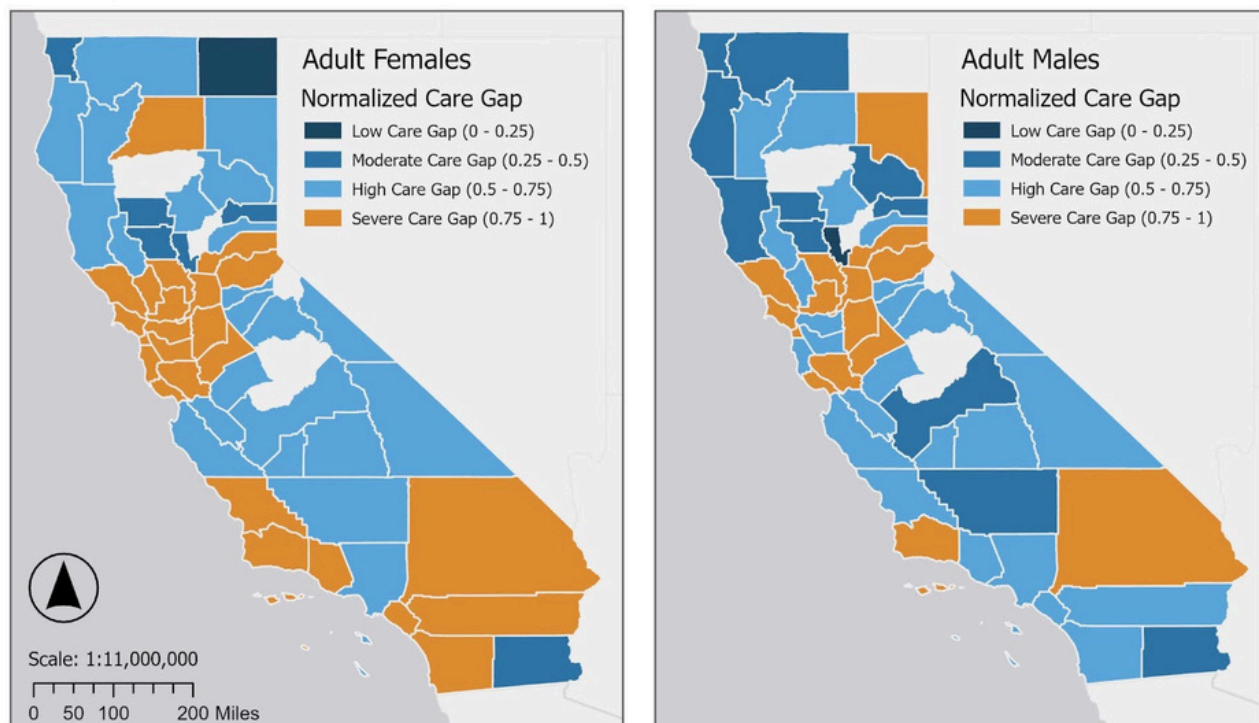
Source: Developed by authors using ArcGis Pro, based on simple ratio and normalized ratio treatment rates per county.

51. Snowden, L. R., Hastings, J. F., & Alvidrez, J. (2009). Overrepresentation of Black Americans in Psychiatric Inpatient Care. *Psychiatric Services*, 60(6), 779-785. <https://doi.org/10.1176/ps.2009.60.6.779>  
 52. Adult MHS Demographic Dashboard (AB470). (2020). Behavioralhealth-Data.dhcs.ca.gov; California Department of Healthcare Services. <https://behavioralhealth-data.dhcs.ca.gov/pages/adult-mhs-ab470>

When comparing 2023 normalized county treatment ratios across demographics, several key themes emerged. For 2+ races, 39 counties had a normalized ratio of 0.75 or greater, and 47 of the 58 counties had direct treatment rates of less than 25%. Imperial County was the only county with a normalized ratio below 0.5 for the 2+ races demographic, indicating that Imperial County has higher treatment rates for that demographic compared to other counties. 41 counties had normalized ratios above 0.5 for women ages 18-25, indicating that the majority of counties had lower treatment rates for that demographic (Figure 6). Black or African Americans, however, had decent treatment coverage; 37 of the 57 counties had above a 50% direct treatment rate, and 42 counties had normalized ratios less than or equal to 0.5. These results show that those who identify as either a young woman or 2+ races are more likely to have an SMI, but less likely to get treated.

Trend analysis from 2021 to 2023 show minor fluctuations in normalized ratio across demographics, with 2+ races being the only demographic to show significant change. This demographic experienced the largest increase in normalized treatment ratios across the most counties; in 2023, 32 counties had normalized ratios greater than or equal to 0.75, compared to 12 counties in 2021. When evaluating changes in direct treatment rates, men ages 60+ had the largest decrease in treatment rate across the most counties; only 9 counties had a 75% or higher treatment rate in 2023 for that demographic, compared to 31 counties in 2021. Black or African American and AIAN populations, on the other hand, had the highest treatment rates across the most counties, which aligns with statewide trends. In fact, our analysis shows that they are the only demographics where at least 10 counties have a 75% or higher treatment rate.

**FIGURE 5. GAPS IN SMI TREATMENT RATES BY GENDER, 2023**



Source: Developed by authors using ArcGis Pro, based on simple ratio and normalized ratio treatment rates per county.

### Case Study Counties: SMI Prevalence & Treatment Rates

To evaluate treatment gaps for the eight counties we interviewed, we used the California normalized ratio baseline and compared average normalized ratios to determine which counties fell below or above the California average. Los Angeles (0.56), Mono (0.55), San Diego (0.59), and San Mateo (0.59) counties had lower normalized ratios compared to California (0.62), indicating that their treatment rates were better than average. Both Los Angeles and San Mateo are considered to be more urban compared to Mono, but each county represents a small, medium, and large population size. Although Sacramento and San Diego Counties had lower ratios, they were minor differences, indicating that their treatment rates were on par with California. Yolo (0.78) and Placer (0.77) Counties, classified as suburban, had lower treatment rates compared to the California average.

Table F outlines how each county compares across direct treatment ratios by age, sex, and race/ethnicity. Overwhelmingly, 2+ races and young women had lowest treatment rates, similar to statewide findings. White and Asian American demographics had the highest treatment rates across the eight counties (Appendix O). Placer and Yolo Counties have lower treatment rates for Asian Americans compared to other counties, and men ages 26-59 consistently were among the highest treated demographic.

According to our analysis, every case study county except San Diego experienced a decrease in SMI treatment rate between 2021 and 2023. However, five counties saw an increased treatment rate from 2022 to 2023: San Mateo (+7.7%), San Diego (+7.6%), Orange (+4.5%), Los Angeles (+4.3%), and Mono (+0.33%). When examining treatment rates across race/ethnicity, age, and sex, AIAN individuals had increased treatment rates across all counties, with Black or African American individuals experiencing an increase for four case study counties (Los Angeles, Orange, San Diego, and San Mateo). However, all counties experienced a decrease in treatment rates for both men and women across all age groups. Appendix O provides a full breakdown of treatment rates for each case study county.

**TABLE F. 2023 TREATMENT PROFILES, CASE STUDY COUNTIES**

| County             | % Treated (18+) | Most Treated (Age, Sex) | Most Treated (Race/Ethnicity) | Least Treated (Age, Sex) | Least Treated (Race/ Ethnicity) |
|--------------------|-----------------|-------------------------|-------------------------------|--------------------------|---------------------------------|
| <b>Los Angeles</b> | 27.88%          | Women, 60+              | AIAN, Black/AA                | Women, 18-25             | 2+ races                        |
| <b>Mono</b>        | 28.71%          | Women 60+               | Hispanic/Latino               | Men ages 18+             | n/a                             |
| <b>Orange</b>      | 21.08%          | Men, 26-59              | AIAN, Black/AA                | Women, 60+               | 2+ races                        |
| <b>Placer</b>      | 13.02%          | Men, 26-59              | AIAN, Black/AA                | Women, 18+               | 2+ races                        |
| <b>Sacramento</b>  | 18.24%          | Men, 60+                | AIAN, Black/AA                | Women, 18+               | 2+ races                        |
| <b>San Diego</b>   | 25.80%          | Men, 60+                | AIAN, Black/AA                | Women, 18-25             | 2+ races                        |
| <b>San Mateo</b>   | 25.96%          | Men, 60+                | AIAN, Black/AA                | Women, 18+               | 2+ races                        |
| <b>Yolo</b>        | 12.29%          | Men, 60+                | AIAN, Black/AA                | Women, 18+               | Asian/NHOPI                     |

Source: Computed by authors based on SMI count analysis and CSI treatment counts.

## County Interviews: SMI Level of Care Systems

Our qualitative interviews provided information about how counties use SMI levels of care frameworks to assess and treat individuals with SMIs. Below outlines our main findings.

Each county has different strategies and processes for evaluating and placing patients in SMI levels of care. Los Angeles and Sacramento counties have the most sophisticated and standardized assessment process, whereas Mono has the least standardized process. Appendix P includes key findings for each county interviewed. This was determined based on their procedures across several domains: Initial Evaluation, Reassessment, Full Service Partnership (FSP) and Assertive Community Treatment (ACT) Evaluation, Data Management, and SMI Level of Care Tools:

- **SMI Level of Care Tools:** Refers to the specific tools counties use to evaluate and place patients, based on intensity of symptoms and needs
- **Initial Evaluation:** refers to how counties assess new patients
- **Reassessment:** Refers to how counties monitor progress among patients currently in higher levels of care
- **Full Service Partnership (FSP) and Assertive Community Treatment (ACT) Evaluation:** Refers to how counties place patients in specific types of FSPs and ACTs once deemed eligible
- **Data Collection & Management:** Refers to what data counties collect in reference to SMI levels of care and how that data is managed/stored

Across the eight counties we interviewed, four SMI Levels of Care tools were identified, with some counties using the same tools for different purposes. Table G outlines each tool one of the eight counties use, their assessment domains, and their different levels of care.

**TABLE G. SMI LEVEL OF CARE (LOC) TOOLS USED BY CASE STUDY COUNTIES**

| Tool                                            | Counties                                 | Assessment Domains                                                                                                                                                                                                | Levels of Care/Needs                                                                                                                                                                                                                                                                    |
|-------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Level of Care Utilization System (LOCUS)</b> | Los Angeles, Sacramento, Yolo, San Diego | 1. Risk of Harm<br>2. Medical, addictive, & psychiatric comorbidity<br>3. Recovery environment<br>a. Level of stress<br>b. Level of support<br>4. Treatment & recovery history<br>5. Engagement & recovery status | 1. Recovery Maintenance and Health Management<br>2. Low Intensity Community Based Services<br>3. High Intensity Community Based Services<br>4. Medically Monitored Non-Residential Services<br>5. Medically Monitored Residential Services<br>6. Medically Managed Residential Services |
| <b>Level of Intensity Screening Tool (LIST)</b> | Sacramento                               | 1. Clinical Complexity<br>2. Risk Factors<br>3. Life Circumstances<br>4. Comorbidity                                                                                                                              | 1. Managed Care Plan/PCP<br>2. Community Outreach Recovery Empowerment (CORE) Programs<br>3. FSP Programs<br>4. Sub-acute Consideration                                                                                                                                                 |

**TABLE G. SMI LEVEL OF CARE (LOC) TOOLS USED BY CASE STUDY COUNTIES, CONTINUED**

| Tool                                                            | Counties          | Assessment Domains                                                                                                                                   | Levels of Care/Needs                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Milestones of Recovery Scale (MORS)</b>                      | Orange, San Diego | 1. Clinical status<br>2. Quality of life<br>3. Adverse events<br>4. Satisfaction with Care                                                           | 1. Extreme risk<br>2. High risk/not engaged<br>3. High risk/engaged<br>4. Poorly coping/not engaged<br>5. Poorly coping/engaged<br>6. Coping/rehabilitating<br>7. Early recovery<br>8. Advanced recovery                                                                                                                       |
| <b>Adult Needs and Strengths Assessment (ANSA)<sup>53</sup></b> | Sacramento        | 1. Life Functioning<br>2. Strengths<br>3. Cultural Factors<br>4. Behavioral/Emotional Needs<br>5. Risk Behaviors<br>6. Caregiver Resources and Needs | 1. No evidence/no action needed<br>2. Significant history or possible need that is not interfering with functioning/ watchful waiting/prevention/additional assessment<br>3. Need interferes with functioning / Action/intervention required<br>4. Need is dangerous or disabling / Immediate action/Intensive action required |
| <b>A/OA Outpatient Utilization Management Form</b>              | San Diego         | 1. Client Specific Issues<br>2. Environmental Issues<br>3. Clinical Issues                                                                           | 1. Ongoing Services at County Outpatient Program<br>2. Primary Care Referral<br>3. Fee for Service or Managed Care Plan Referral                                                                                                                                                                                               |

Four of the eight counties use the Level of Care Utilization System (LOCUS) in some capacity, largely considered the best level of care tool in the market.<sup>54</sup> While Los Angeles and Yolo use LOCUS across every type of placement, Sacramento only uses LOCUS for higher levels of care placements, such as subacute programs and semi-locked facilities. Appendix Q provides more information on LOCUS.

Two counties, San Diego and Sacramento, use multiple tools to assess clients at various levels of care. Both counties referenced adjusting their processes to fit the unique needs of their patients. Sacramento, for instance, developed a custom tool, LIST<sup>55</sup>, for FSP placements because LOCUS was causing administrative barriers that caused delays for patients accessing FSPs. For reassessments, they use both Adult Needs and Strengths Assessment (ANSA) tool (Appendix R) and specifically highlighted their use of the CalAIM Assessment tool (Appendix S). Counties are required to use this assessment for individuals eligible to receive Specialty Mental Health Services (SMHS), as established in BHIN 23-068.<sup>56</sup>

San Diego uses three different tools for various use cases. Outpatient adult clinics use the Milestones of Recovery Scale (MORS) Assessment for assessing patients who may need a higher level of care (Appendix T). Practitioners in higher levels of care programs use LOCUS for placing patients in specific ACT or ICMS programs.<sup>57</sup> They use the A/OA Outpatient Utilization Management Form for reassessments to monitor progress and continued eligibility for services (Appendix U).

53. Adult Needs and Strengths Assessment (Standard Comprehensive ANSA 3.0). (2020). The John Praed Foundation. [https://praedfoundation.org/wp-content/uploads/2023/06/2021.03.03\\_REFERENCE-GUIDE\\_Standard-Comprehensive-ANSA\\_FINAL\\_Hyperlinked.pdf](https://praedfoundation.org/wp-content/uploads/2023/06/2021.03.03_REFERENCE-GUIDE_Standard-Comprehensive-ANSA_FINAL_Hyperlinked.pdf)

54. Sowers, W., George, C., & Thompson, K. (1999). Level of care utilization system for psychiatric and addiction services (LOCUS): a preliminary assessment of reliability and validity. *Community Mental Health Journal*, 35(6), 545–563. <https://doi.org/10.1023/a:1018767403107>

55. Sacramento County Department of Health Services. (2024). Level of Intensity Screening Tool (LIST) Instruction Manual. Retrieved from <https://dhs.sacounty.gov/BHS/SiteAssets/Pages/GI-Provider-Resources-Forms/LIST%20Instruction%20Manual-%20Updated%20November%202024.pdf>

56. Baass, M., & Newsom, G. (2023). Behavioral Health Information Notice No: 23-068. California Department of Healthcare Services. <https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf>

57. Level of Care Utilization System for Psychiatric and Addiction Services - Adult Version 20, December 2016. (2016, December). Optum San Diego. [https://www.optumandiego.com/content/dam/san-diego/documents/organizationalproviders/ucrm/LOCUS\\_Instrument\\_Version\\_20.pdf](https://www.optumandiego.com/content/dam/san-diego/documents/organizationalproviders/ucrm/LOCUS_Instrument_Version_20.pdf)



Placer County doesn't use an SMI level of care tool for all specialty mental health services evaluations. Rather, they use the Key Event Tracking (KET), a tool required to use in cases of significant incidences, to evaluate an individual's eligibility for FSPs.<sup>58</sup>

LOCUS is Los Angeles's only level of care tool<sup>59</sup>, used for initial evaluation, reassessment, and FSP/ACT evaluation. After CalAIM was implemented across their system, they experienced a large influx of new patients across different levels of care, resulting in capacity issues for certain programs and patients getting stuck in treatment. They hope LOCUS will help in assessing program utilization across different levels of care and identifying gaps in their system. Although they are still in the process of implementing the tool across all adult programs, they have developed rigorous processes around reassessment and data collection that will enable them to iterate as implementation continues.

“

*As CalAIM was implemented and as network adequacy standards were developed and counties were held to those standards, we realized that we had...a freeway that had 15 on ramps and two off ramps.*

”

Mono County shared different experiences with standardized assessments. As a small county with just over 10,000 adults, they know the majority of their SMI patients and prefer using a localized, case-by-case approach when it comes to SMI level of care. They expressed dissatisfaction with the current level of standardization of screening, saying that it works for large counties like Los Angeles, but “undermines” small counties and the unique challenges they face. While they acknowledge that data collection and analysis is important, they emphasize how the state needs to recognize the nuance and narratives of counties as small as Mono.

Overall, counties use a small range of LOC tools but for different use cases and purposes, tailoring their approach to fit the unique needs of their county.

### ***Challenges with SMI levels of care***

These interviews brought to light four key challenges counties face with existing SMI level of care processes: data collection and management; interpretation of assessment results; program capacity; and gaps in levels of care.

Table H evaluates counties across their multiple assessment phases, data tracking and collection methods, and overarching themes related to SMI levels of care assessments.

58. The State requires a county to submit a KET to DHCS when a “key event” occurs for a FSP client. Key events include: changes to residential status, employment, emergency room visits, arrests, and/or discontinuance from the program.

