The California Model for Behavioral Health

A Standard of Care for All

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Executive Summary

Behavioral Health Action is a coalition of more than 50 statewide organizations united to raise awareness about behavioral health issues in California. Our mission is to elevate, educate and innovate in California's behavioral health arena. Behavioral Health Action represents individuals and families, small businesses, labor, law enforcement, service and not-for-profit providers, county mental health departments and more.

In the early months of 2019, we committed to developing a modern model, standard of care for behavioral health in California. In this document, we provide guiding principles and a vision, as well as describe a standard of care for behavioral health that should be available to promote the health and well-being of *all* Californians.

To develop this proposed model, we closely reviewed the current benefits provided through health plans and public programs in California. We identified numerous areas where coverage for mental health and substance use disorders varies widely, depending on where an individual resides and the type of health coverage they hold.

Behavioral Health Action believes the priority for new and existing behavioral health investments should ***focus on prevention and early intervention to promote health and well-being,*** which will reduce the need to expand costly and restrictive types of care, such as crisis intervention, law enforcement involvement, emergency department visits, out-of-home care, involuntary detention, and conservatorship. Additionally, all services should be provided in a client-centered fashion with the involvement of families and seek to avoid restrictive levels of care.

Behavioral Health Action proposes the following seven components that form a standard for behavioral health care in California:

I. Prevention and Early Intervention
II. Assessment and Treatment Planning
III. Services and Supports
IV. Crisis Care and Alternatives to Hospitalization
V. Hospitalization and Transitional Care
VI. Long-Term Care
VII. Involuntary Care

Providing equal access to the proposed California Model for Behavioral Health will save money, improve and save lives, promote behavioral health as a part of overall health, and create a healthier California overall.

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Our Vision

California will lead the nation by offering a robust continuum of prevention services and behavioral health care that is person-centered, culturally competent, evidence-based, and creates wellness and hope to all residents and families with mental health and substance use disorder treatment needs.

Who We Are

Behavioral Health Action is a coalition of more than 50 statewide organizations united to raise awareness about behavioral health issues in California. Our mission is to elevate, educate and innovate in California's behavioral health arena. Behavioral Health Act is a unique, first-of-its-kind alliance of not only hospitals and healthcare providers, but also groups representing families and individuals, the criminal justice system, labor, local government, not-for-profit organizations and business. We are engaging California's leaders and bringing people together to talk about positive solutions to behavioral health and stopping stigma.

Introduction

In the early months of 2018, Behavioral Health Action members committed to a momentous task: to develop a **modern model, standard of care for behavioral health in California**. We began to convene a series of committee meetings to develop recommendations on an ideal continuum of care, crisis services, and finance and delivery system issues. When Behavioral Health Action met to review our achievements from the past year and set priorities for year 2019, we were fortunate to hear a presentation from one of our own members about a paper published in 1981 that inspired us: "A Model for California Community Mental Health Programs."

The project completed in 1981 had been initiated by now-retired California Assembly Member, Thomas H. Bates., who chaired the California Assembly Permanent Subcommittee on Mental Health and Development Disabilities. Following a 1979 Subcommittee hearing on the future of mental health in California, Chairman Bates and the Subcommittee members unanimously voted to ask a coalition of mental health providers and consumers to develop a consensus among themselves and their constituencies about appropriate mental health care in California. Over the two years that followed, a work group determined the basic needs for chare, which were evolved into standards, resulting in the Model for California Community Mental Health Programs.

After hearing this presentation, Behavioral Health Action members saw clearly the need to not only update the model, but to identify an ideal continuum of care that included care for both mental health and substance use disorder services. In this document, we describe **a standard of care for behavioral health that should be available to promote the health and well-being of *all* Californians**. Despite the fact that one in

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four Americans experience a behavioral health challenge in any given year, and half of us will care for someone living with a mental health issue during our lives, too many Californians still struggle to access a full array of health care and supports. According to a 2017 Substance Abuse and Mental Health Services Administration “Behavioral Health Barometer for years 2014-2015:”[1]

- 10.9% of all adolescents used alcohol in the past month, and 6.6% of all individuals age 12 or older had an alcohol use disorder in the past year, and 3.3% had an illicit drug use disorder.
  12.3% of all adolescents had experienced a major depressive episode in the past year, but only 32.1% who had his experience in the prior 5 years received treatment for their depression
- 3.5% of all adults had a serious mental illness in the past year
- Only 37.2% of all adults with any level of mental illness between 2011 to 2015 received mental health services in the past year

Additionally, California’s most robust behavioral health investments have been reactive rather than prevention-oriented. Rather than investing in prevention and early identification, most of California’s current behavioral health expenditures focus on individuals already quite ill and for whom more intensive and costly treatments are provided. Investments in behavioral health must match those made in primary health care, in which the goal is to *prevent illness* and *detect early signs* as soon as possible (see the “Inverting the Triangle” illustration below).

While more Californians should have access to behavioral health coverage today, thanks in large part to the expansion of Medicaid under the Affordable Care Act, Proposition 63 or the Mental Health Services Act (MHSA), and the Drug Medi-Cal Organized Delivery System waiver, most still lack effective access to care.

Behavioral Health Action recognizes that California has invested in county-run community behavioral health services with dedicated tax revenues, and that Medi-Cal managed care plan benefits now offer outpatient mental health services for individuals with a mild or moderate mental health condition. Additionally, the Affordable Care Act requires commercial insurance plans in California to cover mental health and substance use disorder services.

Despite these reforms and investments, the types of care available and the settings in which care may be provided still depend on where an individual resides and the type of health care coverage they hold, rather than on what the individual needs to stay health or get healthy.

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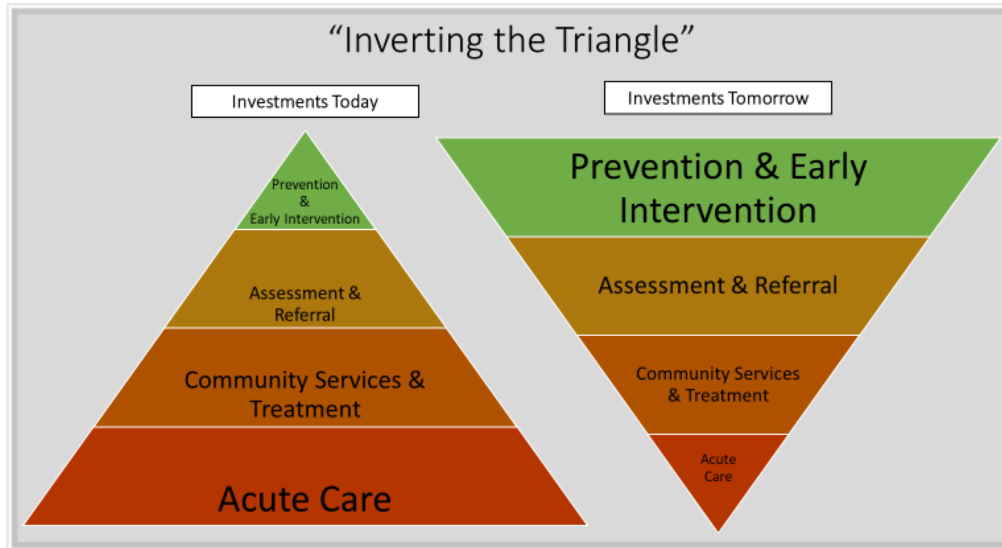

We believe that as the year 2020 approaches, California has a historical opportunity to lead the nation in making behavioral health parity a true reality – where behavioral health services are expected to be just as robust as primary health care services, and our investments in prevention and early intervention reduce our need for more restrictive and costly types of care. With this in mind, Behavioral Health Action boldly proposes that *all Californians* should have access to the dynamic continuum of behavioral health care described in the pages that follow, regardless of the type of health coverage they have.

Providing equal access to the proposed California Model for Behavioral Health will save money, improve and save lives, promote behavioral health as a part of overall health, and create a healthier California overall. However, we would be remiss if we did not acknowledge the many and significant roles played by other, non-behavioral health care factors, and these are discussed in the "Important Considerations" section of this document.

Guiding Principles

Within all levels of services and supports presented in the California Model for Behavioral Health Care, the following principles should influence the way in which care is provided and experienced by individuals and families.

Services offered should:

1. Prioritize prevention and early intervention strategies to prevent the need for higher levels of care.
2. Be provided timely and in the least restrictive setting possible.
3. Embrace recovery and resilience principles and practices, with a focus on strengthening the individual.
4. Involve family members and parents, when appropriate, in treatment decisions and as a critical source of support to individuals of all ages.

5. Be provided in culturally and linguistically competent ways in order to reduce disparities in access and quality of care.
6. Use evidence-based and community-defined best practices.
7. Respect and promote individuals' rights, including the rights to be treated with respect, to dignity and independence, and to be fully informed.
8. Be provided in a trauma-informed way by providers at all levels that have received training and education about trauma's role in behavioral health.
9. Be easy to navigate and access, with information readily available through the telephone, Internet, and among health insurers and providers.

Providers and leaders working as a system should:

1. Actively seek and utilize input from diverse individuals and families with lived experience and stakeholders when developing behavioral health services and supports.
2. Utilize peer providers as a key component of the behavioral health workforce and utilize peer support throughout the continuum of care.
3. Recognize the critical role that families play in the support, recovery and development of children and adults. Research overwhelmingly shows that when families take an active part in treatment decisions, consumer outcomes are better.
4. Overcome and eliminate barriers to providing an integrated care experience for individuals with mental health, substance use disorder, and primary care needs.
5. Require collaboration and coordination among the many of state agencies, commissions, and councils involved in the administration of behavioral health.
6. Value performance measurement to assess the quality of care provided to individuals and families.
7. Embrace non-stigmatizing language and practices and make investments in educating and training others in the community to reduce the stigma experienced by individuals and families with behavioral health needs.
8. Increase opportunities for public and private partnerships, including in designing innovations for behavioral health care and investing in workforce development.

The California Model for Behavioral Health Care

Behavioral Health Action proposes that the standard of care for behavioral health in California includes the following dynamic continuum of behavioral health care:

I. **Prevention and Early Intervention**
II. **Assessment and Treatment Planning**
III. **Services and Supports**
IV. **Crisis Care and Alternatives to Hospitalization**
V. **Hospitalization and Transitional Care**
VI. **Long-Term Care**
VII. **Involuntary Care**

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California law requires most insurance policies to cover Essential Health Benefits, which notably include preventive care, mental health care, emergency and urgent care, rehabilitation therapy, home health or nursing home care after a hospital stay, prescription drugs, and substance abuse treatment. However, the specific definitions and range of these behavioral health-related services vary greatly between health plans and public benefit programs such as Medi-Cal and Medicare. Additionally, federal block grants and state tax revenues provide augmented behavioral health services currently provided only by counties.