59. Wong, L. H. (2025). Quality Assurance Bulletin. Lacounty.gov; County of Los Angeles – Department of Mental Health. [https://file.lacounty.gov/SDSInter/dmh/1170563\\_OABulletin24-091LOCUSImplementationforAdults.pdf](https://file.lacounty.gov/SDSInter/dmh/1170563_OABulletin24-091LOCUSImplementationforAdults.pdf)

**TABLE H. CASE STUDY COUNTY THEMATIC TABLE**

| Initial Evaluation                                                                                                                                                                                                                                                                                       | Reassessment                                                                                                                                                                                                                                | FSP/ACT Evaluation                                                                                                                                                                                   | Data Tracking                                                                                                                                                                     | Features & Themes                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LOS ANGELES</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                             |                                                                                                                                                                                                      |                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>Practitioners are being trained on LOCUS; full County implementation goal of July '25.</li> <li>Concordance in LOC assignment with providers is currently high.</li> </ul>                                                                                        | <ul style="list-style-type: none"> <li>Clients reassessed using LOCUS every 6 months.</li> </ul>                                                                                                                                            | <ul style="list-style-type: none"> <li>Assess clients with LOCUS (levels 4 and 5 are FSP).</li> <li>Reevaluated quarterly vs 6 months.</li> </ul>                                                    | <ul style="list-style-type: none"> <li>Currently monitor data every two weeks given stage in implementation, but will continue to evolve.</li> </ul>                              | <ul style="list-style-type: none"> <li>Emphasizes <b>provider training</b> and <b>clinical judgment</b>.</li> <li>Consistent <b>LOCUS</b> use across LOC assessments.</li> <li>Specific LOC servicing <b>Unhoused Population</b>.</li> </ul>                                                                                 |
| <b>MONO</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                             |                                                                                                                                                                                                      |                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>County performs case-by-case client evaluation and does not rely heavily on screening tools for SMI assessment.</li> </ul>                                                                                                                                        | <ul style="list-style-type: none"> <li>Per the clinician and the client based on assessment of their needs.</li> </ul>                                                                                                                      | <ul style="list-style-type: none"> <li>Rehab-aid as one of the higher LOCs. No official "wraparound" services, so they create them for clients as needed.</li> </ul>                                 | <ul style="list-style-type: none"> <li>Reports has hired someone to track the data required by the State including time to service, number of providers, etc.</li> </ul>          | <ul style="list-style-type: none"> <li>Emphasizes how <b>standardization of LOC</b> can hurt small counties.</li> <li>Has had to swap <b>staff</b> from patient care to admin work due to state requirements.</li> </ul>                                                                                                     |
| <b>ORANGE</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                             |                                                                                                                                                                                                      |                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>Uses repurposed MORS for initial evaluation at every location &amp; crisis lines. Assesses homelessness, hospitalizations, and MCP histories.</li> <li>Every program is an access point for higher level of care. Have three levels of outpatient LOC.</li> </ul> | <ul style="list-style-type: none"> <li>Clients reassessed at minimum every 6 months.</li> </ul>                                                                                                                                             | <ul style="list-style-type: none"> <li>MORS + specific eligibility criteria for FSPs.</li> <li>Keep clients in FSP until deemed ready to step down to MCP.</li> </ul>                                | <ul style="list-style-type: none"> <li>Tracks data from assessments and reassessments in the EMR, but the current system makes accessing and analyzing data difficult.</li> </ul> | <ul style="list-style-type: none"> <li>Concerns for data system funding to analyze data.</li> <li>Clients do not step down from FSP until ready for MCP.</li> <li>Emphasizes the importance of No Wrong Door in care access.</li> <li>Updated hospitalization criteria for FSPs.</li> </ul>                                  |
| <b>PLACER</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                             |                                                                                                                                                                                                      |                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>Psychosis and suicide attempt are automatic SMHS placements.</li> <li>Once SMHS need is determined, three supervisors work together to determine level of care.</li> </ul>                                                                                        | <ul style="list-style-type: none"> <li>Once in crisis services, discuss the need to move them up a level. Lots of clinical judgment.</li> <li>Meet weekly to determine transition plan for people who are already in the system.</li> </ul> | <ul style="list-style-type: none"> <li>Uses KET to determine specific FSP placement for clients deemed FSP-eligible.</li> <li>Reassesses frequently and when there's a significant change</li> </ul> | <ul style="list-style-type: none"> <li><i>NOT OBTAINED</i></li> </ul>                                                                                                             | <ul style="list-style-type: none"> <li>Created <b>new LOC with client counsel, Mid-Service Partnerships</b>, to address steep drop btw FSP &amp; clinical LOCs</li> <li>Doesn't use SMI LOC tool; use KET for FSP assessment.</li> <li>Reports LOCUS not sensitive enough when used. Currently refining new tool.</li> </ul> |

**TABLE H. CASE STUDY COUNTY THEMATIC TABLE, CONTINUED**

| Initial Evaluation                                                                                                                                                                                                                                              | Reassessment                                                                                                                                                                                                                                                                                  | FSP/ACT Evaluation                                                                                                                                                                                                                                                      | Data Tracking                                                                                                                                                              | Features & Themes                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SACRAMENTO</b>                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                         |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>One Core services hub for step down and escalating LOC.</li> <li>Uses LIST to assess LOC and LOCUS for sub-acute and locked facilities.</li> <li>Modified LIST in Jan '25 to emphasize homelessness as a need</li> </ul> | <ul style="list-style-type: none"> <li>Clients reassessed using CalAIM Assessment and ANSA tools every 6 months.</li> </ul>                                                                                                                                                                   | <ul style="list-style-type: none"> <li>LIST, ANSA, and clinical assessment are used to assess for FSP.</li> <li>ANSA scores and biopsychosocial indicators used for FSP reassessment</li> </ul>                                                                         | <ul style="list-style-type: none"> <li>No data infrastructure for assessing clients in each LOC.</li> <li>Developing algorithm based on ANSA.</li> </ul>                   | <ul style="list-style-type: none"> <li>Different LOC tools per LOC (admin barriers with LOCUS).</li> <li>Core services flex up and down as needed rather than transferring between levels.</li> <li>Developed FSP graduation guidelines</li> </ul>                                                                    |
| <b>SAN DIEGO</b>                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                         |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Uses LOC tools for assessments, but places emphasis on clinician input and nuanced evaluations for final placements</li> <li>Use MORS for outpatient clinics</li> </ul>                                                  | <ul style="list-style-type: none"> <li>Clients reassessed using A/OA Outpatient Utilization Management Form.</li> <li>Reassesses clients on "case by case plan".</li> <li>Highly consider suicidality and screen utilizing the Columbia, but evaluate for biopsychosocial factors.</li> </ul> | <ul style="list-style-type: none"> <li>Use LOCUS for ACT and IMCS program placements.</li> </ul>                                                                                                                                                                        | <ul style="list-style-type: none"> <li><i>NOT OBTAINED</i></li> </ul>                                                                                                      | <ul style="list-style-type: none"> <li>Emphasizes "clinical art" in tandem with LOC tools.</li> <li>Uses different LOC tools per program</li> <li>Low capacity with higher LOCs and lack of beds for step-down.</li> <li>Concerns with how CARE Act impacts service utilization, esp. for FSPs &amp; ACTs.</li> </ul> |
| <b>SAN MATEO</b>                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                         |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Regional team conducts full assessment for incoming clients with SMIs.</li> <li>Does not use any SMI LOC tool for evaluations.</li> </ul>                                                                                | <ul style="list-style-type: none"> <li>Uses a transition tool for step down requests, at the request of 3<sup>rd</sup> party provider</li> <li>Step down determined by both the tool and clinician judgement.</li> </ul>                                                                      | <ul style="list-style-type: none"> <li>FSP eligibility is based on acuity and need for intensive level services.</li> <li>Criteria includes: recent PES/ED visits, psychiatric hospitalizations, locked/secure facility history, and loss of support system.</li> </ul> | <ul style="list-style-type: none"> <li>Wants more client data access for providers to see client system history. Unclear how they currently track data.</li> </ul>         | <ul style="list-style-type: none"> <li>Two LOC assessment levels: Screening tool and biopsychosocial assessment by clinician.</li> <li>Provider training is a limitation on assessing LOC.</li> <li>Concern for cultural limitation in standardized assessments.</li> </ul>                                           |
| <b>YOLO</b>                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                         |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Uses LOCUS for all 6 LOCs</li> <li>Performs biopsychosocial assessment and uses LOCUS to assign LOC.</li> </ul>                                                                                                          | <ul style="list-style-type: none"> <li>Reassess clients at least 1x yr using LOCUS.</li> <li>Administer the CANs and PSC 35 every 6 months.</li> <li>Use LOCUS when there is a significant change in functioning.</li> </ul>                                                                  | <ul style="list-style-type: none"> <li>Uses LOCUS for FSP assessments</li> <li>Assign clients to a lower level of care if FSPs are full in an attempt to still provide necessary support.</li> </ul>                                                                    | <ul style="list-style-type: none"> <li>Trying to improve ability to data analyze in-house.</li> <li>Limited by antiquated EMR and lack of data analytics staff.</li> </ul> | <ul style="list-style-type: none"> <li>Concern for provider training and availability in smaller county with high needs.</li> <li>Considered ANSA, but continued with LOCUS due to staff preference.</li> </ul>                                                                                                       |

### **Data collection and management**

Antiquated systems, lack of data collection requirements, and client history access all contribute to challenges counties face around data collection and management for SMI level of care specifically. Counties discussed how data challenges can cause a lack of understanding in how to allocate resources, where to place patients who have unique cases, and accuracy of tool assessment results. Orange and Yolo counties specifically discussed Electronic Medical Records (EMRs); despite EMRs holding valuable patient history, providers are unable to track and pull specific information around assessment and reassessment results. Sacramento, Orange, San Mateo, and Yolo counties all expressed challenges with outdated systems that don't allow them to collect specific data around level of care outcomes and illness severity. Los Angeles, although they collect detailed data around level of care placements, didn't specify how they track or manage that data.

“

***It's just a harder decision to make, to say that [a] program is going to go away because [the county] needs to have a better technology system...Long term, having great technology in your program is probably going to help you. But it's always that upfront cost.***

”

### **Interpretation of assessment results**

Overall, every county official we spoke to emphasized the importance of clinical judgment in the evaluation process. Serious mental illness is complex, and solely relying on a level of care tool to place patients can have adverse consequences. San Diego's county official discussed how tools are useful, but final decisions on placing patients should have “more nuanced aspects of clinical artistry.” Additionally, Orange County discussed the challenges of where to place a patient who is “right on the edge” of two levels of care, which can lead to patients being bounced back and forth between different treatments.

“

***There are cases where...one can sort of make a considered decision based upon screening. [It's] not going to be the score on an instrument, but all of the sort of tools of clinical art will be weighed into making a decision.***

”

However, leveraging SMI level of care tools to assess system gaps and patient progress has shown to be useful for certain counties, especially when using them in ways to fit their specific needs. Los Angeles, for example, discussed their switch to LOCUS as one method in improving program capacity challenges. Placer County, despite not using a SMI level of care tool, uses KET, a tool typically used to measure patient progress within FSPs, for initial FSP placements due to its questions around suicide attempts, utilization of crisis services, and hospital visits. Orange County, on the other hand, leverage elements of MORS for their initial screening process, but use MORS in its entirety for reassessments at lower levels of care.

Training was also identified as a key component of effectively analyzing tool assessment results. Yolo expressed their concern with reliability and quality, stating that training is “important to ensure inter-rater reliability.” San Mateo also discussed the nuances of placing individuals in care based on tool results. They discussed how some patients assessed at initial screening were placed in non-specialty services, but ended up being hospitalized and eventually placed into higher levels of care. They also discussed how common disorders like personality disorders tend to immediately get diagnosed as serious when they may not require higher levels of care.

### ***Program capacity***

Low program capacity was frequently cited as a concern, which can make level of care evaluations irrelevant if there is no capacity for the recommended placement. Los Angeles, Yolo, and Sacramento all discussed low availability in their Full Service Partnership (FSP) programs, which can lead to patients getting placed in lower or higher levels of care that aren’t suited for their needs. Yolo, for example, has their lower intensity service teams “step up” and provide the higher levels of care to patients who are waitlisted for FSPs, but this isn’t always successful and can cause strain on staff. San Diego, on the other hand, referenced low capacity of beds in residential care, saying “we got a healthy dose of people sitting in acute psych[iatry]...that do not meet medical necessity but whom we cannot step down because we do not have the beds available.”

“

***We just don't have enough capacity to meet the growing need...We're seeing people with higher acuity needs and more people coming in the front door. And we're really struggling with workforce shortage and vacancies as well. And so that's making it difficult to be able to serve the growing need.***

”

Counties referenced three factors that may contribute to limited program capacity: funding constraints, challenges surrounding the implementation of the No Wrong Door Policy, and workforce shortages.



Yolo specifically discussed funding as an issue, saying that they have fewer funding opportunities based on their size, but their needs for FSPs require more funding from the state. The No Wrong Door Policy, implemented through CalAim, enables anyone seeking care to enter the system at any location. Although it has been helpful in increasing access to needed care, several counties discussed how the No Wrong Door Policy can contribute to capacity challenges and keep patients in the wrong level of care. Orange County, for instance, said that when they don't have capacity in higher levels of care, they will place patients in lower levels of care instead. San Diego County, on the other hand, discussed how some patients who come to them "shouldn't be [their] patients", but they are required to provide them care. However, county officials also acknowledged that in many instances, clients would not otherwise receive care if not for No Wrong Door.

“

*The door leading into the county system is on very loose hinges. The door exiting the county system is **rusty**.*

”

Multiple counties also discussed provider availability and quality in relation to program capacity. Yolo and Mono counties both expressed challenges how provider shortages impact their ability to meet their SMI population's need for treatment. Los Angeles discussed the value of undertaking a needs assessment to identify provider gaps in particular service areas. Both San Mateo County and Placer County discussed the importance of provider training to ensure both quality of services and proper usage of level of care tools. This emphasis on the quality and availability of providers by the counties indicates an essential cog in the management of SMI populations across systems.

### ***Level of care gaps***

Level of care gaps is another challenge referenced in our interviews that can lead to steep changes in care intensity and program capacity.

In relation to level of care gaps, Los Angeles County described the large gap in care intensity between residential treatment programs and outpatient programs like FSPs and ACTs. They discussed how this can lead to challenges for patients who are eligible to step down a level of care, but need an intensity that is higher than what is available.

Orange County approaches this challenge by keeping individuals in FSPs and providing the “entire continuum” of care at each stage of recovery until they are deemed ready to step down to a Managed Care Plan (MCPs), which are more traditional services for individuals with mild to moderate mental illnesses. Placer County, on the other hand, created a new program, named Mid-Service Partnerships, to address the steep drop-off of intensity of care between FSPs and clinical services.

“

***About a year ago, we recognized that between FSPs and clinic services...there was a big gap and there was nowhere for people to step down to or step up that didn't really need FSP.***

”

In relation to level of care gaps, Mono County discussed how a lack of good quality providers can result in patients staying in higher levels of care longer than necessary. They referenced that when a patient is ready to step down, their referred providers often aren't adequate, causing clients to abandon care or stay in their current level of care.

Processes for stepping down to different levels of care has its own nuances across counties. San Mateo referenced how comorbidities like substance use disorder can lead to patients getting placed in the wrong level of care. They also shared scenarios where patients will get prescribed medication in their higher levels of care, which improves their conditions and make them no longer eligible for higher levels of care, so “they're kind of in the wrong place.”

## **Discussion**

Across all demographics and ages, all eight counties had less than a 30 percent treatment rate for individuals with SMIs. This indicates there is room for improvement around program capacity. Additionally, our qualitative analysis demonstrated how assessments can impact program capacity. Los Angeles County explicitly discussed how LOCUS can help them identify such program capacity gaps to ensure more resource allocation, indicating the importance of rigorous level of care assessment processes for serious mental illnesses. Mono County, on the other hand, discussed how standardization has negatively impacted care. For this reason, it is important to develop a framework that emphasizes standardization while also recognizing the unique needs of smaller counties.

Some connections can be made between SMI treatment rates, identified in our quantitative analysis, and program capacity, mentioned in our interviews. Yolo County, for instance, had low treatment rates across all demographics and referenced program capacity issues, specifically for FSPs. While we cannot draw causal conclusions around SMI treatment and levels of care, this research offers several avenues for the Steinberg Institute to focus their future research, particularly around best practices for level of care assessments and how standardization impacts the efficiency and equitability of treatment placement and outcomes.

## SECTION FOUR

# POLICY OPTIONS





# Policy Options

From our analysis outlined in the previous chapter, we identified key policy approaches to enhance care assessment and promote greater equity and access to treatment. Our team did not research the implementation of these policy options, so we encourage trials before widespread adoption for each of our policy ideas.

## POLICY OPTION ONE

**Statewide Standardized  
Level of Care Model & Opt  
Out Option**

## POLICY OPTION TWO

**Strengthen Data  
Infrastructure for Care  
Quality Assessment**

## POLICY OPTION THREE

**Strengthen Level of Care  
Assessment Training**

## POLICY OPTION FOUR

**Continue Research on  
Level of Care**

### ***Policy Option #1: Statewide Standardized Level of Care Model & Opt-Out Option***

According to our findings, some counties across California use different tools to assess the level of care for individuals with serious mental illness (SMI) which may create inconsistencies in diagnosis and care assignment. While some counties (e.g Los Angeles, Orange, Yolo) rely on standardized tools like LOCUS or MORS, others such as Sacramento have developed their own assessments or lack the capacity to implement a formalized tool. These disparities contribute to inefficiencies in implementing behavioral health initiatives across the state and could lead to inequitable access to appropriate care across the state. To address this, we propose implementing a Statewide Standardized Level of Care Model that ensures uniform assessment practices across all counties. ***We recommend LOCUS to be used as the standardized assessment framework for all California counties*** because it is a consistent and objective evaluation tool across various care settings, enhancing the quality and coordination of mental health services statewide.

***LOCUS is one of the most credited and used levels of care frameworks in the United States.***

Since its development, LOCUS has become extensively used throughout the United States, with 26 states utilizing the system. By utilizing this tool, states have been able to promote effective resource allocation, improve treatment outcomes, and facilitate communication among providers, payers, and other stakeholders.

The tool utilizes six categories called ‘dimensions’ that describe different aspects of a person and their illness: 1) risk of harm, 2) functional status, 3) medical, addictive and psychiatric co-morbidity, 4) recovery environment, 5) treatment and recovery history and 6) engagement and recovery status. Using a scale of 1 to 5, the clinician ranks a patient based on observed severity on each dimension, with 5 being the most severe. The clinician then adds the numbers for each dimension together for a total score that indicates a person’s degree of need and the corresponding level of care needed. Once LOCUS identifies the correct level of care, providers select from a series of county-provided services tailored to a person’s particular need.

While statewide standardization is vital for achieving equitable rollout of behavioral initiatives and ensuring transparency and accountability of patient centered outcomes, interviews with county officials revealed that some counties are unable to conform to the standard model in California based on county demographics (e.g., population size, rural vs urban) and as such may benefit from maintaining local control over their level of care assessments.