Further, coverage of mental health services for Medi-Cal beneficiaries is delivered through either counties or managed care plans, depending on level of impairment of the individual and services available differ among these two separate systems. These distinctions create confusion for consumers, families, and health and social service partners. By contrast, if California's Medi-Cal program delivered by counties and plans, and the Essential Health Benefits delivered by health plans, covered the same effective and reasonable continuum of care, Californians would have substantially more equitable access to behavioral health care.

As described earlier, Behavioral Health Action believes the priority for new and existing behavioral health investments should ***focus on prevention and early intervention to promote health and well-being,*** which will reduce the need to expand costly and restrictive types of care, such as crisis intervention, law enforcement involvement, emergency department visits, out-of-home care, involuntary detention, and conservatorship. Additionally, the components of the model for behavioral health are flexible. While each service component should be available to every resident in need, we recognize that not every resident with behavioral health needs will need or choose to utilize every component.

I. Prevention & Early Intervention

Service Components

A. **PUBLIC EDUCATION:** Outreach and dissemination of culturally, linguistically, and age appropriate information to the public that reduces stigma, and educates about the signs of suicide risk, early signs of mental health or substance use disorder needs, and how to seek help.

B. **SCREENING:** Trauma-informed screenings for mental health, alcohol, and other substance use concerns for all latency age youth, adolescents, and adults with referrals to treatment when needed.

C. **EARLY INTERVENTION**: Services that support individuals at risk or who are showing the early signs of a behavioral health need, supports to prevent relapse such as self-help groups, and supports to the individual and his or her family that prevent the need for higher levels of service.

Discussion

Half of all cases of mental illness begin by age 14, and 75% by age 24. Sometimes decades elapse, unnecessarily, between the first appearance of symptoms and when people get help.[2] According to the National Institute of Mental Health, the average delay between onset of symptoms and intervention is between eight and ten years. Depression is among the leading causes of disability in persons 15 years and older, and affects individuals, families, businesses, and society and is common in patients seeking care in the primary care setting.[3] Children and adolescents with depression typically have difficulties in their performance at school or work, as well as in their interactions with their families and peers and major depressive disorder in children and adolescents is strongly associated with recurrent depression in adulthood, other mental disorders, and increased risk for suicidal ideation, suicide attempts, and suicide completion.[4]

According to the Surgeon General's 2016 report on substance use disorders, "Because substance misuse has traditionally been seen as a social or criminal problem, prevention services were not typically considered a responsibility of health care systems and people needing care for substance use disorders have had access to only a limited range of treatment options that were generally not covered by insurance. Effective integration of prevention, treatment, and recovery services across health care systems is key to addressing substance misuse and its consequences and it represents the most promising way to improve access to and quality of treatment."[5]
Excessive alcohol use is one of the most common causes of premature mortality in the United States; unhealthy alcohol use is the third-leading preventable cause of death in the United States. Alcohol use during pregnancy is also one of the major preventable causes of birth defects and developmental disabilities.[6]
These alarming figures present an immense opportunity for California to educate the public, screen individuals of all ages, and provide interventions and referrals at the earliest possible time. The recommendations of others, described below, bolster our recommendation that screening and prevention services must become more widely used in California.

The US Preventive Services Task Force (USPSTF), which reviews the evidence of both benefits and harms, recommends screening for depression in the general adult population, including pregnant and postpartum women, and found convincing evidence that treatment using antidepressants, psychotherapy, or both decreases clinical morbidity.[7] Further, USPSTF recommends depression screening in adolescents aged 12 to 18 years.[8] The American Academy of Pediatrics' Bright Futures program recommends annual screening in child and adolescent patients for emotional and behavioral problems. Medicaid's child health component, the Early and Periodic Screening, Diagnosis, and Treatment program, recommends screening to detect physical and mental conditions at periodic, age-appropriate intervals and, if risk is identified, follow-up with diagnostic and treatment coverage.

The USPSTF also recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[9] The US Surgeon General, Centers for Disease Control and Prevention, and American Society for Addiction Medicine (ASAM) all recommend routinely screening adults for unhealthy alcohol use and providing them with appropriate interventions, if needed.[10] ASAM and the American College of Preventative Medicine urge all insurers to provide coverage of services that target early detection of and intervention for substance use and to do so without burdensome utilization management oversight.[11]

According to 2018 State reports on California's use of the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, evidence-based prevention strategies have returns on investment of up to 18:1, meaning for every $1 invested in prevention, $18 are saved due to reduced medical costs, increased productivity in work and school, reduced crime, and generally better quality of life.[12]

The Affordable Care Act includes "preventive and wellness services and chronic disease management" in its definition of the 10 essential health benefits that must be covered by all Marketplace health plans at no cost to enrollees. However, these are currently limited to alcohol misuse and depression screening for adults, postpartum women, and adolescents; developmental screenings for infants and youth; and behavioral assessments for infants and youth. Other than these limited screenings and assessments, the bulk of prevention and early intervention services in California are provided and financed by county behavioral health departments under the federal Substance Abuse Prevention & Treatment (SAPT) Block Grant, Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots, and Mental Health Services Act (MHSA).

Behavioral Health Action recommends the inclusion of public education, prevention, and early intervention in California's standard of behavioral health care.

II. Assessment and Treatment Planning

Components

A. ASSESSMENT: Assessments to identify biological, psychological, and social needs and strengths of the individual.

B. DIAGNOSIS: Diagnosis of any substance use disorders and/or mental health disorders that may be present, utilizing the most recent edition of the Diagnostic Statistical Manual (DSM).

C. TREATMENT PLANS: Individualized treatment plans that include the goals of the individual and his or her family members, when appropriate,

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and which address individuals’ health care, education, housing, recovery or wellness services, social and community supports needs and preferences.

Discussion

Currently, the Medi-Cal Specialty Mental Health, Drug Medi-Cal, and Mental Health Services Act programs require in-depth assessments of each individual, as well as require the development and ongoing updating of individualized treatment plans.

Behavioral Health Action recommends the inclusion of biopsychosocial assessments and individualized, comprehensive treatment plans reflecting the goals and needs identified by each individual be included in California’s standard of behavioral health care.

III. Services and Supports

Components

A. INDIVIDUAL, GROUP, OR FAMILY-BASED OUTPATIENT PSYCHOTHERAPY AND COUNSELING

B. LABORATORY TESTS, MEDICATIONS, SUPPLIES, AND SUPPLEMENTS

C. PSYCHIATRIST OR OTHER PHYSICIAN CONSULTATION

D. PSYCHOLOGICAL TESTING

E. OUTPATIENT SUBSTANCE USE DISORDER SERVICES

Currently available as a Drug Medi-Cal benefit, these services include physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling.

F. MEDICATION ASSISTED THERAPY (MAT)

MAT is the use of United States Food and Drug Administration (FDA)-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Medications commonly used include Methadone, Buprenorphine and Naltrexone, which reduce or prevent cravings and withdrawal symptoms, and reduce the risk of overdose. Additionally, Acamprosate may be used to reduce cravings for individuals with alcohol use disorder, and Disulfiram deters drinking because

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combining it with alcohol causes physical illness.[13]

G. REHABILIATIVE AND RECOVERY SERVICES

Rehabilitative and recovery services assist individuals, and family members when appropriate, with a range of needs that impact behavioral health. These include coaching, peer-to-peer services and relapse prevention; linkages to life skills, employment services, job training, and education services; family support, linkages to childcare, parent education, child development support, family/marriage education; support groups; and ancillary services, linkages to housing assistance, and transportation. Rehabilitative and recovery services can be provided anywhere in the community, as well as in an individual's or family's residence.

H. CASE MANAGEMENT

Case management is provided by a single point of contact who assists individuals and their families in accessing needed services, monitors the treatment plan, and coordinates services and treatment plans with other systems, including primary care providers, schools, child welfare agencies, and the criminal justice system.

I. RESIDENTIAL TREATMENT

Residential treatment can be an effective method for treating both mental health and substance use disorders, as well as co-occurring disorders. Residential programs provide a non-institutional, non-medical program in which individuals live on the premises and are supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs include a range of activities and services and staff are present 24 hours per day, 7 days per week. In the case of residential treatment for mental health conditions, residential treatment can be an effective alternative to psychiatric hospitalization. The length of stay for residential programs is typically no more than 90 days.

Currently, substantial discrepancies exist in the coverage of this range of services and supports among health plans and public programs. Behavioral Health Action recommends the inclusion of each service described above within California's standard of behavioral health care.

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IV. Crisis Care and Alternatives to Hospitalization

Components

A. CRISIS INTERVENTION

Crisis intervention services are provided face-to-face by a therapist or counselor and an individual in crisis. Lasting less than 24 hours, these services are provided when a response that is faster than a regularly scheduled visit is necessary. As part of crisis intervention services, the therapist or counselor may provide an assessment of the individual, consult with significant support persons, and/or provide counseling and therapy in order to address the crisis.

B. CRISIS STABILIZATION

Also lasting less than 24 hours, crisis stabilization services are unplanned, expedited services to address an urgent condition that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services by providing care in a licensed 24-hour health care facility. Some communities have established "Crisis Stabilization Units" or "Centers" to offer residents and law enforcement a safe alternative to hospital emergency departments or to avoid making a criminal arrest.

C. DETOXIFICATION/WITHDRAWAL MANAGEMENT

Detoxification is a set of interventions aimed at managing acute alcohol or drug intoxication and withdrawal. Supervised detoxification may prevent potentially life-threatening complications that might appear if an individual is left untreated. Detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalization or legal involvement. Finally, for some individuals, detoxification may be a point of first contact with treatment and the first step to recovery.[14] Detoxification services may be provided on an inpatient basis in a general acute care hospital or in an outpatient setting, when safe and appropriate.

"Withdrawal management" has replaced the term "detoxification" in the treatment guidelines published by the American Society of Addiction Medicine (ASAM). Withdrawal management refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of a drug or alcohol for which they are physiologically dependent.[15] The symptoms, management practices, use of medications, and follow-up care depend on the substance from which an individual may experience withdrawal symptoms, as well as the acuity of the withdrawal symptoms.

D. CRISIS RESIDENTIAL TREATMENT

Crisis residential treatment services are therapeutic or rehabilitative services provided in a non-institutional residential setting that provides a structured program as an alternative to hospitalization for individuals experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. Crisis residential treatment services are typically provided for three months or less. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, 7 days a week. Currently, crisis residential treatment facilities are licensed as “social rehabilitation” facilities by California Department of Social Services.