***To balance these perspectives, we propose an Opt-Out option within the Statewide Standardization Level of Care Model.*** This would establish a statewide standard, but allow counties that fit specific criteria to opt out if they develop and implement their own validated assessment tool that meets both key state-defined criteria and their own unique needs of their locale.

Opt-out criteria would be modeled after Proposition 1, a ballot measure passed by California voters in March 2024 that included the Behavior Health Services Act (Senate Bill 326 Eggman).<sup>60</sup> BHSA mandates key reforms to behavioral health services across all counties but includes specific provisions for smaller counties with populations, allowing them to request adjustments to mental health funding. For instance, counties with populations of less than 200,000 can request exemptions on spending 30% of administered funds to Housing Interventions.<sup>61</sup> This approach ensures a baseline level of consistency while giving certain counties the flexibility to tailor their assessment methods to local needs. Additionally, counties opting out would be required to demonstrate the effectiveness of their tools through data reporting and evaluations, ensuring accountability and equitable care access.

The Level of Intensity Screening Tool (LIST) is a standardized assessment tool developed by Sacramento County's Division of Behavioral Health Services to determine the appropriate level of care for individuals with mental health needs. It evaluates various domains to support clinical decisions regarding service intensity and placement. ***LIST is tailored to the unique factors affecting individuals in Sacramento County, while LOCUS has a broader, more generalizable structure.*** For example, Sacramento County integrated justice involvement and social determinants of health (e.g., housing instability) into LIST, recognizing these as major factors influencing mental health outcomes locally. LOCUS focuses on assigning a level of care ranging from basic outpatient services to inpatient services but LIST ensures alignment with local programs such as their community outreach recovery empowerment (CORE) or sub-acute consideration.

LIST was also designed to fit within the county’s electronic medical records system. LOCUS is a standalone national tool that requires additional integration for use within county-level service

60. California Department of Health Care Services. (2024). Proposition 1 Fact Sheet. Retrieved from <https://www.dhcs.ca.gov/BHT/Pages/Fact-Sheet-Prop-1.aspx>

61. Behavioral Health Services Act County Policy Manual. (2025). In dhcs.ca.gov. California Department of Healthcare Services. <https://www.dhcs.ca.gov/BHT/Documents/Behavioral-Health-Services-Act-County-Policy-Manual.pdf>



networks. So, if a county who is not currently using LOCUS, for example, is required to use it, there may be administrative and funding capacity issues preventing sound implementation.

## ***Policy Option #2: Strengthen Data Infrastructure for Care Quality Assessment***

***Strengthening Data Collection and Data Infrastructure for Level of Care across all California counties can provide invaluable information to help the state better understand inequities and gaps in systems.*** Counties currently use fragmented data and do not have the ability to track the severity of illness for people enrolled in treatment. Additionally, they do not have the ability to track the severity of illness for people enrolled in treatment, nor do they have the data to better understand what types of individuals would benefit from specific programs. For example, Orange County stated that they have no ability to track the severity of illness for people enrolled in treatment, nor do they have the data to better understand what types of individuals would benefit from specific programs.

***Counties indicate that this issue largely stems from outdated technological systems, which limit the ability of counties to track and share essential mental health data.*** Updating these systems and establishing standardized data collection practices can help close this gap, allowing counties to better assign care, track patient progress, and improve treatment outcomes. By creating a shared database for counties to report on level of care assessments and service utilization, the state can gain a clearer picture of regional disparities, resource needs, and best practices. This, in turn, will support data-driven decision-making, ensuring that California allocates mental health resources equitably and effectively across all counties

## ***Policy Option #3: Strengthen Level of Care Assessment Training***

Some counties expressed that they either do not use formal levels of care tools or struggle to implement them effectively due to a lack of training. Additionally, there is no mandatory training for level of care assessments across the state or counties.<sup>62</sup> Without adequate training, even standardized tools like LOCUS or MORS may not be used correctly, leading to discrepancies in care assignment. Additionally, limited staff capacity and high turnover rates further exacerbate the challenge of maintaining trained personnel who can effectively conduct level of care assessments.

***To address these challenges, we propose Strengthening Level of Care Assessment Training to ensure that mental health professionals across counties have the knowledge and skills to implement assessment tools effectively.*** By investing in comprehensive training, the state can improve the reliability of level of care assessments, ensuring that individuals with SMI receive appropriate and equitable care across all counties.

62. Toward A National Standard for Service Intensity Assessment and Planning for Mental Health Care. (2025, January 30). National Council for Mental Wellbeing. <https://www.thenationalcouncil.org/resources/service-intensity-assessment-and-planning/>

### ***Policy Options #4: Continue Research on Level of Care***

While our research provides valuable insights into how different California counties administer level of care tools, we recognize that a more comprehensive study is needed to fully understand the relationship between SMI prevalence, treatment outcomes, and the implementation of level of care assessments. Given the limited scope of our study, we were unable to explore all 58 counties, making it difficult to draw definitive conclusions about how assessment methods impact service accessibility and care quality statewide.

We recommend that the Steinberg Institute continue investigating the role of level of care tools in shaping mental health service delivery across California. Future research could focus on how different assessment methods influence treatment engagement, resource allocation, and overall health outcomes for individuals with serious mental illness. Additionally, further study is needed to evaluate the feasibility of our proposed policy options in real-world settings.

By deepening this research, the Steinberg Institute can help inform evidence-based policy solutions that address gaps in care and initiate a broader statewide conversation on how level of care assessments can improve mental health outcomes. We encourage continued engagement with county staff, providers, and stakeholders to ensure that future policy decisions are grounded in a robust understanding of local needs, challenges, and best practices.

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SECTION FIVE

# POLICY EVALUATION





# Policy Evaluation

We plan to evaluate our proposed policy options based on the following four criteria: (1) equity, (2) effectiveness, (3) efficiency and (4) feasibility. These criteria are in accordance with our overall policy question and were generated in coordination with our client; we used the Steinberg Institute's 2022-25 Strategic Plan<sup>63</sup> to align the proposed criteria to their foundational objectives. This strategic plan highlights the institute's mission to "transform California's systems of care for those living with mental health and substance use disorders by establishing a right to care for all; ensuring a system that prioritizes transparency and accountability and health equity; and inspiring leadership and spreading innovation and best practices."

We developed this evaluative criteria to aid in determining how Steinberg Institute should prioritize future research and legislative policy efforts related to levels of care. This approach ensures that our policy recommendations are aligned with the goals of our client and the needs of stakeholders in California. A detailed description of each criterion follows:

- **Effectiveness:** This criterion measures the extent to which a policy achieves its intended goals and delivers the expected outcomes in addressing the identified issue
- **Equity:** This criterion evaluates whether a policy distributes benefits fairly, ensuring that vulnerable or historically marginalized communities receive adequate support and protection from adverse impacts
- **Efficiency:** This criterion considers how well a policy uses resources by comparing the outcomes achieved to the costs incurred.
- **Feasibility:** This criterion considers the practical likelihood of a policy's implementation by assessing administrative constraints

To assist with evaluating our policy options, we will be using a Criteria Alternatives Matrix (CAM) and weigh all criteria equally. In conversations with our client, we determined that each of these criteria are important and must be equally considered when evaluating mental health policy. To receive the full points, we decided on a simple evaluation by indicating if a policy option does not or does meet the criteria. If a policy option scores a 1, it does not meet the criteria. If a policy option scores a 2, it does meet the criteria.

## Criteria

In conducting the analysis, the Steinberg Institute is most concerned about access and the overall distribution of mental health resources; the effectiveness of connecting clients to the types of mental health services that are needed to address severe mental health diagnoses; and what adopted approaches are likely to generate the highest benefit per unit cost. Below we describe equity, effectiveness, and efficiency fully as the guiding values used to evaluate policy alternatives under consideration.

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63. Vision 2030 - Steinberg Institute. (2023, September 21). Steinberg Institute. <https://steinberginstitute.org/vision-2030/>

## Equity

We have determined that equity as a criteria option in our evaluation is essential to promote the goals set forth by the Steinberg Institute's strategic plan. Both Steinberg Institute and the literature recognize that Black, Indigenous, Persons of Color (BIPOC), LGBTQ+, and rural populations carry a comparatively higher disease burden to other Californian populations likely leading to poorer mental health outcomes and greater system involvement.<sup>64</sup>

Additionally, untreated mental illness and substance misuse in these communities in turn increases the severity of illness impact on the individual, families, and community. This conscious focus on equity reflects our client's commitment to advancing equitable access to care for all Californians living with mental health issues and ensures that our policy evaluation is capturing and quantifying policy impact on vulnerable populations. To evaluate whether a policy option promotes equity, we ask the following question:

**Does the policy option distribute benefits equitably, ensuring that vulnerable or historically marginalized communities receive adequate support and protection from adverse impacts?**

|          |                                                                                                               |
|----------|---------------------------------------------------------------------------------------------------------------|
| Low (1)  | The policy option does not increase resources to close gaps in care for historically marginalized populations |
| High (2) | The policy option does increase resources to close gaps in care for historically marginalized populations     |

## Effectiveness

Steinberg Institute highlights the importance of utilizing models of care that demonstrate tangible improved outcomes and reflect these improvements across diverse California communities. Effectiveness will be emphasized as a criteria because it is essential to consider the extent to which a policy achieves its intended goals and delivers the expected outcomes in addressing the issue. Our client's goal to develop more effective mental health policy has an overarching goal of reducing homelessness, incarceration, and re-admittance into the public mental health system. By incorporating effectiveness into our policy criteria, we are ensuring that our recommendations can achieve these crucial outcomes. To evaluate whether a policy option promotes effectiveness, we ask the following question:

**Does the policy option achieve its intended goals and deliver the expected outcomes in addressing the identified issue?**

|          |                                                                                             |
|----------|---------------------------------------------------------------------------------------------|
| Low (1)  | The policy option is not effective in/at addressing level of care utilization in California |
| High (2) | The policy option is effective in/at addressing level of care utilization in California     |

64. Everett, B. G., Onge, J. S., & Mollborn, S. (2016). Effects of Minority Status and Perceived Discrimination on Mental Health. *Population Research and Policy Review*, 35(4), 445–469.



### ***Efficiency***

Results from our level of care tools evaluation demonstrated the importance of considering the policy criteria of efficiency. Level of care tools were designed to enable more accurate treatment plans to ensure patients are getting assigned to appropriate levels of care. The tools assist health professionals in deciding whether a person should receive outpatient services, residential treatment, crisis stabilization or other levels of care. The inclusion of efficiency aligns with our client's goals in evaluating how well a policy uses resources by comparing the outcomes achieved to the costs incurred. To evaluate whether a policy option promotes efficiency, we ask the following question:

**Does the policy option measure how well a policy uses resources by comparing the outcomes achieved to the costs incurred?**

|          |                                                                                          |
|----------|------------------------------------------------------------------------------------------|
| Low (1)  | The policy option is not efficient in addressing level of care utilization in California |
| High (2) | The policy option is efficient in addressing level of care utilization in California     |

### ***Feasibility***

Drawing upon interviews with California county officials of SMI level of care systems, we determined the importance of including feasibility as a policy criteria. This criteria considers the practical likelihood of a policy's implementation by assessing administrative constraints. In discussion with our client, we recognize that feasibility may encompass administrative, economic and political feasibility. Based on our interviews with county officials, we focus on administrative feasibility given the varying needs and challenges in implementing policies and programs due to technical limitations. The inclusion of feasibility aligns with our clients goals to ensure that innovative best practices are highlighted and that both local and national stakeholders are engaged to transform California's systems of care. To evaluate whether a policy option promotes feasibility, we ask the following question:

**Does the policy option create administrative and/or technical issues?**

|          |                                                |
|----------|------------------------------------------------|
| Low (1)  | The policy option is not feasible to implement |
| High (2) | The policy option is feasible to implement     |

## Criteria Alternatives Matrix (CAM)

Below outlines how each policy option scores based on our outlined criteria.

**TABLE I. POLICY EVALUATION MATRIX (CAM) TABLE**

| POLICY APPROACH |        | Statewide<br>Standardized Level<br>of Care Model & Opt<br>Out Option | Strengthen<br>Data<br>Collection | Strengthen<br>Level of Care<br>Assessment<br>Training | Continue<br>Research on<br>Level of Care |
|-----------------|--------|----------------------------------------------------------------------|----------------------------------|-------------------------------------------------------|------------------------------------------|
| Criteria        | Points | Score Per Criteria                                                   |                                  |                                                       |                                          |
| Equity          | 25     | 25                                                                   | 25                               | 25                                                    | 25                                       |
| Effectiveness   | 25     | 0                                                                    | 25                               | 25                                                    | 25                                       |
| Efficiency      | 25     | 25                                                                   | 25                               | 0                                                     | 25                                       |
| Feasibility     | 25     | 0                                                                    | 0                                | 0                                                     | 25                                       |
| Total Score     | 100    | 50                                                                   | 75                               | 50                                                    | 100                                      |

SECTION SIX



# POLICY RECOMMENDATIONS

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# Policy Recommendations

## ***Primary Recommendation***

### **→ POLICY OPTION 4: CONTINUE RESEARCH ON LEVELS OF CARE**

Our primary policy recommendation is to Continue Research on Levels of Care. This policy option received the highest score across our evaluation criteria: equity, effectiveness, efficiency, and feasibility. This policy option recognizes the complexity of level of care assessments across California and affirms the need for further research before informing future policy decisions.

More specifically, this policy option acknowledges critical gaps in research between level of care assessment frameworks and SMI treatment gaps and outcomes. While our research uncovered differences in how different types of California counties assess SMI levels of care, time constraints and lack of publicly available data prevented us from evaluating all 58 counties to fully determine the nuances and impact of level of care processes. Further research into how the level of care tools influence treatment accessibility can help refine future policy decisions and ensure that California's mental health system is equipped to meet the needs of individuals with serious mental illness (SMI). For instance, while LOCUS is a widely used tool across the United States and is used across several California counties, counties such as Sacramento have shown the ability to create standardization while also tailoring tools to the unique characteristics of the California behavioral landscape more specifically.

We considered policy options that allowed counties to opt out if they developed their own screening tool. However, given the lack of data in how local tools and statewide tools perform, we did not consider that as a policy option. For example, Sacramento County developed the Level of Intensity Screening Tool (LIST), a locally tailored assessment used to determine appropriate levels of care. The County integrates justice involvement and social determinants of health (e.g., housing instability) into LIST, recognizing these as major factors influencing mental health outcomes locally. In contrast, LOCUS is a nationally recognized tool, but it requires additional administrative resources for local integration. While LIST appears well-suited to Sacramento's specific context, there is no public evaluation comparing LIST and LOCUS in terms of accuracy, outcomes, or equity. The lack of data makes it difficult to assess whether a locally developed tool offers advantages over standardized ones.

By continuing this research, the Steinberg Institute can lead efforts to strengthen the mental health system through data-driven policymaking.



## ***Secondary Recommendation***

### **→ POLICY OPTION 2: STRENGTHEN DATA INFRASTRUCTURE FOR CARE QUALITY ASSESSMENT**

Our secondary policy recommendation is to improve the data collection and reporting infrastructure across California counties. Currently, many counties lack the technological capacity to track the severity of illness or determine which individuals benefit from specific levels of care. For example, Orange County reported that they have no ability to track the severity of illness for people in treatment, making it difficult to evaluate service effectiveness. Improving data collection systems and requiring standardized reporting across counties would allow policymakers to identify gaps in service delivery, assess the effectiveness of different levels of care tools, and allocate resources more equitably. While strengthening data infrastructure may require additional investments in technology and staff training, this policy option has the potential to improve efficiency and accountability in California's mental health system.

A sample implementation budget outlining estimated costs for a centralized data infrastructure system is provided in Appendix V.

## ***Other Considerations***

### **→ POLICY OPTION 1: STATEWIDE STANDARDIZED LEVEL OF CARE MODEL & OPT-OUT OPTION**

### **→ POLICY OPTION 3: STRENGTHEN LEVEL OF CARE ASSESSMENT TRAINING**

While these policy options offer potential benefits, they present challenges in feasibility and county-level support. For example, strengthening the level of care assessment training is important for ensuring consistency, but some counties lack the staffing or funding capacity to implement such training programs effectively. Moreover, there is limited data to support which standardized assessment tool should be put forth, impacting the feasibility and efficacy of putting forth these policy recommendations with the present information.

## ***Conclusion***

Ensuring equitable, effective, and efficient mental health care for individuals with serious mental illness (SMI) requires a balanced approach that respects local control while establishing statewide accountability. Our findings suggest that counties vary widely in their level of care assessment methods, and this inconsistency may impact SMI prevalence and treatment outcomes. By continuing research into the effectiveness of different tools (Policy Option 4), the Steinberg Institute can help shape future policies that improve mental health outcomes across California. This recommendation aims to initiate a meaningful policy discussion and drive long-term improvements in California's mental health system.

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# APPENDICES

# Appendices

**APPENDIX A. 2021-2023 American Community Survey Variables**

| Tool  | Age & Sex          | Demographics (18+)                         |
|-------|--------------------|--------------------------------------------|
| 18+   | Male Total (18+)   | All                                        |
| 18-20 | Male 18-20         | White                                      |
| 21-25 | Male 21-25         | Black or African American                  |
| 26-29 | Male 26-29         | American Indian and Alaskan Native (AIAN)  |
| 30-34 | Male 30-34         | Native Hawaiian or Pacific Islander (NHOP) |
| 35-39 | Male 35-39         | Asian                                      |
| 40-44 | Male 40-44         | Hispanic or Latino                         |
| 45-49 | Male 45-49         | 2+ races                                   |
| 50-54 | Male 50-54         |                                            |
| 55-59 | Male 55-59         |                                            |
| 60-64 | Male 60-64         |                                            |
| 65+   | Male 65+           |                                            |
|       | Female Total (18+) |                                            |
|       | Female 18-20       |                                            |
|       | Female 21-25       |                                            |
|       | Female 26-29       |                                            |
|       | Female 30-34       |                                            |
|       | Female 35-39       |                                            |
|       | Female 40-44       |                                            |
|       | Female 45-49       |                                            |
|       | Female 50-54       |                                            |
|       | Female 55-59       |                                            |
|       | Female 60-64       |                                            |
|       | Female 65+         |                                            |



## APPENDIX B. National Survey on Drug Use and Health – 2012 SMI Predictor Model

NSDUH's 2012 model predicting SMI, the logistic regression still in use today, includes these predictor variables:

- Past year K6 score
- Past year WHODAS score
- **Age**
- **Past year MDE (major depressive episode)**
- **Past year Suicidal thoughts**

Based on the analyses of the nearly 5,500 clinical interviews from 2008 through 2012, NSUDH updated their original 2008 model to produce more accurate estimates of serious mental illness.