E. PSYCHIATRIC HEALTH FACILITY SERVICES

Psychiatric Health Facility (PHF) services are provided in a multidisciplinary model as an alternative to psychiatric inpatient hospital for individuals who need acute psychiatric care, but do not require services to treat a physical health condition in an inpatient setting. Currently, PHFs are licensed by California Department of Health Care Services.

F. PARTIAL HOSPITALIZATION

Partial hospitalization services for individuals with a substance use disorder provide 20 or more hours of clinically intensive programming per week. Typically, these programs have direct access to psychiatric, medical, and laboratory services, and are designed to meet needs that warrant daily monitoring or management and can be addressed in a structured outpatient setting. Services consist primarily of counseling and education about addiction-related problems, as well as include family therapy, medication services, crisis intervention services, and discharge services.

G. NALOXONE

Naloxone is a medication approved by the Food and Drug Administration to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. A doctor can prescribe naloxone to patients who are in medication-assisted treatment (MAT), especially if an individual is taking medications used in MAT or is considered at risk for opioid overdose. Naloxone is effective if opioids are misused in combination with other sedatives or stimulants. It is not effective in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines.[16]

Discussion

At times, an individual with a mental health or substance use disorder may encounter a crisis. A mental health crisis is a non-life threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress, disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and unable to be calmed. In the case of substance use disorders, a crisis may occur if an individual has a relapse, or if an unforeseen event or circumstance presents an imminent threat of relapse. The range of services described above are effective, sometimes lifesaving interventions for individuals in crisis and can often avert the need to treat an individual in a more costly and restrictive inpatient hospital setting.

Currently, substantial discrepancies exist in the coverage of this range of services and supports among health plans and public programs. Behavioral Health Action recommends all of the services described above be included in California's standard of behavioral health care.

V. Hospitalization and Transitional Care

Components

A. INPATIENT PSYCHIATRIC HOSPITALIZATION

An individual experiencing an acute psychiatric episode that cannot be safely treated at a lower level of care may requires psychiatric inpatient hospital services. Specifically, this occurs if an individuals' symptoms or behaviors due to a mental disorder: represent a current danger to self or others, or significant property destruction; prevent the individual from providing for or utilizing food, clothing or shelter; present a severe risk to the individual's physical health; or represent a recent, significant deterioration in ability to function.

In California, psychiatric inpatient hospital services may be provided in a Freestanding Acute Psychiatric Hospital (FAPH) or within a psychiatric unit of a General Acute Care Hospital (GACH). Both types of hospitals are licensed and certified by the California Department of Public Health. Individuals may be admitted to psychiatric inpatient care on a voluntary basis, or on an involuntary basis under the Lanterman Petris Act of California discussed later in this document.

A 2016 review of national hospital inpatient data among individuals with a mental or substance use disorder found that the most common type of disorder among inpatient stays was depressive disorders (26.1%), followed by alcohol-related disorders and schizophrenia (nearly 25%), bipolar disorders (12.5%), opioid-related disorders (6.7%), and suicidal ideation or attempt (5.7%).[17]

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B. CHEMICAL DEPENDENCY RECOVERY HOSPITALIZATION

Chemical dependency recovery hospitals provide 24-hour inpatient care to persons with a dependency on alcohol and/or other drugs. Services provided include patient counseling, group therapy, physical conditioning, family therapy, outpatient services, and dietetic services. Chemical dependency recovery beds may be available in a general acute care hospital, acute psychiatric hospital, or a freestanding facility within a 15-mile distance from a general acute care hospital or the acute psychiatric hospital that owns or leases the facility.[18]

C. DISCHARGE PLANNING AND CARE COORDINATION

According to a study published in 2012 by SAMHSA, [19] management of transitions is a key element of effective care and involves the coordination of care across the often-siloed domains of mental health, general health and substance abuse. Systematic protocols and communication procedures for managing transitions have been shown to be effective in managing handoffs. The period directly following hospitalization carries many risks for persons with serious mental illness, including symptom relapse and hospital readmission, an increased risk of homelessness and the possibility of violent behavior or suicide. Suicide risks are particularly high after inpatient discharges, especially among people with depressive disorder, followed by bipolar disorder and schizophrenia.[20]

In its 2012 report, SAMHSA states, "Although these risks are well documented, there are many inadequacies in the process of planning among care providers and their patients upon discharge. Models to address high-risk transitions have largely focused on the general medical patient population and few have been reported that are specifically focused on the mentally ill."

While a variety of approaches can be used to conduct discharge and transition planning for an individual leaving mental health or substance use disorder treatment in a hospital or other facility, a 2013 study reviewing 15 specific interventions identified a statistically significant impact on readmission and identified the following effective components of discharge and transition planning:

- Psychoeducation interventions targeting disease management and living skills
- Structured assessments of patients' discharge needs
- Pre-discharge medication education/reconciliation
- Post-discharge telephone follow-up
- Efforts to ensure timely follow-up appointments
- Home visits
- Peer support
- Bridging components and timely communication between transition manager and inpatient staff with outpatient care or community providers during the transition

D. HOME VISITS

When an individual returns home after a hospitalization or nursing facility care, nurses, other health providers, or peer supporters visit individuals in their homes to reduce risk of re-hospitalization and to improve individuals' well-being. Supports may include regular visits, education and support for individuals and family members, medications and administration instructions, and building coping skills.

Additionally, the In-Home Supportive Services (IHSS) Medi-Cal program allows low income aged, blind, and disabled persons, including children, who are at risk for out-of-home placement, to remain safely at home by providing payment for care provider services. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Additionally, Medi-Cal Specialty Mental Health and the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit enables counselors and therapists to provide support to individuals, parents, and other family members in the field – including in an individual's home.

E. RESPITE CARE

Family members frequently serve as the main supporters of children and adults with behavioral health conditions. Respite provides caregivers with a short period of rest or relief by arranging alternative caregiving for the child or adult family member needing support. Respite may be planned, providing scheduled services to allow for intermittent breaks from caregiving, or may be available on an emergency basis in the case of unexpected life events that would negatively impact the individual receiving care. Emergencies could include a personal health crisis, job loss, or housing problem experienced by the caregiver.

Family caregivers report improved physical and emotional health and reduced stress when respite is available for their loved one. Individuals receiving support also experience improved well-being, and decreased likelihood of hospitalization or out-of-home placement. Respite can be provided in a variety of settings, including at home or at community-based agencies.

Additionally, respite care can be provided by peers in a residential, homelike setting. According to the National Empowerment Center: "A peer respite is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates 24 hours per day in a homelike environment....

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Peer respites are staffed and operated by people with psychiatric histories or who have experienced trauma and/or extreme states."[21]

Currently, discrepancies exist in the coverage of this range of crisis services and alternatives to hospitalization among health plans and public programs. Behavioral Health Action recommends the inclusion of each of the services described above in California's standard of behavioral health care.

VI. Long Term Care

Licensed board and care homes, assisted living facilities, and nursing homes provide highly structured living for people with severe mental illness, disability or medical complications. With access to staff 24-hours a day and meals provided, residents usually use most of their income to purchase their room, board, and care. Listed below are facilities licensed to provide long-term care to individuals with behavioral health needs in California:

A. MENTAL HEALTH REHABILITATION CENTERS (MHRCs)

MHRCs are long term care facilities that provide individualized treatment for clients and staffing levels are lower than those of Skilled Nursing Facilities and other health care settings. MHRCs provide intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning.

B. ADULT RESIDENTIAL FACILITIES

Sometimes referred to as "board and care homes," Adult Residential Facilities provide services to persons who need assistance with activities of daily living such as dressing, bathing, receiving an adequate diet, etc. Residents may have some functional disabilities but should not require medical care and supervision on a daily basis. State regulations are very specific on physical space, care provided, food and the provision of a Needs and Services Plan for each resident.

C. SKILLED NURSING FACILITIES (SNFs)

SNFs provide 24-hour nursing supervision for resident, as well as physician services, skilled nursing services, dietary services, pharmaceutical services, activity program, special disability resources/social services, transportation to medical and therapeutic services and emergency access to physician's services. The SNF is for the individual who requires continuous skilled nursing care but does meet the requirements either for acute hospital care or for home health care related services.

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Currently, discrepancies exist in the coverage of behavioral health long-term care benefits among health plans and public programs. Behavioral Health Action recommends the inclusion of each of the services described above in California's standard of behavioral health care.

VII. Involuntary Care

Components

- **INVOLUNTARY DETENTION, EVALUATION, TREATMENT**

  Under the Lanterman-Petris-Short (LPS) Act, California law allows police officers and certain mental health professionals designated by county mental health directors to take an individual into custody if they believe that, due to a mental health disorder, the individual presents a danger to self, danger to others, or are gravely disabled (i.e., unable to provide for their own food, clothing, or shelter).

  For up to a 72-hour period, individuals can be involuntarily detained and transported to an LPS designated facility while they are assessed by mental health professionals to determine whether they can be safely released, provided voluntary inpatient or outpatient services, or it is clinically appropriate to apply for a 14-day hold under Welfare and Institutions Code Section 5250 at the expiration of the 72-hour period. If the facility initiates a 14-day hold, a hearing will be held within four days where a hearing officer will either authorize the facility to continue to detain the individual or release them. Authorized detention pursuant to Section 5250 does not authorize the facility to provide treatment against the patient's will.

  If at the end of the 14-day detention the treating professionals determine that an individual continues to be a danger to self, a danger to others, or gravely disabled, the authorized facility representatives may apply for one, of three subsequent holds: an additional 14 days for continued dangerousness to self, 180 days for continued dangerousness to others, or 30 days for continued grave disability (in counties where Welfare and Institutions Code Section 5270 has been adopted). Finally, an individual considered gravely disabled may be placed under LPS Conservatorship (described below).

- **CONSERVATORSHIP**

  Under the LPS Act in California, conservatorship gives legal authority to an adult conservator to make certain decisions for a person with serious mental illness (a conservatee) who is unable to care for him or herself. If asked, the court can give the LPS conservator the duty to take care of and protect the person (conservator of the person) and also the power to handle the financial matters of the individual (conservator of the estate). The conservator can give consent to mental health treatment, even if the conservatee objects, and can agree to the use of psychotropic (mind-altering) drugs.

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The conservator can agree to place the individual with mental illness in a locked facility if a psychiatrist says it is needed and the hospital agrees to take the person, whether or not the conservatee agrees. The conservator can also decide where the mentally ill person will live when s/he is not in a locked psychiatric facility. An LPS conservator must have enough medical and social information before making decisions for the conservatee. And, the conservator must only take actions that are best for the mentally ill person. The LPS conservator can also make financial decisions for the seriously mentally ill person, like paying the bills and collecting a person's income.