Revisions for 2012 model are as follows:

- Revised the weights used in fitting the model in the clinical sample
- Added covariates (new covariates above in bold) to improve the accuracy of SMI predictions and to remove biases in prevalence estimates at the subpopulation level, particularly within age groups; and the use of the entire clinical sample from 2008 to 2012 in fitting the model for SMI.

### Process for Selecting Predictor Variables

- A covariate related to a domain of interest would tend to fix the relationship between SMI and that domain
  - Domains of interest: were gender, age group, race/ethnicity group, region, county type, employment level, education, whether the adult received mental health treatment, whether the adult had health insurance, and the adult's household income in relation to the poverty threshold.
- NSDUH tested different SMI models based on the different predictor variables using the overall error rate and domain-level bias.
  - Error rate: the sum of the estimated fraction of false positives and false negatives in the adult population. Models with lower error rates produce more accurate predictions of SMI than models with higher error rates.
  - Domain-level bias: as the difference between the weighted proportions across the clinical sample within a domain of respondents predicted to have SMI, and those actually diagnosed to have SMI. Under the null hypothesis that there is no bias in the domain, this bias measure would not be significantly different from zero.

### Direct Estimate of SMI - Model

- $Y_k$  = actual SMI diagnosis
- $C_k$  = model-based SMI prediction
- $W_k$  = main NSDUH weigh
- $\omega_k$  = clinical sample weight
- $K$  = respondent
- $H_0$  = no bias in the domain
- Cut point estimator for a domain-level prevalence is:  $CD = \sum D\omega_k c_k / \sum D\omega_k$
- $\sum D$  = summation over the domain



## APPENDIX C. 2021 NSDUH Detailed Tables and 2022-2023 NSDUH Detailed Tables

**Table 6.4B – Serious Mental Illness in Past Year: Among People Aged 18 or Older; by Gender and Detailed Age Category, Percentages, 2021**

| Age Category       | Total (2021) | Male (2021) | Female (2021) |
|--------------------|--------------|-------------|---------------|
| <b>TOTAL</b>       | 5.5          | 4.0         | 7.0           |
| <b>18-25</b>       | 11.4         | 6.9         | 16.0          |
| <b>18-20</b>       | 11.2         | 5.8         | 16.9          |
| <b>21-25</b>       | 11.6         | 7.5         | 15.4          |
| <b>26 or Older</b> | 4.7          | 3.5         | 5.7           |
| <b>26-49</b>       | 7.1          | 5.7         | 8.5           |
| <b>26-29</b>       | 9.5          | 6.2         | 12.8          |
| <b>30-34</b>       | 8.0          | 6.4         | 9.5           |
| <b>35-39</b>       | 7.6          | 6.2         | 9.1           |
| <b>40-44</b>       | 4.8          | 4.3         | 5.3           |
| <b>45-49</b>       | 5.6          | 5.0         | 6.3           |
| <b>50 or Older</b> | 2.5          | 1.6         | 3.4           |
| <b>50-54</b>       | 4.8          | 3.1         | 6.3           |
| <b>55-59</b>       | 3.8          | 2.8         | 4.8           |
| <b>60-64</b>       | 2.6          | 1.2         | 3.9           |
| <b>65 or Older</b> | 1.3          | 0.7         | 1.7           |

**Table 6.5B – Serious Mental Illness in Past Year: Among People Aged 18 or Older; by Age Group and Demographic Characteristics, Percentages, 2021**

| Demographic                      | 18+ (2021) | 18-25 (2021) | 26+ (2021) | 26-49 (2021) | 50+ (2021) |
|----------------------------------|------------|--------------|------------|--------------|------------|
| <b>TOTAL</b>                     | 5.5        | 11.4         | 4.7        | 7.1          | 2.5        |
| <b>GENDER</b>                    |            |              |            |              |            |
| <b>Male</b>                      | 4.0        | 6.9          | 3.5        | 5.7          | 1.6        |
| <b>Female</b>                    | 7.0        | 16.0         | 5.7        | 8.5          | 3.4        |
| <b>HISPANIC ORIGIN AND RACE</b>  |            |              |            |              |            |
| <b>Not Hispanic or Latino</b>    | 5.6        | 11.9         | 4.8        | 7.7          | 2.5        |
| <b>White</b>                     | 6.1        | 13.3         | 5.2        | 8.8          | 2.6        |
| <b>Black or African American</b> | 4.3        | 7.7          | 3.7        | 5.3          | 2.1        |
| <b>AIAN</b>                      | 9.3        | *            | 5.6        | 5.5          | *          |
| <b>NHOPI</b>                     | 6.3        | *            | *          | *            | *          |
| <b>Asian</b>                     | 2.8        | 6.7          | 2.3        | 3.2          | *          |
| <b>Two or More Races</b>         | 8.2        | 14.0         | 6.7        | 8.5          | 4.2        |
| <b>Hispanic or Latino</b>        | 5.1        | 9.8          | 4.0        | 4.8          | 2.9        |

**Table 6.4B – Serious Mental Illness in Past Year: Among People Aged 18 or Older; by Gender and Detailed Age Category, Percentages, 2021**

| Age Category       | Total (2022) | Total (2023) | Male (2022) | Male (2023) | Female (2022) | Female (2023) |
|--------------------|--------------|--------------|-------------|-------------|---------------|---------------|
| <b>TOTAL</b>       | 6.0          | 5.7          | 4.8         | 4.3         | 7.1           | 6.9           |
| <b>18-25</b>       | 11.6a        | 10.3         | 8.5         | 7.1         | 14.7          | 13.6          |
| <b>18-20</b>       | 10.9         | 9.2          | 7.8         | 6.1         | 14.3          | 12.5          |
| <b>21-25</b>       | 12.0         | 11.0         | 9.0         | 7.7         | 14.9          | 14.1          |
| <b>26 or Older</b> | 5.1          | 5.0          | 4.2         | 3.9         | 6.0           | 6.0           |
| <b>26-49</b>       | 7.6          | 7.9          | 6.4         | 6.1         | 8.8           | 9.7           |
| <b>26-29</b>       | 9.3          | 11.0         | 7.2         | 8.4         | 11.4          | 13.7          |
| <b>30-34</b>       | 9.8          | 10.3         | 8.4         | 8.7         | 11.2          | 11.8          |
| <b>35-39</b>       | 7.2          | 6.9          | 6.7         | 5.5         | 7.6           | 8.4           |
| <b>40-44</b>       | 6.0          | 6.0          | 5.4         | 4.2         | 6.6           | 7.8           |
| <b>45-49</b>       | 5.8          | 5.6          | 4.1         | 4.0         | 7.4           | 7.1           |
| <b>50 or Older</b> | 3.0          | 2.4          | 2.2         | 1.8         | 3.6           | 2.9           |
| <b>50-54</b>       | 5.4          | 4.5          | 3.0         | 3.4         | 7.4           | 5.5           |
| <b>55-59</b>       | 4.2          | 3.0          | 4.6         | 2.2         | 3.7           | 3.8           |
| <b>60-64</b>       | 3.5          | 2.7          | 3.1         | 2.7         | 4.0           | 2.6           |
| <b>65 or Older</b> | 1.4          | 1.4          | 0.5         | 0.8         | 2.2           | 1.9           |

**Table 6.5B – Serious Mental Illness in Past Year: Among People Aged 18 or Older; by Age Group and Demographic Characteristics, Percentages, 2022 and 2023**

| Demographic                      | 18+<br>(2022) | 18+<br>(2023) | 18-25<br>(2022) | 18-25<br>(2023) | 26+<br>(2022) | 26+<br>(2023) | 26-49<br>(2022) | 26-49<br>(2023) | 50+<br>(2022) | 50+<br>(2023) |
|----------------------------------|---------------|---------------|-----------------|-----------------|---------------|---------------|-----------------|-----------------|---------------|---------------|
| <b>TOTAL</b>                     | 6.0           | 5.7           | 11.6a           | 10.3            | 5.1           | 5.0           | 7.6             | 7.9             | 3.0           | 2.4           |
| <b>SEX</b>                       |               |               |                 |                 |               |               |                 |                 |               |               |
| <b>Male</b>                      | 4.8           | 4.3           | 8.5             | 7.1             | 4.2           | 3.9           | 6.4             | 6.1             | 2.2           | 1.8           |
| <b>Female</b>                    | 7.1           | 6.9           | 14.7            | 13.6            | 6.0           | 6.0           | 8.8             | 9.7             | 3.6           | 2.9           |
| <b>HISPANIC ORIGIN AND RACE</b>  |               |               |                 |                 |               |               |                 |                 |               |               |
| <b>Not Hispanic or Latino</b>    | 6.1           | 5.7           | 12.0            | 10.8            | 5.3           | 5.0           | 8.3             | 8.3             | 3.0           | 2.4           |
| <b>AIAN</b>                      | 7.3a          | 3.3           | *               | 14.0            | 5.9b          | 1.7           | 9.0a            | 3.7             | 2.3           | 0.2           |
| <b>Asian</b>                     | 4.1           | 2.9           | 14.3b           | 7.0             | 2.3           | 2.3           | 2.6             | 3.2             | 1.9           | *             |
| <b>Black or African American</b> | 4.7           | 3.7           | 7.3             | 6.4             | 4.3           | 3.3           | 6.0             | 5.2             | 2.5           | 1.3           |
| <b>NHOPI</b>                     | 3.5           | *             | *               | *               | 3.9           | *             | *               | *               | *             | *             |
| <b>White</b>                     | 6.5           | 6.1           | 12.8            | 11.9            | 5.6           | 5.4           | 9.3             | 9.6             | 3.1           | 2.6           |
| <b>Two or More Races</b>         | 11.8          | 14.0          | 15.8            | 18.9            | 10.9          | 12.7          | 14.9            | 15.1            | 6.1           | *             |
| <b>Hispanic or Latino</b>        | 5.3           | 5.5           | 10.1            | 8.9             | 4.1           | 4.7           | 5.2             | 6.4             | 2.6           | 2.2           |



## APPENDIX D. R Code – K-Means Clustering Procedure for Normalized Treatment Gaps

```
# visualize wss to determine optimal k
fviz_nbclust(scaled_matrix, kmeans, method = "wss") +
  labs(title = "Elbow Method: within-Cluster Sum of Squares")

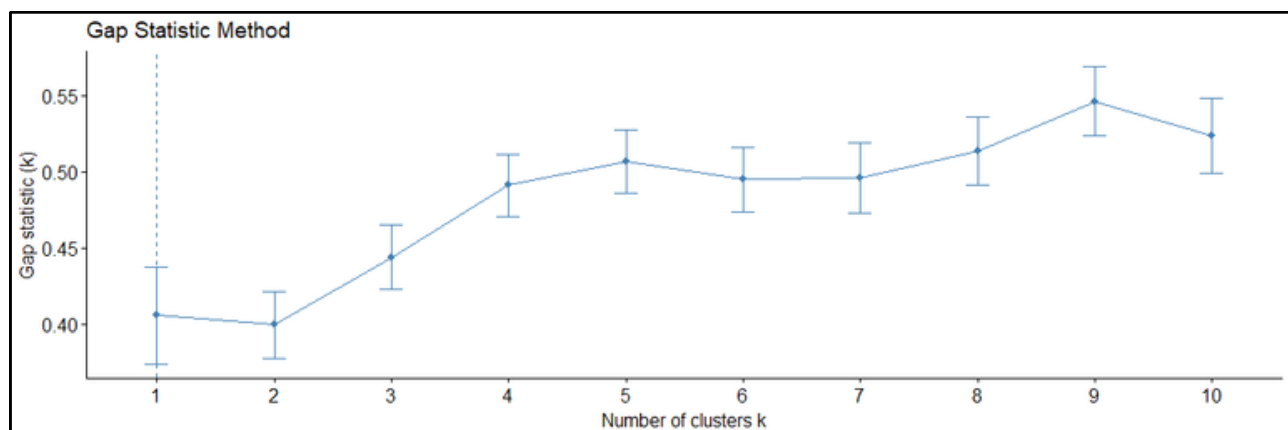
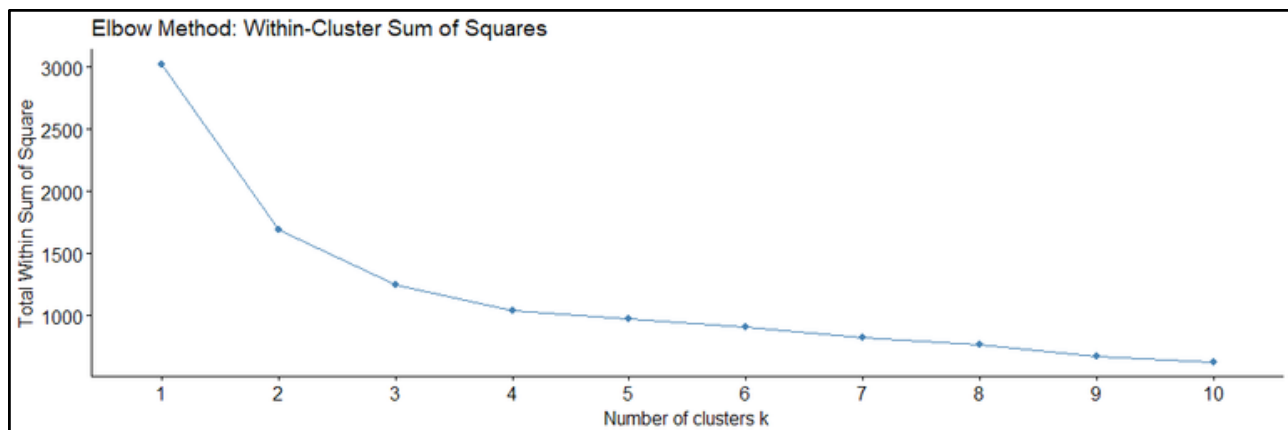
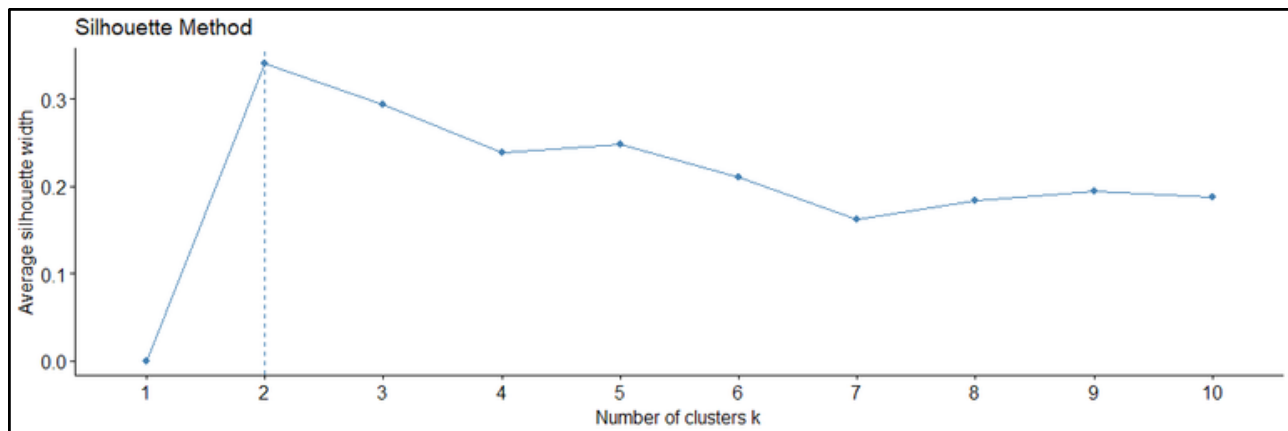
# visualize silhouette scores
fviz_nbclust(scaled_matrix, kmeans, method = "silhouette") +
  labs(title = "Silhouette Method")

# visualize gap statistic
set.seed(123)
fviz_nbclust(scaled_matrix, kmeans, method = "gap_stat") +
  labs(title = "Gap Statistic Method")

## perform clustering with chosen k
## chosen k: 4
set.seed(123)
kmeans_result <- kmeans(scaled_matrix, centers = 4, nstart = 25)
```

## APPENDIX E. County Grouping via Cluster Analysis

To segment counties by patterns in SMI treatment coverage, we employed k-means clustering on a matrix of normalized difference ratios across 18 demographic groups through the years 2021, 2022, and 2023. K-means was selected for its ability to partition observations into non-overlapping groups that minimize within-cluster variance, offering interpretable clusters based on relative treatment coverage gaps. Diagnostic plots were used to assess model fit across varying numbers of clusters. While the silhouette method indicated a local maximum at  $k = 2$ , both the elbow and gap statistic methods demonstrated inflection points near  $k = 4$ , beyond which marginal gains in explanatory power diminished (Appendix D). A four-cluster solution was therefore selected to preserve analytical granularity while avoiding overfitting. Below outlines the code used for the clustering and diagnostics.



## APPENDIX F. Cluster Profiles Based on Treatment Gap Patterns

We conducted an unsupervised clustering analysis using the normalized difference ratio metric across all counties and demographic groups from 2021 to 2023. This multivariate method groups counties based on the structure of their treatment gap profiles. Clustering procedures and visual diagnostics are provided in Appendix T and U.

### Cluster 1 – High Coverage Across Most Demographics

This group exhibits the lowest average normalized difference ratios across nearly all age, gender, and racial demographics, reflecting a close alignment between estimated serious mental illness (SMI) need and treatment volume. For example, women ages 26–59 have an average ratio of 0.22, and men ages 60 and over average 0.15. Gaps for younger adults are also relatively small, including 0.29 for women and 0.31 for men ages 18–25. Racial groups similarly show low values, such as an average of 0.23 for Hispanic or Latino populations and 0.20 for Black or African American populations. This cluster reflects consistent, above-average coverage across both age-based and racial/ethnic groups.