- **CIVIL COMMITMENT**

  Involuntary civil commitment in the United States is a legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital or receive supervised outpatient treatment for some period of time.

  Under the LPS Act in California, if a conservatorship is granted by a judge, the appointed conservator may place the conservatee in a medical, psychiatric, nursing, or other state-licensed facility, or a state hospital, county hospital, hospital operated by the Regents of the University of California, a United States government hospital, or other nonmedical facility approved by the California Department of Health Care Services or an agency accredited by the State Department of Health Care Services, or in addition to any of the foregoing, in cases of chronic alcoholism, to a county alcoholic treatment center.

  The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) provides useful guidelines pertaining to civil commitment, including but not limited to the following:[22]
  - Civil commitment, whether inpatient or outpatient, should be reserved for those reliably diagnosed with a serious mental illness for which there is available treatment that is likely to be effective.
  - If the person is willing and able to engage with services voluntarily, he or she should not be committed.
  - A person should not be subject to inpatient commitment unless, without a hospital level of care, the person will be at significant risk, in the foreseeable future, of behaving in a way, actively or passively, that brings harm to the person or others.

- **ASSISTED OUTPATIENT TREATMENT**

  Assisted Outpatient Treatment, or outpatient commitment, is when an individual is mandated by a judge to follow a treatment plan, which typically includes visits to a mental health provider and taking prescribed medication. The types of services often included in AOT treatment plans include Assertive Community Treatment (ACT), intensive case management, supported housing, prescribed medication and frequent individual therapy visits. While controversial, a body of

empirical research has shown that these laws, as implemented in some jurisdictions, can make a difference. “If kept in place for at least 6 months and paired with intensive services,16 are associated with reduced incidence of hospitalization and improved quality of life for many persons with a serious mental illness.”[23]

In California, a County’s Board of Supervisors, through the resolution process, is authorized to fund AOT services using money allocated to them from various sources. If a resolution is passed and the county opts to implement the AOT Program, courts in participating counties may order a person into treatment. According to the most recent California Department of Health Care Services’ report on AOT to the Legislature, seventeen counties have Board of Supervisors approval to operate an AOT program: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Stanislaus, Ventura, and Yolo.

According to SAMHSA, some have held that AOT plays a public safety function in that it might prevent random acts of serious violence by persons with untreated mental illness. This has been the case in a few states, including California where “Laura’s Law” (enacted in 2002) is named for Laura Wilcox, a college student who was fatally shot inside a public behavioral health clinic in Nevada County by Scott Harlan Thorpe in 2001. SAMHSA states, “The promotion of AOT as a way to prevent violence—especially with regard to rare and extreme acts such as multi-casualty mass public shootings—is largely misplaced and can have the unintended adverse effect of reinforcing and increasing the social stigma associated with mental illness.” [24]

- **STATE HOSPITAL TREATMENT**

The California Department of State Hospitals (DSH) oversees five state hospitals, which are all licensed by the California Department of Public Health and must meet or exceed regulatory standards to continue providing care. These facilities provide mental health services to patients referred to them by a county court, a prison or a parole board. In 2017–18, California Department of State Hospitals cared for almost 12,000 patients with serious mental health challenges — far more than any other state hospital system nationwide. In 2017-18, most of the patients were forensic commitments, with only 9% civilly committed, 41% were White, and most were male and between 41 and 64 years old. The most common diagnosis among DSH patients was schizophrenia or schizoaffective disorder.[25] Individuals eligible to be treated in California state hospitals include[26]:

- *Incompetent to Stand Trial (IST)* – Referred to DSH if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings.
- *Not Guilty by Reason of Insanity (NGI)* – Individuals found guilty of an offense but are admitted to DSH if a court determines the individual was “insane” at the time the crime was committed.

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- *Mentally Disordered Offenders (MDO)* – State prison parolees who meet specific criteria, including but not limited to: the presence of a severe mental disorder that is not in remission or requires treatment to be kept in remission, the mental disorder was a factor in the commitment offense, the commitment offense involved force or violence or serious bodily injury, or the prisoner continues to be dangerous due to the severe mental disorder.
- *Sexually Violent Predators (SVP)* – SVP commitments are civil commitments of prisoners released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior.
- *Lanterman-Petris-Short (LPS)* – LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.
- *Coleman Class Patients (Mentally Ill Prisoners)* – Coleman patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill while in prison. Coleman patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as MDO.

Behavioral Health acknowledges that involuntary treatment should be available in California for those who pose a danger to their selves and others. However, involuntary care should be used only as a last resort, and last as little as possible so that individuals can quickly return to receiving care on a voluntary basis.

Important Additional Considerations

While the proposed California Model for Behavioral Health Care presented by Behavioral Health Action is extremely comprehensive, there are a number of important intersecting issues that must be further considered in order to achieve the vision of a robust continuum of behavioral health care residents and families with mental health and substance use disorder treatment needs.

- **Housing and Homelessness**

  The critical role of affordable, safe, and stable housing cannot be understated. Approximately one quarter of California's 130,000 homeless individuals are chronically homeless (homeless at least a year or repeatedly). According to the National Alliance to End Homelessness, "People experiencing chronic homelessness typically have complex and long-term health conditions, such as mental illness, substance use disorders, physical disabilities, or other medical conditions.