### Cluster 2 – Moderate Coverage with Some Gaps

Counties in this cluster tend to have mid-range average normalized ratios, with moderate gaps among younger and working-age adults. For instance, the gap for women ages 18–25 is 0.42 and 0.39 for women ages 26–59. Older adults show stronger alignment, with ratios of 0.26 for men and 0.29 for women ages 60 and over. Black or African American and Hispanic or Latino populations also fall within the moderate range, with average gaps around 0.38 and 0.40, respectively. Coverage varies by group but remains relatively balanced, with no single demographic experiencing extreme under-treatment.

### Cluster 3 – Uneven Coverage, Gaps in Key Populations

This cluster displays pronounced demographic disparities, particularly for women and younger adults. Women ages 26–59 have an average normalized difference ratio of 0.56, while women ages 18–25 average 0.57. Men in these age ranges also experience sizable gaps, averaging 0.52 and 0.49, respectively. Racial gaps are more uneven—Hispanic or Latino populations average 0.50, and American Indian or Alaska Native populations approach 0.58. These counties reflect inconsistent coverage with notable deficits concentrated in younger and middle-aged adults and several racially defined groups.

### Cluster 4 – High Treatment Gaps Across Most Demographics

This group exhibits the most substantial SMI treatment gaps across nearly every demographic. Women ages 18–25 have an average ratio of 0.68 and men of the same age group average 0.64. Among women ages 26–59, the gap increases to 0.61. Even older adults show higher-than-average unmet need, with normalized ratios of 0.50 for women and 0.46 for men ages 60 and over. Hispanic or Latino populations average 0.60 and American Indian or Alaska Native populations reach 0.65, suggesting systemic under-treatment across both age and racial/ethnic lines.

| Cluster          | Description                                  | Counties                                                                                                                                                      |
|------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cluster 1</b> | High Coverage Across Most Demographics       | Colusa, Del Norte, Glenn, Imperial, Modoc, Plumas, Sierra, Siskiyou, Sutter/Yuba                                                                              |
| <b>Cluster 2</b> | Moderate Coverage with Some Gaps             | Amador, Butte, Calaveras, Fresno, Humboldt, Inyo, Kern, Kings, Lake, Mendocino, Merced, Mono, Monterey, Nevada, San Benito, Shasta, Trinity, Tulare, Tuolumne |
| <b>Cluster 3</b> | Uneven Coverage, Gaps in Key Populations     | El Dorado, Marin, Napa, Placer, San Bernardino, San Joaquin, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Yolo                         |
| <b>Cluster 4</b> | High Treatment Gaps Across Most Demographics | Alameda, Alpine, Contra Costa, Lassen, Los Angeles, Orange, Riverside, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Tehama, Ventura      |

## APPENDIX G. County Official – Interview Protocol Template

### Draft Consent

Thank you so much for your time today. We are Public Policy Masters students from UCLA. My name is \_\_\_, I will be leading this interview, and this is \_\_\_, who will be taking notes. We are working with the Steinberg Institute to understand how counties assess individuals with SMIs, specifically around SMI levels of care assessments. We will use this information and interviews from other counties to generate a report of SMI levels of care assessments across California counties. We are excited to interview you today and want to clarify that all of our questions are completely voluntary, and we can stop at any time. We will reference information obtained in this interview from the standpoint of \_\_\_ county. If there is a specific quote from this interview we'd like to incorporate into our report, we will reach out with permission, ensuring you won't be identified to protect your privacy. We also want to confirm that it is okay for us to record audio of this call for later transcription and reference to ensure we accurately capture what you say.

### Positionality of Interviewee

Thank you again for being here today. We would like to better characterize your role within your county regarding mental health access and services. We understand that counties have an important role in assessing the level of care for individuals with SMIs. Can you elaborate on your role specifically in this larger system?

### How Counties Assign Level of Care

We are interested in understanding how your county determines what level of care an individual with serious mental illness requires (i.e., in-patient, outpatient, or FSP services).

Could you please speak to how your county assesses what level of care a client living with SMI should enroll in?

#### *Potential followups:*

- Do you use a tool to make your decisions about what level of care your clients are eligible for / will be enrolled in
- Standardized tool (enter name): \_\_\_\_\_
- If no, how do you assess level of care? \_\_\_\_\_
- What are the various levels of care that your county offers?
- What is the eligibility criteria for each level of care?
- How do FSPs fit into broader levels of care?

We would be interested in learning a little bit more about the level of care assessment tool you are using. How does the County determine when clients are ready to step down to a lower level of care?

#### *Potential followups:*

- Does the county have a process for re-assessing level of care needs at regular intervals?
  - What happens after it is readministered?
  - Change in placement if a different determination is reached?

Are you satisfied with how your county is currently assessing the level of care for a client living with an SMI? What strengths or challenges have you noticed?

#### *Potential followups:*

- What are the barriers to getting an individual initially assessed and/or using the tool?
- What are the barriers to getting clients into the level of care they are assessed for?
- What is the desired outcome when evaluating a patient and assigning them to a level of care? What would be considered a poor outcome?



Next we are interested in learning more about what the process looks like after the level of care tool is administered for those that are most vulnerable. How do you anticipate these levels of care will be impacted by the priority populations identified within Behavioral Health Transformation? More specifically, how is this process the same vs different for your FSPs?

*Potential followups:*

- How do you prioritize who is enrolled in services if there is greater need than slots available?
- Do you track the severity of illness for people enrolled in each level of care?
- How would you describe the capacity versus need of these programs?
- How do FSPs fit into your broader levels of care?

Thank you so much for taking the time to answer these questions. We plan to compile this information along with data collected from other counties to create a more standardized framework to better understand county service utilization. Are you interested in helping us get that data and are you the right person to help? If not, do you have the contact information for who could help us access that information or a public access point for this level of data?

- Yes
  - No
-

## APPENDIX H. Thematic Codebook for Semi-Structured Interviews

### **Part 1. Deductive Code Derivation**

#### *Theme 1: Structural Implementation of SMI care*

- Mental Health Service Act
- County Administration of Mental Health Care
- Proposition 1
- Medi-Cal Insurance
- Financing SMI care
- Levels of care

#### *Theme 2: Impact of Social Determinants*

- Housing Status
- Race/Ethnicity
- Gender Identity
- Socioeconomic Status

#### *Theme 3: Strategic interventions for SMI evaluation and prevention*

- LOCUS
- Level of Care Tools
- Levels of care assessment
- Specialty Mental Health Services
- Full Service Partnerships

#### *Theme 3: SMI data collection, research and information systems*

- Data collection methodology
- Demographic Data
- Service utilization
- Data collection challenges
- Data management systems / technology

### **Part 2. Inductive Code Derivation (Theme / Subtheme)**

- Impact of Social Determinants / Substance use
- Strategic interventions for SMI evaluation and prevention / ANSA
- Strategic interventions for SMI evaluation and prevention / Residential services
- Strategic interventions for SMI evaluation and prevention / Acute services
- Provider level and training
- Structural Implementation of SMI care / Behavioral Health Transformation
- Impact of Social Determinants / Justice Involved Populations
- Structural Implementation of SMI care / Provider availability
- Strategic interventions for SMI evaluation and prevention / Clinical Decision Making
- Impact of Social Determinants / Multiple/Comorbid Diagnoses
- Structural Implementation of SMI care / CARE Act
- Strategic interventions for SMI evaluation and prevention / Medication

### Part 3. Final Codebook

| Theme                                        | Subtheme                                    | Derivation | Example Quote                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------|---------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Structural Implementation of SMI care</b> | County administration of mental health care | Deductive  | "The door leading into the county system is on very loose hinges. The door exiting the county system is rusted." "And so what's the nice thing about that is what the state calls no wrong door. But what really it means is when somebody walks into services, I don't have to know that they meet my level of care for me to be able to provide treatment. Get them what they need that day and then worry about making sure they get to the correct location....they should get help wherever they walk in on that day"                                                                                                                                                                                                     |
|                                              | Medi-Cal insurance                          | Deductive  | "Yeah, so we have four levels of care, and this is for the Medicaid or MediCal population. We primarily only work with those who are uninsured, or have MediCal, or some Medicare, or sometimes there's private insurance with MediCal, but that's really rare." "Our hospital has a behavioral health team. They take MediCal. They see severe people, but they don't offer the array of services that we're required to do. They're a rural health center, so they get the top dollar for MediCal, so they will see some of the severe folks. They don't send them our way, and we try to send the mild to moderate their way through the contract with the managed care system. But they have a 4 to 6 month waiting list." |
|                                              | Financing SMI care                          | Deductive  | "Yeah, I think I think the other piece and I didn't really speak to this is just some of the funding challenges and different counties have different fiscal opportunities. We have a really small share of the general fund. Our realignment draw isn't what it needs to be to match the needs. So funding is also really a challenge for us. And I think that contributes to the challenges for our capacity."                                                                                                                                                                                                                                                                                                               |
|                                              | Levels of care                              | Deductive  | "We're really focused on, you know, connecting individuals to the least restrictive level of care possible within the system. And then kind of from that, you know, we have our high intensity programs which really comprise of our full service partnership programs."                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                              | Provider availability                       | Inductive  | "I would say that we really are struggling with the capacity to meet the need. We just don't have enough capacity to meet the growing need. We're seeing higher acuity on an anecdotal level. We're seeing people with higher acuity needs and more people coming in the front door. And we're really struggling with workforce shortage and vacancies as well. And so that's making it difficult to be able to serve the growing need."                                                                                                                                                                                                                                                                                       |
|                                              | Provider level and training                 | Inductive  | "But we have providers who will request for a higher level of care, and it might just be that, like they don't have DBT expertise. But just because someone has a certain diagnosis does not necessarily mean they're seriously mentally ill."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Impact of Social Determinants</b>         | Housing status                              | Deductive  | "Sometimes we will get like a higher level of care form, and it'll just say, like client needs housing case management which could be something where the Managed Care Plan can help with their care coordination, and not necessarily related to the client, having, you know, SMI symptoms."                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                              | Substance use                               | Inductive  | "And I know that this is specific to SMI. But it's hard for me to have that conversation without also thinking about our substance use treatment as well and just having access to treatment beds across the state. They're just all in short supply. So that's another challenge that we are experiencing."                                                                                                                                                                                                                                                                                                                                                                                                                   |

| Theme                                                            | Subtheme                         | Derivation | Example Quote                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------|----------------------------------|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Impact of Social Determinants, cont'd</b>                     | Justice Involved Populations     | Inductive  | "...They were in an acute psych setting. They absolutely need ongoing care. And so this is where the sort of clinical arts thing will come into play. Right? We would diagnose them with schizophrenia. They're on, you know. They're on olanzapine. They're adherent. Their meds regimen. They seem totally fine. But you know they committed a felony a few years ago. History of violence. Somewhere back there, up specialty, care. So that kind of thing right? Like, yeah, this person probably should go to our specialty care clinic...They would need ACT services that's not accessible anywhere outside of the county. So let's connect them, you know. Let's make them county."                                                                                                        |
| <b>Strategic interventions for SMI evaluation and prevention</b> | LOCUS                            | Deductive  | "What would happen is that people were getting stuck in treatment right? So there was kind of a bottleneck of clients, and we didn't have a way in which to manage capacity. So a couple years ago, we started looking at the various level of care options and looked at reaching recovery, which is what some of the counties use, and realized that probably the best tool was the level of care utilization scale or the LOCUS".                                                                                                                                                                                                                                                                                                                                                               |
|                                                                  | Level of Care Tools              | Deductive  | "Absolutely. Yeah, I mean. And I think one of the benefits is that we're utilizing similar language [which] really creates like a language across all levels of cares as well as our referring parties. It's like we're talking about the same kind of needs in the same way, which I think has been a benefit as well. So having some, even though it's a separate tool, having some consistency within those."                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                  | Levels of care assessment        | Deductive  | "The biggest challenge is if you come up with a level of care, people within that level of care will often figure out why the person doesn't belong in that level of care. And so a lot of times you're in the wrong place and it's easy to mark those checkboxes off based on what your level is...How do you make sure that people are going to get a service and still set those boundaries around what a level of care is? It's like any time you draw a box, you can say you fell outside the box. And then especially if it's really close, you're right on the edge, people bounce back and forth and that's not what we want. So if you're asking me what's the hardest part about a level of care, it's just that we have to draw a box around it. And we have to say that's what it is." |
|                                                                  | Specialty Mental Health Services | Deductive  | "Our mandate really is to serve the MediCal population. So specialty mental health meant for the mental health population and then for Substance use population."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                  | Full Service Partnerships        | Deductive  | "And within our system, when our full service partner providers are full, or all of our Fsp slots are full, our lower intensity service teams will step up and try to provide the level of care necessary to support somebody who has that need for a higher level of care. Even if we don't have the slots available, it's not always possible. Given the capacity and the staffing patterns that we have."                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                  | Acute services                   | Inductive  | "We got all we got a healthy dose of people sitting in acute psych in this county that do not meet medical necessity but whom we cannot disposition to step down because we do not have the step down beds available."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>SMI data collection, research and information systems</b>     | Data collection methodology      | Deductive  | "We utilize the required data tracking for the Mental Health services, acts, tools. We utilize results based accountability in terms of having really meaningful clinical metrics and a reliable data source and a reliable analytical capability. I think that's an area that we're continuing to work on. There's ample opportunity for improvement in our data, reporting and analytical capabilities."                                                                                                                                                                                                                                                                                                                                                                                         |

| Theme                                                                | Subtheme                             | Derivation | Example Quote                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------|--------------------------------------|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SMI data collection, research and information systems, cont'd</b> | Data collection methodology          | Deductive  | "We utilize the required data tracking for the Mental Health services, acts, tools. We utilize results based accountability in terms of having really meaningful clinical metrics and a reliable data source and a reliable analytical capability. I think that's an area that we're continuing to work on. There's ample opportunity for improvement in our data, reporting and analytical capabilities."                                                                                                                                                                                                                               |
|                                                                      | Service utilization                  | Deductive  | Barriers to moving between levels of care, bed availability, capacity with our higher intensity levels of services are really are the biggest barriers that we have in terms of moving people between levels of care. So whether it's bed availability at a residential treatment facility for a longer term placement for a higher acuity client or in our full service partnership programs having those programs being full and at capacity, and trying to move clients through that process is, I would say, the biggest barrier that we anticipate, or that we excuse me, that we encounter                                         |
|                                                                      | Data collection challenges           | Deductive  | "Those are just kind of the hard decisions that we have to make. I would say that, like, long term, having great technology in your program is probably going to help you. But it's always that upfront cost, like this, but what about this year? And so what does that mean? You have to take that money from somewhere, because there's not extra money coming into the system. And it's just shifted into different buckets".                                                                                                                                                                                                        |
|                                                                      | Data management systems / technology | Deductive  | "I don't have a ton of money right now to invest in new data systems, which I wish I did, but those are the areas where like we know how to screen, we know how to do it, we know what our system needs and where in the types of services we wrap around people when they're in those different levels, we have that. But what we need is an ability to make, to plan future focused and to look at that data future focused to be able to just make good decisions around like where we put resources, really." "...And then staffing and having expertise in data analytics. That's an area that's a weakness in our system as well." |

### **Qualitative Coding Process**

#### **Primary Coder**

- Locate transcript. Make sure transcript is also uploaded to google drive folder labeled as "County" Interview\_Raw\_Transcript
- Read through the transcript for any immediate/obvious errors. Utilize the audio if necessary to ensure the transcript is accurate. Save any edits as "County" Interview\_Clean\_Transcript in this folder. (If no edits are necessary, simply save a new version of the raw transcript under this label).
- During the time of the first review, Primary coders should look out for any new codes to add to the codebook under tab "inductive code derivation."
- Upload "County" Interview\_Clean\_Transcript to Taguette. Begin to code for both deductive and inductive themes.
- Track quotes on exported excel file and add findings to sheet Qualitative Coding By County
- Mark date reviewed on tracking spreadsheet

#### **Secondary Coder**

- Upload "County" Interview\_Clean\_Transcript found in this folder to Taguette. Begin to code for both deductive and inductive themes.
- Track quotes on exported excel file and add findings to sheet Qualitative Coding By County
- Mark date reviewed on tracking spreadsheet



## APPENDIX I. R code – Uniform Distribution to re-distribute Age Ranges

```
## calculate 18_to_20 from (18_and_over_total - 21_and_over_total)
tot18over <- extract_vals("18_and_over_total")
tot21over <- extract_vals("21_and_over_total")
male18over <- extract_vals("18_and_over_male")
male21over <- extract_vals("21_and_over_male")
fem18over <- extract_vals("18_and_over_female")
fem21over <- extract_vals("21_and_over_female")

new_tot_18_20 <- ceiling(tot18over - tot21over)
new_male_18_20 <- ceiling(male18over - male21over)
new_fem_18_20 <- ceiling(fem18over - fem21over)

df_18_20_tot <- data.frame(demographics = "18_to_20_total", t(new_tot_18_20))
df_18_20_male <- data.frame(demographics = "18_to_20_male", t(new_male_18_20))
df_18_20_fem <- data.frame(demographics = "18_to_20_female", t(new_fem_18_20))
names(df_18_20_tot)[-1] <- num_cols
names(df_18_20_male)[-1] <- num_cols
names(df_18_20_fem)[-1] <- num_cols

## calculate 21_to_25 via fractional breakdown:
## (18_to_24_total - 18_to_20_total) + 1/5 of 25_to_29_total
tot1824 <- extract_vals("18_to_24_total")
male1824 <- extract_vals("18_to_24_male")
fem1824 <- extract_vals("18_to_24_female")

tot2529 <- extract_vals("25_to_29_total")
male2529 <- extract_vals("25_to_29_male")
fem2529 <- extract_vals("25_to_29_female")

new21_24_tot <- tot1824 - new_tot_18_20
new21_24_male <- male1824 - new_male_18_20
new21_24_fem <- fem1824 - new_fem_18_20

new21_25_tot <- ceiling(new21_24_tot + (1/5) * tot2529)
new21_25_male <- ceiling(new21_24_male + (1/5) * male2529)
new21_25_fem <- ceiling(new21_24_fem + (1/5) * fem2529)

df_21_25_tot <- data.frame(demographics = "21_to_25_total", t(new21_25_tot))
df_21_25_male <- data.frame(demographics = "21_to_25_male", t(new21_25_male))
df_21_25_fem <- data.frame(demographics = "21_to_25_female", t(new21_25_fem))
names(df_21_25_tot)[-1] <- num_cols
names(df_21_25_male)[-1] <- num_cols
names(df_21_25_fem)[-1] <- num_cols

## calculate 18_to_25 as the sum of the new 18_to_20 and 21_to_25 rows
new_tot_18_25 <- new_tot_18_20 + new21_25_tot
new_male_18_25 <- new_male_18_20 + new21_25_male
new_fem_18_25 <- new_fem_18_20 + new21_25_fem

df_18_25_tot <- data.frame(demographics = "18_to_25_total", t(new_tot_18_25))
df_18_25_male <- data.frame(demographics = "18_to_25_male", t(new_male_18_25))
df_18_25_fem <- data.frame(demographics = "18_to_25_female", t(new_fem_18_25))
names(df_18_25_tot)[-1] <- num_cols
names(df_18_25_male)[-1] <- num_cols
names(df_18_25_fem)[-1] <- num_cols
```

## APPENDIX J. R Code – 2021-2023 CSI Dashboard Data, Uniform Distribution to Reapply Year Ranges

```
# treatment_2022: average values from fy_21_22 and fy_22_23
data_21_22 <- csi_recoded %>%
  filter(fiscal_year == "fy_21_22") %>%
  select(-fiscal_year)
data_22_23 <- csi_recoded %>%
  filter(fiscal_year == "fy_22_23") %>%
  select(-fiscal_year)

treatment_2022 <- inner_join(data_21_22, data_22_23, by = "demographics",
                             suffix = c("_21_22", "_22_23"))
# average the paired numeric columns
cols_21_22 <- names(treatment_2022)[grepl("_21_22$", names(treatment_2022))]
for (col in cols_21_22) {
  base <- sub("_21_22$", "", col)
  col1 <- paste0(base, "_21_22")
  col2 <- paste0(base, "_22_23")
  treatment_2022[[base]] <- round(0.5 * (treatment_2022[[col1]] + treatment_2022[[col2]]))
}
# remove the fy-specific columns and set fiscal_year to "2022"
treatment_2022 <- treatment_2022 %>%
  select(demographics, everything(), -ends_with("_21_22"), -ends_with("_22_23")) %>%
  mutate(fiscal_year = "2022") %>%
  select(fiscal_year, demographics, everything())

# treatment_2023: use the fy_22_23 data directly
treatment_2023 <- csi_recoded %>%
  filter(fiscal_year == "fy_22_23") %>%
  select(-fiscal_year) %>%
  # multiply by 0.5 and then double to effectively retain original values (for consistency)
  mutate(across(-demographics, ~ round(2 * 0.5 * .))) %>%
  mutate(fiscal_year = "2023") %>%
  select(fiscal_year, demographics, everything())
```

## APPENDIX K. R Code – Proportional Distribution to Manage ‘other’ and ‘unknown’ Genders

```
## recode 'unknown' and 'other' in gender data by proportionally distributing their numeric values
## to the corresponding male and female rows for the same age group and fiscal year, then remove these rows
numeric_cols <- names(csi_recoded)[sapply(csi_recoded, is.numeric)]

csi_recoded <- csi_recoded %>%
  group_by(fiscal_year) %>%
  do({
    df_group <- .
    # identify rows with demographics ending in '_unknown' or '_other'
    idx_ou <- which(str_detect(df_group$demographics, "_(unknown|other)$"))

    if (length(idx_ou) > 0) {
      for (i in idx_ou) {
        # get the full label from the unknown/other row
        unknown_label <- df_group$demographics[i]
        # derive the base prefix by removing the suffix
        prefix <- sub("_(unknown|other)$", "", unknown_label)

        # find known rows for this age group (matching prefix with '_female' or '_male')
        known_idx <- which(df_group$demographics %in% c(paste0(prefix, "_female"),
                                                         paste0(prefix, "_male")))

        if (length(known_idx) > 0) {
          # for each numeric column, sum the known values in this group
          for (col in numeric_cols) {
            total_known <- sum(df_group[[col]][known_idx], na.rm = TRUE)
            # if the total known is greater than zero, distribute the unknown value proportionally
            if (total_known > 0) {
              unknown_val <- df_group[[col]][i]
              for (k in known_idx) {
                current_val <- df_group[[col]][k]
                fraction <- current_val / total_known
                # add proportional share from the unknown row to the known row
                df_group[[col]][k] <- df_group[[col]][k] + fraction * ifelse(is.na(unknown_val), 0, unknown_val)
              }
            }
          }
        }
      }
    }
    df_group
  }) %>%
  ungroup() %>%
  # remove rows where demographics end with '_unknown' or '_other', and rows starting with 'total'
  filter(!str_detect(demographics, "_(unknown|other)$"),
         !str_starts(demographics, "total"))
```

## APPENDIX L. R Code – Proportional Distribution to Manage ‘other’ and ‘unknown’ Races

```
## recode race unknown and other categories, mapped onto other races proportionally
# define known race categories
known_races <- c("american_indian_and_alaska_native",
                "asian_hawaiian_and_other_pacific_islander",
                "black_or_african_american",
                "hispanic_or_latino",
                "two_or_more_races",
                "white")

# get names of numeric columns from csi_recoded
numeric_cols <- names(csi_recoded)[sapply(csi_recoded, is.numeric)]

# process each fiscal_year group to distribute 'other' and 'unknown' values proportionally
csi_recoded <- csi_recoded %>%
  group_by(fiscal_year) %>%
  do({
    df_group <- .
    # select rows for race breakdowns (including known races, 'other', and 'unknown')
    race_rows <- which(df_group$demographics %in% c(known_races, "other", "unknown"))
    if (length(race_rows) > 0) {
      known_idx <- which(df_group$demographics %in% known_races)
      ou_idx <- which(df_group$demographics %in% c("other", "unknown"))

      # replace NA with 0 in numeric columns for 'other' and 'unknown' rows
      if (length(ou_idx) > 0) {
        df_ou <- df_group[ou_idx, ]
        df_ou[numeric_cols][is.na(df_ou[numeric_cols])] <- 0
        ou_sum <- colSums(df_ou[, numeric_cols, drop = FALSE])

        # for each numeric column, distribute the sum proportionally to the known race rows
        for (col in numeric_cols) {
          total_known <- sum(df_group[[col]][known_idx], na.rm = TRUE)
          if (total_known > 0 && ou_sum[col] > 0) {
            for (i in known_idx) {
              fraction <- df_group[[col]][i] / total_known
              df_group[[col]][i] <- df_group[[col]][i] + ou_sum[col] * fraction
            }
          }
        }
      }
    }
    df_group
  }) %>%
  ungroup() %>%
  # remove rows with demographics 'other' or 'unknown'
  filter(!demographics %in% c("other", "unknown"))
```

## APPENDIX M. California DHCS Penetration Rates by Race/Ethnicity, 2022

Utilization rates of DHCS Mental Health Services, Speciality vs. Non-Specialty, by Race/Ethnicity.  
*Black individuals make up a greater percentage of specialty, whereas white individuals make up greater percentage of non-specialty.*

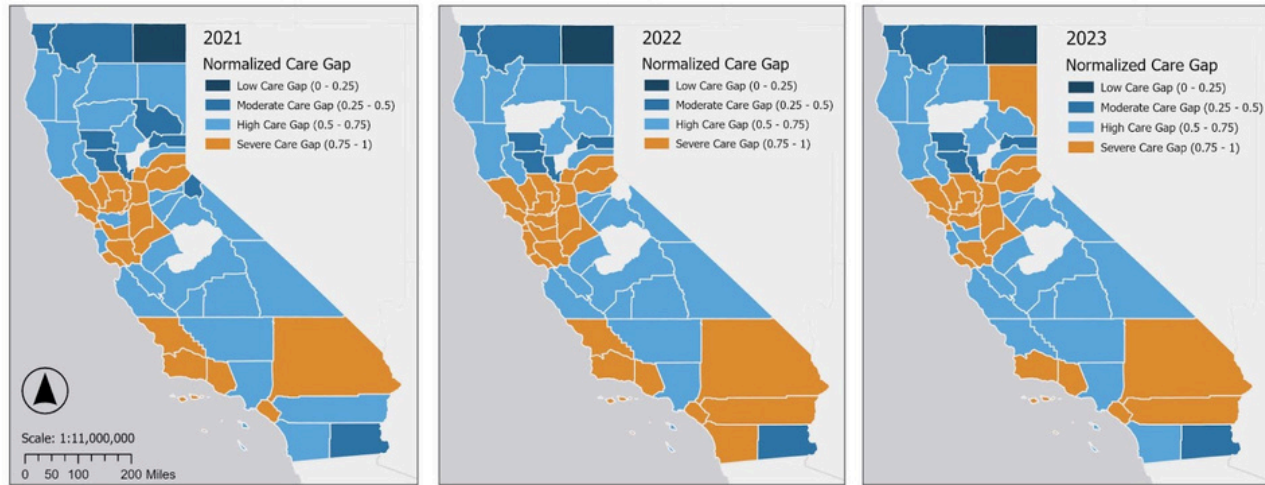
| Demographic | Non-specialty | Speciality |
|-------------|---------------|------------|
| Hispanic    | 8.2%          | 2.5%       |
| White       | 14.9%         | 5.1%       |
| Black       | 11.1%         | 7.1%       |
| AIAN        | 14.9%         | 5.5%       |
| Asian/NHOPI | 5.8%          | 1.8%       |
| Unknown     | 7.9%          | 4.4%       |
| Other       | 12.4%         | 3.8%       |

Source: <https://behavioralhealth-data.dhcs.ca.gov/pages/adult-mhs-ab470>



## APPENDIX N. Normalized Treatment Rates by County – 2021, 2022, 2023

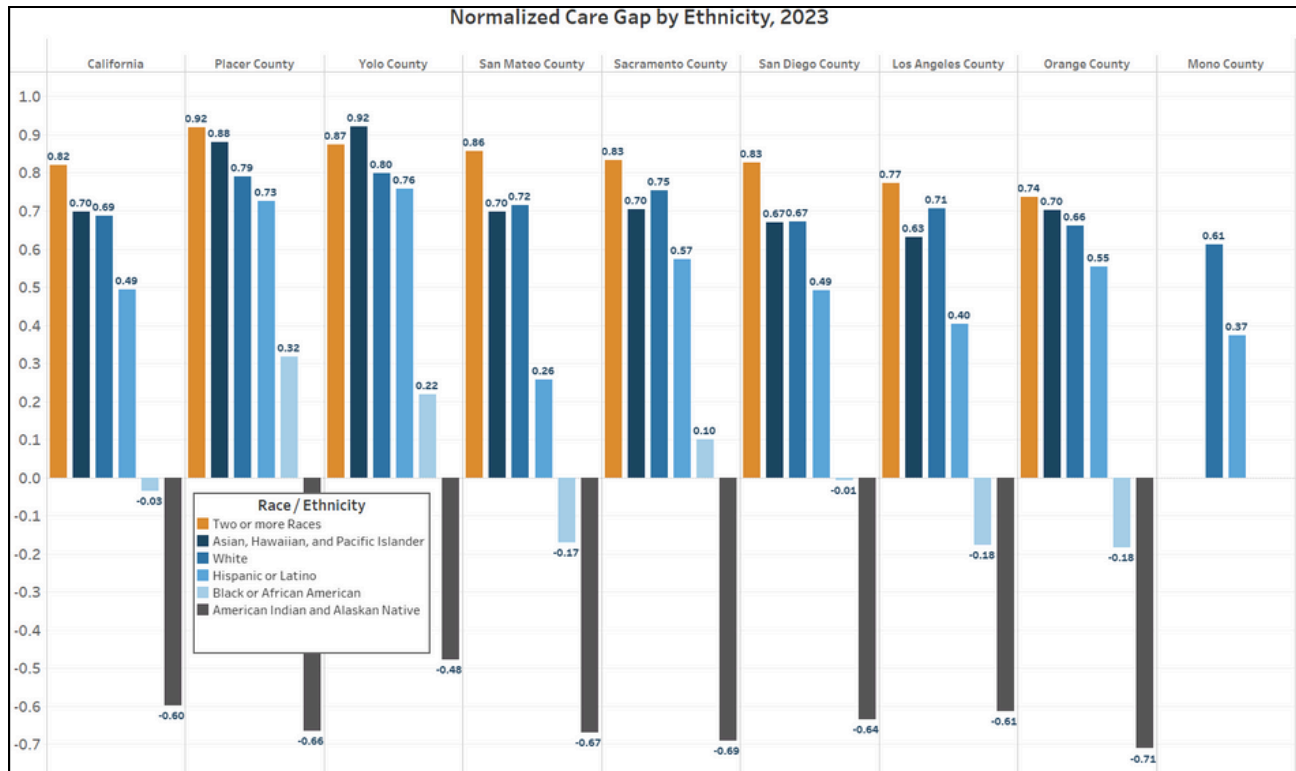
Gaps in Serious Mental Illness (SMI) Treatment, California 2021 - 2023



| county              | 2021 | 2022 | 2023 |
|---------------------|------|------|------|
| Alameda County      | 0.61 | 0.61 | 0.59 |
| Alpine County       | 0.26 | 1.00 | 1.00 |
| Amador County       | 0.41 | 0.41 | 0.38 |
| Butte County        | 0.46 | 0.52 | 0.52 |
| Calaveras County    | 0.44 | 0.48 | 0.46 |
| Colusa County       | 0.25 | 0.28 | 0.25 |
| Contra Costa County | 0.58 | 0.62 | 0.61 |
| Del Norte County    | 0.22 | 0.29 | 0.26 |
| El Dorado County    | 0.76 | 0.75 | 0.73 |
| Fresno County       | 0.42 | 0.45 | 0.42 |
| Glenn County        | 0.33 | 0.33 | 0.28 |
| Humboldt County     | 0.42 | 0.43 | 0.37 |
| Imperial County     | 0.22 | 0.24 | 0.22 |
| Inyo County         | 0.48 | 0.57 | 0.56 |
| Kern County         | 0.39 | 0.43 | 0.40 |
| Kings County        | 0.48 | 0.51 | 0.48 |
| Lake County         | 0.49 | 0.50 | 0.50 |
| Lassen County       | 0.49 | 0.60 | 0.64 |
| Los Angeles County  | 0.54 | 0.58 | 0.56 |
| Madera County       | 1.00 | 1.00 | 1.00 |
| Marin County        | 0.83 | 0.85 | 0.82 |
| Mariposa County     | 1.00 | 1.00 | 1.00 |
| Mendocino County    | 0.40 | 0.43 | 0.39 |
| Merced County       | 0.46 | 0.47 | 0.44 |

| county                 | 2021 | 2022 | 2023 |
|------------------------|------|------|------|
| Modoc County           | 0.09 | 0.13 | 0.09 |
| Mono County            | 0.48 | 0.56 | 0.55 |
| Monterey County        | 0.44 | 0.49 | 0.46 |
| Napa County            | 0.69 | 0.71 | 0.69 |
| Nevada County          | 0.53 | 0.55 | 0.53 |
| Orange County          | 0.64 | 0.66 | 0.65 |
| Placer County          | 0.67 | 0.74 | 0.77 |
| Plumas County          | 0.30 | 0.36 | 0.36 |
| Riverside County       | 0.57 | 0.62 | 0.62 |
| Sacramento County      | 0.62 | 0.68 | 0.69 |
| San Benito County      | 0.44 | 0.50 | 0.50 |
| San Bernardino County  | 0.86 | 0.88 | 0.89 |
| San Diego County       | 0.59 | 0.61 | 0.59 |
| San Francisco County   | 0.70 | 0.74 | 0.73 |
| San Joaquin County     | 0.67 | 0.75 | 0.78 |
| San Luis Obispo County | 0.61 | 0.62 | 0.60 |
| San Mateo County       | 0.58 | 0.61 | 0.59 |
| Santa Barbara County   | 0.75 | 0.78 | 0.78 |
| Santa Clara County     | 0.69 | 0.76 | 0.79 |
| Santa Cruz County      | 0.83 | 0.85 | 0.84 |
| Shasta County          | 0.51 | 0.54 | 0.52 |
| Sierra County          | 0.29 | 0.27 | 0.19 |
| Siskiyou County        | 0.28 | 0.32 | 0.30 |
| Solano County          | 0.69 | 0.71 | 0.70 |
| Sonoma County          | 0.83 | 0.83 | 0.82 |
| Stanislaus County      | 0.69 | 0.72 | 0.70 |
| Sutter & Yuba Counties | 0.15 | 0.22 | 0.21 |
| Tehama County          | 0.52 | 1.00 | 1.00 |
| Trinity County         | 0.52 | 0.54 | 0.50 |
| Tulare County          | 0.48 | 0.50 | 0.47 |
| Tuolumne County        | 0.54 | 0.51 | 0.43 |
| Ventura County         | 0.61 | 0.63 | 0.61 |
| Yolo County            | 0.75 | 0.78 | 0.78 |

## APPENDIX O. Serious Mental Illness Treatment Gap by Race/Ethnicity, Case Study Counties



## **APPENDIX P. County Summaries from Qualitative Interviews**

### 1. Los Angeles County

The Los Angeles County Department of Mental Health has adopted the LOCUS tool as a primary method for determining levels of care for individuals ages 21 and above who meet the criteria for Specialty Mental Health Services. This tool is used at intake, during reassessments every six months (or quarterly for Full Service Partnership (FSP) clients), and to manage transitions between levels of care. The Department began LOCUS implementation in December 2024 in order to better manage timely access to care mandates and flow into and through the Specialty Mental Health Service system. The Department has aligned its mental health services with that of the levels of the LOCUS categorizing services into six levels, ranging from 24-hour residential programs (Level 6) to minimal-support, recovery maintenance and health management support (Level 1). The LOCUS tool is not meant to replace clinical judgment, and does allow clinicians to override tool results. However, it serves as a decision aid to help clinicians determine whether a client requires a higher or lower level of care. It is currently too early to assess the impact of the tool because the county is currently in Phase 1 of implementation for adult mental health programs, with a goal of completion by mid-year.

Los Angeles County currently faces challenges related to system capacity and level of care transitions. Managing transitions to lower levels of care in a thoughtful way can be a struggle for the county due to the fear clients and/or their families experience with a change of service type and intensity. Another significant issue is the "bottlenecking" of clients in higher levels of care due to limited availability in step-down programs. Additionally, financial constraints and funding shifts impact outpatient services, raising concerns about long-term sustainability. The county is using its LOCUS data to better assess service needs and improve utilization management. As implementation continues, key concerns include refining best practices for stepping down clients and ensuring that no one is prematurely discharged due to capacity and funding limitations.

### 2. San Mateo County

San Mateo County Health, Behavioral Health and Recovery Services (BHRS) follows a structured approach to SMI care, primarily working with uninsured individuals and those covered under Medi-Cal. The county uses the DHCS screening tool to determine where a client will be assessed, but if a client enters through hospital discharge or crisis intervention this process is streamlined, bypassing the screening process, and moving directly to assessment. If a client meets screening criteria for Specialty Mental Health Services, they are referred to a regional team for further evaluation for a full assessment which determines the ultimate level of care. They previously used its own tool for initial placement in MCPs or SMHS but transitioned to the DHCS tool per the state's mandate. While this new system has improved efficiency, there are concerns that the rigid yes/no format does not capture clinical nuances as effectively as the previous method. For example, the tool does not include a question related to eating disorders.

A major challenge for San Mateo Health, BHRS, is ensuring that clients are placed in the appropriate level of care and remain there without unnecessary transitions between SMHS and MCPs. The county's Access Team acts as a safety net, reviewing transition requests to ensure clients are not prematurely stepped down or stepped using a combination of a transition tool and Access Team judgment. Issues such as comorbid substance use, cultural factors in assessment, and variability in provider training complicate the accuracy of level-of-care determinations. San Mateo Health, BHRS, is also working to enhance provider education to ensure accurate screening and assessment to ensure clients get the right level of care for their specific mental health impairments. This determination is not based solely on specific diagnoses, such as personality disorders but on the client's current mental health and social functioning. Overall, BHRS aims to maintain continuity of care while adapting to evolving state-level mandates.

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### 3. Mono County

Mono County, as a small jurisdiction with just over 10,000 adults, takes a highly personalized approach to assessing and managing individuals with Serious Mental Illness (SMI). The county does not heavily rely on standardized tools, instead opting for a case-by-case evaluation process due to their close familiarity with most clients. They argue that rigid screening methods designed for larger counties do not account for the unique challenges faced by smaller populations, including the need to serve all clients regardless of whether they are supposed to receive services through the county or the MCP. While they acknowledge the importance of data collection, they emphasize that qualitative narratives are just as crucial as numerical assessments in determining the appropriate level of care.

A key challenge for Mono County is the lack of reliable providers for step-down care, which leads to patients staying in higher levels of care longer than necessary. This strains resources but prevents individuals from transitioning into more independent living arrangements. The county believes that the client should be responsible for determining when they are ready to step-down from their current level of care.

Overall, Mono County believes that broader state policies should be more flexible to accommodate the realities of smaller systems. While their intimate knowledge of clients allows for tailored interventions, the absence of standardized assessment tools may pose difficulties in securing state funding or aligning with broader policy shifts.

### 4. Orange County

Orange County's outpatient structure has three primary levels of care: Full Service Partnerships (FSPs), county-operated outpatient clinics, and a recovery-level program that transitions individuals back to Managed Care Plans (MCPs). They have developed separate screening tools for each of the three levels of care, but emphasize the "No Wrong Door" approach by utilizing questions around chronic homelessness and hospitalizations at every initial screening. Part of those questions in that initial screening process comes from the Milestones of Recovery Scale (MORS) tool, which the county primarily uses to determine when clients are ready to step down to lower levels of care. They also use the MORS tool to facilitate reevaluation for individuals at lower levels of care.

To qualify for FSPs, the county uses its own custom tool to assess the individual's risk of homelessness, their previous hospitalization lengths, and their history with more traditional mental health care. The county does not facilitate step downs from the FSP level of care, meaning clients remain in FSP until they are fully ready for transition, which can create inefficiencies in managing caseloads, although 75 percent of FSP clients do eventually go to a lower level of care.

Orange County faces several challenges, including financial constraints that limit their ability to analyze assessment data effectively. They struggle to maintain sufficient capacity within higher levels of care, sometimes placing individuals in lower levels due to lack of availability. Another issue is managing clients who fall outside the strict criteria for county services but still require significant support. Additionally, funding limitations force difficult decisions between investing in data infrastructure and maintaining direct service programs. Despite these constraints, Orange County continues to refine its approach, emphasizing accessibility and real-time screening at multiple entry points.

### 5. Placer County

Placer County follows a structured approach to assessing and managing SMI care, starting with the DHCS screening tool to differentiate between mild/moderate and severe cases. They operate three primary levels of care: Full Service Partnerships (FSPs), mid-service partnership (MSP) (a newly introduced category), and clinical service teams (general outpatient and intake). Clients can be assessed through walk-in services or scheduled screenings, and a weekly supervisory meeting determines the most appropriate level of care. The county previously attempted to use the LOCUS tool, but found it lacked sensitivity in distinguishing mid-tier cases, prompting them to develop a more customized

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assessment method which is still being refined, but includes the Key Event Tracking (KETs) tool to determine FSP placement. While counties are required to use KETs for significant events while an individual is enrolled in an FSP, Placer County also utilizes it to evaluate for FSP placement. Clients eligible for FSP are evaluated using KETs whenever there is a “significant change”, and the results help determine their specific level of care placement.

One of Placer County’s main challenges is managing transitions between levels of care, which led to the development of the mid service partnership. The new level of care launched in January 2025 and is in the early stages of refinement. Historically, FSPs struggled with clients who remained in FSP longer than necessary due to a lack of step-down options. The new mid-service partnership aims to address this, and ensuring its long-term sustainability and effectiveness will be the next steps. The county also faces difficulties in data tracking and infrastructure, limiting their ability to make system-wide improvements based on assessment outcomes. However, regular communication between teams has improved service coordination, and the county is optimistic about refining its approach further.

#### 6. Sacramento County

Sacramento County utilizes a multi-tool approach to level-of-care assessments, incorporating LOCUS for subacute placements, a modified LIST tool for FSP placement, and ANSA/CAL-AIM at intake and for reassessments every six months. Their CORE Community Wellness Centers serve as central hubs for both stepping down and escalating care levels, allowing for flexible movement within the system. The modified LIST tool evaluates clinical severity, risk factors, life circumstances, and comorbid conditions for individuals with high intensity needs, ensuring a comprehensive understanding of each client’s needs. However, the county developed this tool specifically to address administrative delays associated with using LOCUS for FSP placements. The county has also developed FSP graduation guidelines as part of an MHSA Innovation grant award.

One of Sacramento’s biggest challenges is the lack of a robust data infrastructure to analyze client severity across different levels of care. A recent transition to a new statewide electronic medical records system has made data collection and tracking difficult, limiting their ability to assess long-term service needs. To address this, Sacramento is working on developing an algorithm based on ANSA scores to enhance level-of-care determinations. Additionally, capacity issues remain a concern, particularly in ensuring that clients receive timely transitions and are not placed inappropriately due to system limitations. The county continues to refine its model, aiming to improve efficiency and reduce barriers to care.

#### 7. San Diego County

San Diego County employs multiple tools for assessing levels of care, including MORS for outpatient clinics, LOCUS for ACT and ICMS programs, the A/OA Outpatient Utilization Management Form for reassessments, and the Columbia screening tool for suicidality, which is the tool that receives the most consideration. San Diego places a strong emphasis on the “clinical art” of mental health assessment, believing that standardized tools should complement, rather than dictate, clinical judgment. While they use structured assessments, they stress that clinician expertise and nuanced evaluation are crucial in making final placement decisions.

The county faces program capacity challenges, particularly when transitioning patients from acute psychiatric care to step-down residential programs due to a shortage of available beds. Administrators expressed concerns that they are often required to provide care for individuals who technically do not meet county criteria but have nowhere else to go. The impact of the CARE Act has also created additional strain, as individuals with strong family support tend to receive priority placement in high-intensity programs like ACT. San Diego is working on improving the flow of care by identifying alternative systems for stable patients, ensuring that higher-intensity programs remain accessible for those who need them most.

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### 8. Yolo County

Yolo County employs LOCUS as its primary assessment tool, integrating it into a six-tier system of care. The LOCUS has the most staff buy-in, as the county explored using the ANSA for a while but decided to stick with the LOCUS due to staff preferences. Adult clients undergo reassessments as needed with changes in functioning/life circumstances or when stepping up/down levels of care. When FSP programs reach capacity, clients may be assigned to lower-intensity teams that attempt to provide additional support. However, this workaround is not always successful and can place a strain on staff attempting to balance high-need cases with limited resources.

A primary challenge for Yolo County is funding, as they receive fewer financial resources compared to larger counties, despite having significant needs. Workforce shortages and limited bed availability for substance use treatment further complicate the ability to provide appropriate care. Concerns have also been raised regarding the reliability of training for assessment tool administrators, with emphasis on the need for inter-rater reliability to ensure consistent evaluations. The county is working to enhance its data infrastructure, but an outdated electronic health record system and a lack of dedicated data analysts present ongoing obstacles.

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## APPENDIX Q. Level of Care Utilization System (LOCUS)

### LOCUS Level of Care Determination Grid

| <b>AACP LEVEL OF CARE DETERMINATION GRID</b>                |                                        |                                        |                                         |                                              |                                          |                                        |
|-------------------------------------------------------------|----------------------------------------|----------------------------------------|-----------------------------------------|----------------------------------------------|------------------------------------------|----------------------------------------|
| <div> <div>Level of Care</div> <div>Dimensions</div> </div> | Recovery Maintenance Health Management | Low Intensity Community Based Services | High Intensity Community Based Services | Medically Monitored Non-Residential Services | Medically Monitored Residential Services | Medically Managed Residential Services |
|                                                             | Level 1                                | Level 2                                | Level 3                                 | Level 4                                      | Level 5                                  | Level 6                                |
| I. Risk of Harm                                             | 2 or less                              | 2 or less                              | 3 or less                               | 3 or less                                    | ④<br>3                                   | ⑤<br>4                                 |
| II. Functional Status                                       | 2 or less                              | 2 or less                              | 3 or less                               | 3 or less                                    | ④*<br>3                                  | ⑤<br>4                                 |
| III. Co-Morbidity                                           | 2 or less                              | 2 or less                              | 3 or less                               | 3 or less                                    | ④*<br>3                                  | ⑤<br>4                                 |
| IV A. Recovery Environment "Level of Stress"                | Sum of                                 | Sum of                                 | Sum of                                  | 3 or 4                                       | 4 or more                                | 4 or more                              |
| IV B. Recovery Environment "Level of Support"               | IV A + IV B<br>is 4 or less            | IV A + IV B<br>is 5 or less            | IV A + IV B<br>is 5 or less             | 3 or less                                    | 4 or more                                | 4 or more                              |
| V. Treatment & Recovery History                             | 2 or less                              | 2 or less                              | 3 or less                               | 3 or 4                                       | 3 or more                                | 4 or more                              |
| VI. Engagement & Recovery Status                            | 2 or less                              | 2 or less                              | 3 or less                               | 3 or 4                                       | 3 or more                                | 4 or more                              |
| <b>Composite Rating</b>                                     | 10 to 13                               | 14 to 16                               | 17 to 19                                | 20 to 22                                     | 23 to 27                                 | 28 or more                             |

○ indicates independent criteria - requires admission to this level regardless of composite score

\* Unless sum of IV A and IV B equals 2

## APPENDIX R. Adult Needs and Strengths Assessment (ANSA) Form

### Six Domains of ANSA

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Life Functioning Domain</b><br>Family Functioning<br>Medical/Physical*<br>Employment Functioning*<br>Social Functioning<br>Recreational<br>Developmental/Intellectual*<br>Sexuality<br>Independent Living Skills<br>Residential Stability<br>Legal<br>Sleep<br>Basic Activities of Daily Living<br>Medication Adherence<br>Transportation<br>Living Situation<br>School<br>Decision Making<br>Involvement in Recovery<br>Parental/Caregiving Role* | <b>Cultural Factors Domain</b><br>Language<br>Traditions and Rituals<br>Cultural Stress<br><br><b>Behavioral/Emotional Needs Domain</b><br>Psychosis (Thought Disorder)<br>Impulse Control<br>Depression<br>Mood Disturbance<br>Anxiety<br>Interpersonal Problems<br>Antisocial Behavior<br>Adjustment to Trauma*<br>Anger Control<br>Substance Use*<br>Eating Disturbances<br><br><b>Risk Behaviors Domain</b><br>Suicide Risk*<br>Non-Suicidal Self-Injurious Behavior<br>Other Self Harm<br>Victimization/Exploitation<br>Danger to Others*<br>Addictive Behaviors<br>Sexual Aggression*<br>Criminal Behavior* | <b>Caregiver Resources and Needs Domain (Optional)</b><br>Involvement with Care<br>Knowledge<br>Social Resources<br>Residential Stability<br>Medical/Physical<br>Behavioral Health<br>Developmental<br>Safety<br>Family Stress<br>Organization |
| <b>Strengths Domain</b><br>Family Strengths<br>Interpersonal/Social Connectedness<br>Optimism<br>Job History<br>Talents and Interests<br>Spiritual/Religious<br>Community Connection<br>Natural Supports<br>Resilience<br>Resourcefulness<br>Volunteering<br>Educational/Vocational<br>Cultural Identity                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |

## APPENDIX S. CalAim Assessment – SMHS Assessment Domains

| <div data-bbox="191 283 267 357"> </div> <div data-bbox="313 283 620 327"> <p>State of California—Health and Human Services Agency<br/>Department of Health Care Services</p> </div> <div data-bbox="669 291 737 359"> </div> <p><b>ATTACHMENT 1: SMHS ASSESSMENT DOMAIN DESCRIPTIONS</b></p> <p>Each of the 7 domains identified in the first column are required components of the SMHS assessment, which shall be documented in the SMHS assessment and kept in the beneficiary's medical record. The assessment shall be completed within a reasonable time and in accordance with generally accepted standards of practice.</p> <p>Descriptions for each domain are set forth in the second column. The descriptions included in the second column provide guidance for addressing each respective domain and are not a prescriptive or required list of elements.</p> <p>For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) assessment tool may be used to help inform the assessment domains requirements.</p> <table border="1"> <thead> <tr> <th>Domain</th><th>Description</th></tr> </thead> <tbody> <tr> <td> <b>Domain 1 requirements:</b> <ul style="list-style-type: none"> <li>Presenting Problem(s)</li> <li>Current Mental Status</li> <li>History of Presenting Problem(s)</li> <li>Beneficiary-identified Impairment(s)</li> </ul> </td><td> <b>Chief complaint:</b> <ul style="list-style-type: none"> <li>Beneficiary-identified problem(s), history of the presenting problem(s), impact of problem(s) on beneficiary.</li> <li>Beneficiary's mental state at the time of the assessment.</li> <li>Impairment identified by the beneficiary including distress, disability, or dysfunction in an important area of life function.</li> </ul> </td></tr> <tr> <td> <b>Domain 2 requirements:</b> <ul style="list-style-type: none"> <li>Trauma</li> </ul> </td><td> <b>History of trauma or exposure to trauma:</b> <ul style="list-style-type: none"> <li>Any psychological, emotional response to an event that is deeply distressing or disturbing.</li> <li>A measure of trauma by a trauma screening tool approved by the DHCS (e.g., Adverse Childhood Experiences screening tools), indicating elevated risk for development of a mental health condition.</li> <li>Experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.</li> </ul> </td></tr> </tbody> </table> | Domain                                                                                                                                                                                                                                                                                      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| <b>Domain 1 requirements:</b> <ul style="list-style-type: none"> <li>Presenting Problem(s)</li> <li>Current Mental Status</li> <li>History of Presenting Problem(s)</li> <li>Beneficiary-identified Impairment(s)</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Chief complaint:</b> <ul style="list-style-type: none"> <li>Beneficiary-identified problem(s), history of the presenting problem(s), impact of problem(s) on beneficiary.</li> <li>Beneficiary's mental state at the time of the assessment.</li> <li>Impairment identified by the beneficiary including distress, disability, or dysfunction in an important area of life function.</li> </ul>                                                                                                                                                                                                                            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| <b>Domain 2 requirements:</b> <ul style="list-style-type: none"> <li>Trauma</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>History of trauma or exposure to trauma:</b> <ul style="list-style-type: none"> <li>Any psychological, emotional response to an event that is deeply distressing or disturbing.</li> <li>A measure of trauma by a trauma screening tool approved by the DHCS (e.g., Adverse Childhood Experiences screening tools), indicating elevated risk for development of a mental health condition.</li> <li>Experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.</li> </ul>                                                                                                     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| <b>Domain 3 requirements:</b> <ul style="list-style-type: none"> <li>Behavioral Health History</li> <li>Comorbidity</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Mental Health History:</b> <ul style="list-style-type: none"> <li>Acute and chronic conditions.</li> <li>Previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions.</li> <li>Inpatient admissions.</li> <li>Crisis-based admissions.</li> </ul> <b>Substance Use History:</b> <ul style="list-style-type: none"> <li>Exposure/substance use, including past and present use.</li> <li>Previous community-based treatment, including providers, therapeutic modality (e.g., medication-assisted treatment, rehabilitative interventions, etc.) and response to interventions.</li> <li>Inpatient psychiatric admissions.</li> <li>Intoxication/detox/withdrawal management-based admissions.</li> </ul> |             |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                     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| <b>Domain 4 requirements:</b> <ul style="list-style-type: none"> <li>Medical History</li> <li>Current Medications</li> <li>Comorbidity with Behavioral Health</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Medical History:</b> <ul style="list-style-type: none"> <li>Relevant current or past physical health conditions.</li> <li>Prenatal and perinatal events, and relevant or significant developmental history.</li> <li>History of medications, medical treatments, and responses.</li> <li>Allergies to medications.</li> </ul>                                                                                                                                                                                                                                                                                              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| <b>Domain 5 requirements:</b> <ul style="list-style-type: none"> <li>Social and Life Circumstances</li> <li>Culture/Religion/Spirituality</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Psychosocial factors:</b> <ul style="list-style-type: none"> <li>Living situation, daily activities, social support, and cultural and linguistic factors.</li> <li>Legal or justice-involved history.</li> <li>Family history and current family involvement.</li> <li>Military history.</li> <li>Tribal affiliation.</li> <li>LGBTQ.</li> <li>BIPOC.</li> </ul>                                                                                                                                                                                                                                                           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| <div data-bbox="506 1201 583 1274"> </div> <div data-bbox="643 1201 987 1247"> <p>State of California—Health and Human Services Agency<br/>Department of Health Care Services</p> </div> <div data-bbox="1040 1209 1117 1276"> </div> <table border="1"> <thead> <tr> <th>Domain</th><th>Description</th></tr> </thead> <tbody> <tr> <td> <b>Domain 6 requirements:</b> <ul style="list-style-type: none"> <li>Strengths, Risk Behaviors, and Safety Factors</li> </ul> </td><td> <b>Strengths, risk behaviors and safety factors:</b> <ul style="list-style-type: none"> <li>Strengths in achieving goals, including personal motivation, drive, and interest.</li> <li>Resilience and coping skills.</li> <li>Protective factors, including the availability of resources, opportunities, and supports (including support persons), interpersonal relationships, systems (family/community/ professional), activities (routines/ social hobbies/ etc.).</li> <li>Situations and triggers that may induce risky behaviors.</li> <li>Suicidal/homicidal ideation.</li> <li>Safety planning, including an individualized plan that can be self-initiated or initiated by a trusted person (e.g. sponsor).</li> </ul> </td></tr> <tr> <td> <b>Domain 7 requirements:</b> <ul style="list-style-type: none"> <li>Clinical Summary and Recommendations</li> <li>Diagnostic Impression</li> <li>Medical Necessity Determination</li> <li>Level of Care/Access Criteria</li> </ul> </td><td> <b>Clinical impression, including etiology, clinical complexity, and impairments:</b> <ul style="list-style-type: none"> <li>Predisposing, precipitating, perpetuating and protective factors.</li> <li>Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified).</li> <li>Service recommendations for the treatment episode.</li> <li>Level of care determination for DMC and DMC-ODS (i.e., ASAM) and/or for SMHS (Access Criteria for SMHS found in <a href="#">BHIN 21-073</a>).</li> </ul> </td></tr> </tbody> </table> | Domain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Description | <b>Domain 6 requirements:</b> <ul style="list-style-type: none"> <li>Strengths, Risk Behaviors, and Safety Factors</li> </ul> | <b>Strengths, risk behaviors and safety factors:</b> <ul style="list-style-type: none"> <li>Strengths in achieving goals, including personal motivation, drive, and interest.</li> <li>Resilience and coping skills.</li> <li>Protective factors, including the availability of resources, opportunities, and supports (including support persons), interpersonal relationships, systems (family/community/ professional), activities (routines/ social hobbies/ etc.).</li> <li>Situations and triggers that may induce risky behaviors.</li> <li>Suicidal/homicidal ideation.</li> <li>Safety planning, including an individualized plan that can be self-initiated or initiated by a trusted person (e.g. sponsor).</li> </ul> | <b>Domain 7 requirements:</b> <ul style="list-style-type: none"> <li>Clinical Summary and Recommendations</li> <li>Diagnostic Impression</li> <li>Medical Necessity Determination</li> <li>Level of Care/Access Criteria</li> </ul> | <b>Clinical impression, including etiology, clinical complexity, and impairments:</b> <ul style="list-style-type: none"> <li>Predisposing, precipitating, perpetuating and protective factors.</li> <li>Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified).</li> <li>Service recommendations for the treatment episode.</li> <li>Level of care determination for DMC and DMC-ODS (i.e., ASAM) and/or for SMHS (Access Criteria for SMHS found in <a href="#">BHIN 21-073</a>).</li> </ul> |  |
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| <b>Domain 7 requirements:</b> <ul style="list-style-type: none"> <li>Clinical Summary and Recommendations</li> <li>Diagnostic Impression</li> <li>Medical Necessity Determination</li> <li>Level of Care/Access Criteria</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Clinical impression, including etiology, clinical complexity, and impairments:</b> <ul style="list-style-type: none"> <li>Predisposing, precipitating, perpetuating and protective factors.</li> <li>Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified).</li> <li>Service recommendations for the treatment episode.</li> <li>Level of care determination for DMC and DMC-ODS (i.e., ASAM) and/or for SMHS (Access Criteria for SMHS found in <a href="#">BHIN 21-073</a>).</li> </ul>                                                                       |             |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |



## APPENDIX T. Milestones of Recovery Scale (MORS) Assessment

| Milestones of Recovery Scale (MORS)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                          |
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| Date: <input style="width: 40px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Client Case #: <input style="width: 40px;" type="text"/> |
| Unit: <input style="width: 40px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Staff ID #: <input style="width: 40px;" type="text"/>    |
| Subunit: <input style="width: 40px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                          |
| <p>Please select the number that best describes the current (typical for the last two weeks) milestone of recovery for the client listed above. If you have not had any contact (face-to-face or phone) with the client in the last two weeks, do not attempt to rate the client.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                          |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <ul style="list-style-type: none"> <li><input type="radio"/> 1. Extreme risk</li> <li><input type="radio"/> 2. High risk/not engaged</li> <li><input type="radio"/> 3. High risk/engaged</li> <li><input type="radio"/> 4. Poorly coping/not engaged</li> <li><input type="radio"/> 5. Poorly coping/engaged</li> <li><input type="radio"/> 6. Coping/rehabilitating</li> <li><input type="radio"/> 7. Early Recovery</li> <li><input type="radio"/> 8. Advanced Recovery</li> </ul> </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <li>• 1. Extreme risk – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.</li> <li>• 2. High risk/not engaged- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.</li> <li>• 3. High risk/engaged – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.</li> <li>• 4. Poorly coping/not engaged – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or</li> </ul> </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"></div> <div style="width: 50%;"> <ul style="list-style-type: none"> <li>jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.</li> <li>• 5. Poorly coping/engaged – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.</li> <li>• 6. Coping/rehabilitating – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing non-disabled roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be testing the employment or education waters, but this group also includes individuals who have retired. That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.</li> <li>• 7. Early Recovery – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.</li> <li>• 8. Advanced Recovery – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.</li> </ul> </div> </div> |                                                          |

## APPENDIX U. A/OA Outpatient Utilization Management Form

| A/OA Outpatient Utilization Management Form                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>Utilization Management processes has been implemented as a way to monitor client's progress and review criteria for continuation of services. Clients shall meet specific criteria and be reviewed through a Utilization Management process which shall be conducted internally by a Utilization Review Committee (URC) at all County and County Contracted Outpatient programs. The Utilization Management form must be completed in order to meet county requirements for UM. Programs are required to have a URC in place to <b>review records at least quarterly, with a minimum of 5 clients being selected</b>. Please see below for instructions on completion of each section. <b>The form shall be reviewed and signed by program manager or designee within 5 business days.</b></p> |  |
| <b>Section A:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <ul style="list-style-type: none"> <li>This section <b>must</b> be completed for all clients evaluated by the URC in order to document rationale for the UM process.</li> <li>Keep in mind when reviewing a chart for UM, a clinician may not review their own client.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>Section B:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <ul style="list-style-type: none"> <li>This section is to be completed, if in Section A, it was determined that review was <b>recommended</b> due to client being enrolled in services for 2 years or longer.</li> <li>This section shall be utilized to determine if additional services are needed to assist client in reaching their treatment goals or if discharge to a lower level of care is appropriate.</li> <li>Once additional areas have been identified, provide explanation as to how the recommendations will help enhance client's continued treatment.</li> </ul>                                                                                                                                                                                                                |  |
| <b>Section C:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <ul style="list-style-type: none"> <li>This section is to be completed, if in Section A, it was determined that review was due to a MORS rating of 6 or higher.</li> <li>It is <b>required</b> to complete this section for clients with a MORS rating of 6 or higher in order to justify ongoing services (JOS). Use this section to either document Justification for Ongoing Services (JOS) or transition to a lower level of care.</li> <li>This section may also be completed, if in Section A, it was indicated that UM was recommended by the treatment team. Use this section to document if additional services are recommended to assist client in reaching their treatment goals or if discharge to a lower level of care is appropriate.</li> </ul>                                   |  |
| <b>Section D:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <ul style="list-style-type: none"> <li>This section is completed for all clients reviewed by the URC, regardless of the UM reason, in order to address the disposition.</li> <li>Use this section to document whether or not client has met criteria for on-going services or referral to a lower level of care.</li> <li>If client is referred to a lower level of care, indicate to which type of provider, the rationale for the provider identified, as well as comments related to client's transition plan.</li> </ul>                                                                                                                                                                                                                                                                      |  |
| BHS QM Rv. 1/30/19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |

| A/OA OUTPATIENT UTILIZATION MANAGEMENT FORM                                                                                                                                                                                                                    |                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| County of San Diego<br>Health and Human Services Agency<br>Mental Health Services                                                                                                                                                                              |                                                                |
| Client Name:                                                                                                                                                                                                                                                   | CCBH Number: Program:                                          |
| <b>Section A</b><br><i>*Note: This section is <b>required</b> for each client being reviewed by the Utilization Management Committee (URC).</i>                                                                                                                |                                                                |
| Utilization Review Reason:                                                                                                                                                                                                                                     |                                                                |
| <input type="checkbox"/> Treatment Team Recommendation (See section C)                                                                                                                                                                                         | <input type="checkbox"/> MORS rating of 6 or > (See section C) |
| <input type="checkbox"/> Enrolled in Program > 2 years (See section B)                                                                                                                                                                                         | <input type="checkbox"/> Potential Discharge                   |
| Quarter/Date:                                                                                                                                                                                                                                                  | Credential:                                                    |
| Utilization Review Committee Chair Person:                                                                                                                                                                                                                     | Credential:                                                    |
| SAI Name:                                                                                                                                                                                                                                                      |                                                                |
| Additional Participants (minimum of two additional participants; cannot review your own client):                                                                                                                                                               |                                                                |
| Name:                                                                                                                                                                                                                                                          | Credential:                                                    |
| Name:                                                                                                                                                                                                                                                          | Credential:                                                    |
| Name:                                                                                                                                                                                                                                                          | Credential:                                                    |
| Name:                                                                                                                                                                                                                                                          | Credential:                                                    |
| MORS History (include the previous two dates and ratings):                                                                                                                                                                                                     |                                                                |
| Date:                                                                                                                                                                                                                                                          | MORS:                                                          |
| Date:                                                                                                                                                                                                                                                          | MORS:                                                          |
| <b>Section B:</b><br><i>*Note: If section A indicated UM was <b>recommended</b> due to client being enrolled in services for 2 years or longer, complete this additional section to document either continued care or transition to a lower level of care.</i> |                                                                |
| Overall Level of Functioning:                                                                                                                                                                                                                                  |                                                                |
| Client Specific Issues (check all that apply):                                                                                                                                                                                                                 |                                                                |
| <input type="checkbox"/> Relationships                                                                                                                                                                                                                         | <input type="checkbox"/> Lack of Support System                |
| <input type="checkbox"/> Aggression                                                                                                                                                                                                                            | <input type="checkbox"/> Domestic Violence                     |
| <input type="checkbox"/> Justice System Involvement                                                                                                                                                                                                            | <input type="checkbox"/> Difficulties with ADLs                |
|                                                                                                                                                                                                                                                                | <input type="checkbox"/> Substance Use                         |
|                                                                                                                                                                                                                                                                | <input type="checkbox"/> Other                                 |
| Environmental Issues (check all that apply):                                                                                                                                                                                                                   |                                                                |
| <input type="checkbox"/> Lack of housing/housing complications                                                                                                                                                                                                 | <input type="checkbox"/> Employment issues                     |
| <input type="checkbox"/> Lack of transportation                                                                                                                                                                                                                | <input type="checkbox"/> Financial hardship                    |
|                                                                                                                                                                                                                                                                | <input type="checkbox"/> Other                                 |
| BHS QM Rv. 1/30/19                                                                                                                                                                                                                                             |                                                                |

| A/OA OUTPATIENT UTILIZATION MANAGEMENT FORM                                                                                                                                                 |                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| County of San Diego<br>Health and Human Services Agency<br>Mental Health Services                                                                                                           |                                                          |
| Clinical Issues (check all that apply):                                                                                                                                                     |                                                          |
| <input type="checkbox"/> Paranoia                                                                                                                                                           | <input type="checkbox"/> Delusions                       |
| <input type="checkbox"/> Suicide Attempts                                                                                                                                                   | <input type="checkbox"/> Suicidal ideation               |
| <input type="checkbox"/> Med non-compliance                                                                                                                                                 | <input type="checkbox"/> Danger to Others                |
| <input type="checkbox"/> Need for continued clinic support                                                                                                                                  | <input type="checkbox"/> Lack of engagement in treatment |
|                                                                                                                                                                                             | <input type="checkbox"/> Other                           |
| Provide explanation and any treatment recommendations based on the above marked answers:                                                                                                    |                                                          |
| <b>Section C:</b><br><i>*Note: If section A indicated that UM was due to a MORS rating of 6 or higher, this section is <b>required</b> as the Justification for Ongoing Services (JOS).</i> |                                                          |
| (client name) was recommended by a member of the treatment team for review.                                                                                                                 |                                                          |
| For on-going services at County or County Contracted Outpatient Program, as evidenced by one of the following:                                                                              |                                                          |
| Check all that apply and describe in comments section below:                                                                                                                                |                                                          |
| <input type="checkbox"/> Client has been in Long Term Care, had a psychiatric hospitalization, or was in a crisis residential facility in the last year                                     |                                                          |
| <input type="checkbox"/> Client has been a danger to self or others in the last 12 months,                                                                                                  |                                                          |
| <input type="checkbox"/> Client's impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless                                  |                                                          |
| <input type="checkbox"/> Client's behavior interferes with client's ability to get care elsewhere, and/or                                                                                   |                                                          |
| <input type="checkbox"/> Client has a complex psychiatric medication regimen and/or is on injectable medication                                                                             |                                                          |
| <input type="checkbox"/> Client is actively using substances                                                                                                                                |                                                          |
| <input type="checkbox"/> Level of support and services cannot be duplicated at a lower level of care, which would risk client decompensation                                                |                                                          |
| Comments and Treatment Plan:                                                                                                                                                                |                                                          |
| BHS QM Rv. 1/30/19                                                                                                                                                                          |                                                          |

| A/OA OUTPATIENT UTILIZATION MANAGEMENT FORM                                                                                                                                                              |             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| County of San Diego<br>Health and Human Services Agency<br>Mental Health Services                                                                                                                        |             |
| <b>Section D:</b><br><i>*Note: This section is <b>required</b> to be completed for all clients being reviewed by URC in order to address the Disposition.</i>                                            |             |
| <input type="checkbox"/> Treatment justification for on-going services is supported for an additional year                                                                                               |             |
| <input type="checkbox"/> Treatment justification for on-going services is not supported (if not supported complete the following questions):                                                             |             |
| <input type="checkbox"/> Client is recommended for referral to Primary Care due to one or more of the following (check all that apply):                                                                  |             |
| <input type="checkbox"/> No mental health related ED visits, PERT intervention START admissions or hospitalizations for >12 months                                                                       |             |
| <input type="checkbox"/> Stable housing/social setting for 12 months                                                                                                                                     |             |
| <input type="checkbox"/> Low risk of harm                                                                                                                                                                |             |
| <input type="checkbox"/> High community support or independent                                                                                                                                           |             |
| <input type="checkbox"/> No group or individual therapy in the last 6 months                                                                                                                             |             |
| <input type="checkbox"/> Medications within scope of primary care and/or no changes within past 6 months                                                                                                 |             |
| <input type="checkbox"/> No group or individual therapy for the past 6 months                                                                                                                            |             |
| <input type="checkbox"/> Client self-report that they are ready to terminate                                                                                                                             |             |
| <input type="checkbox"/> Client is recommended for referral to Fee for Service (FFS) or Medi-Cal Managed Care Plan (MCP) Psychiatry services due to one or more of the following (check all that apply): |             |
| <input type="checkbox"/> Moderate functioning                                                                                                                                                            |             |
| <input type="checkbox"/> Stable housing for 6 months                                                                                                                                                     |             |
| <input type="checkbox"/> Low risk of harm                                                                                                                                                                |             |
| <input type="checkbox"/> Moderate community support or independent                                                                                                                                       |             |
| <input type="checkbox"/> Moderate illness management skills                                                                                                                                              |             |
| <input type="checkbox"/> Complex medications not within scope of primary care and/or no changes within the past 6 months                                                                                 |             |
| <input type="checkbox"/> No hospitalizations or START admissions within the past 6 months                                                                                                                |             |
| <input type="checkbox"/> No group or individual therapy for the past 6 months                                                                                                                            |             |
| Comments and Treatment Plan (be sure to include the name and contact information of referral recommendation, as well as information for boxes that were checked above and frequency of appointments):    |             |
| Provider's Printed Name and Credential:                                                                                                                                                                  |             |
| Provider's Signature:                                                                                                                                                                                    | Date: Click |
| Program Manager Printed Name and Credential:                                                                                                                                                             |             |
| Program Manager Signature:                                                                                                                                                                               | Date: Click |
| BHS QM Rv. 1/30/19                                                                                                                                                                                       |             |

## APPENDIX U. Sample Centralized Data Infrastructure Budget

| Budget Category           | Description                                                                                                                                                                                       | Estimated Cost         |
|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
| System Development        | Design, build, and deploy a centralized data reporting platform for SMI treatment outcomes. Assumes 3 full-time software engineers and 1 full-time project manager for 18 months.                 | \$7,200,000 (one-time) |
| Annual System Maintenance | Includes cloud hosting (e.g., AWS GovCloud), DevOps support, security monitoring, bug fixes, and user support.                                                                                    | \$2,500,000 / year     |
| County Reporting Staff    | Ongoing effort from local staff to collect, validate, and submit standardized SMI treatment data. Assumes 0.5–1.0 FTE per county at an average fully-loaded cost of \$110,000/year.               | \$8,800,000 / year     |
| Training & Onboarding     | One-time training and onboarding for county and regional staff. Includes statewide training workshops, development of learning management system (LMS) modules, and initial technical assistance. | \$3,000,000 (one-time) |
| Oversight & Evaluation    | Third-party monitoring and annual data quality audits to ensure proper implementation, usage, and continuous improvement.                                                                         | \$500,000 / year       |

Total First-Year Cost (including launch): \$21,500,000

Ongoing Annual Cost (post-launch): \$11,800,000

### Assumptions

- Platform development costs assume use of government-compliant infrastructure and standard security protocols.
- Personnel cost assumptions use average loaded rates of \$150/hour for engineers, \$120/hour for project managers, and \$110,000/year for local staff.
- Each of California's 58 counties is expected to maintain at least 0.5 FTE for data reporting and compliance.
- Training and onboarding costs reflect both initial technical training and administrative capacity-building for standardized reporting procedures.
- Annual oversight includes external evaluation and system monitoring to promote continuous improvement.