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Once they become homeless - regardless of what immediately caused them to lose their housing - it is difficult for them to get back into housing and they can face long or repeated episodes of homelessness."[27] Housing costs and income levels are critical factors: close to 2 million low-income households in California are spending more than half of their income on housing costs, according to the California Department of Housing and Community Development. While the individuals who are homeless and living with a behavioral health condition have a variety of health care, social service, and income support needs, most current programs and funding streams are not integrated. As a result, accusations among health and social service sectors ensue about which entity has the responsibility to help individuals and "end homelessness."

- **Quality of Care**

We recognize the importance of the quality of care that is provided. Merely making each service in the California Model for Behavioral Health Care available through both private insurance and public programs will not necessary result in consumer and family satisfaction with the care they received. In a journal article summarizing findings on health care quality by the Institute of Medicine, the authors bleakly state, "Despite the availability of outstanding health care in the United States, several independent reports, including the Institute of Medicine's quality chasm report, found that the gap between the care that patients could receive and do receive is greater than a fissure; it is a chasm. Problems include the underuse, overuse, and misuse of interventions and other errors in care. These problems are found in all types of services (i.e., preventive, acute, and chronic), patient age groups, treatment settings, managed and unmanaged care, and somatic and behavioral health services."

However, the Institute of Medicine identifies the following "Ten Rules to Guide the Redesign of Health Care":[28]

1. Care based upon continuous healing relationships. Patients should receive care whenever they need it and, in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.
2. Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences.
3. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. Evidence-based decision making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. Anticipation of needs. The health system should anticipate patient needs rather than simply reacting to events.
9. Continuous decrease in waste. The health system should not waste resources or patient time.
10. Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care

According to SAMHSA,[29] the 5 signs of quality substance use disorder treatment include:

1) Accreditation: Has the program been licensed or certified by the state? Is the program currently in good standing in the state? Are the staff qualified?
2) Medication: Does the program offer FDA approved medication for recovery from alcohol and opioid use disorders?
3) Evidence-Based Practices: Does the program offer treatments that have been proven to be effective in treating substance use disorders including medication management therapies, such as motivational therapy, cognitive behavioral therapy, drug and alcohol counseling, education about the risks of drug and alcohol use, and peer support?
4) Families: Does the program include family members in the treatment process?
5) Supports: Does the program provide ongoing treatment and supports beyond just treating the substance issues? Quality programs provide treatment for the long term which may include ongoing counseling or recovery coaching and support and helps in meeting other basic needs like sober housing, employment supports, and continued family involvement.

- **Social Determinants**

The social determinants of health and disparities provide both challenges and opportunities to improve the wellbeing of individuals with behavioral health needs. Examples include:

- Availability of resources to meet daily needs (e.g., safe housing and local food
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a

markets)
   - Access to educational, economic, and job opportunities
   - Access to health care services
   - Quality of education and job training
   - Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
   - Transportation options
   - Public safety
   - Social support
   - Social norms and attitudes (e.g., discrimination, racism, and distrust of government)

community)
   - Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
   - Residential segregation
   - Language/Literacy
   - Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
   - Culture

According to the U.S. Office of Disease Prevention and Health Promotion, “Health starts in our homes, schools, workplaces, neighborhoods, and communities. …Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.”[30]

Additionally, trauma can have lasting impacts that affect behavioral health and well-being. A recent study[31] of the impacts of trauma found that childhood trauma is associated with a 2- to 3-fold increase in risk of psychotic experiences. Further, trauma that involves neglect or interpersonal violence appears to be associated with a greater risk of psychotic experiences compared with exposure to unintentional injury, parental loss, or economic adversity. Adolescence was the age period during which exposure to trauma was most strongly associated with risk of psychotic experiences. According to the World Health Organization, severe mental disorders often result in increased risk of poverty, unemployment, social isolation and social stigma. These factors can increase psychological stress and unhealthy behaviors (such as smoking), which in turn increase the risk of chronic illness.

- **Ease of Navigation**

Ensuring the continuum of services in the California Model for Behavioral Health **easy to navigate** for individuals and families is critical. Regardless of their health care coverage, individuals and families have a very difficult time finding the type of care they need when they need it. This results in unnecessary stress and

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frustration, delays in treatment access, and can discourage individuals and families from seeking help. The stigma surrounding mental health and substance use disorders compounds the difficulties in access because people may be reticent to seek assistance in the first place. While a variety of phone numbers and web sites exist to help provide information and resources to individuals seeking behavioral health care, there exists no single place for individuals, families, and providers to obtain help navigating the web of behavioral health care available in each community/county.

- **Outcomes Evaluation**

  Efforts to evaluate the effectiveness of California's behavioral health services are sorely lacking in infrastructure and investment. Establishing a select number of standard client-level outcomes for measurement by all behavioral health care systems and providers would assist with accountability, public transparency, and facilitate better treatment and policy decision making. Current state law already requires a variety of state agencies to evaluate mental health and substance use disorder services. However, none of the existing efforts tell a clear, digestible story about whether individuals being served are actually getting healthier. Most of the data currently collected is reported in a program-by-program fashion, and it is not then assembled at the state level to reach conclusions about the point-in-time or long-term performance trends of programs, counties, Medi-Cal managed care plans, health plans, or the state as a whole.

- **Workforce Development**

  Successful implementation of the California Model for Behavioral Health rests heavily on the availability of a sufficient workforce. According to the California Health Care Workforce Commission earlier this year, "As demand grows for quality health care, California does not have enough of the right type of health workers, with the right skills, in the right places to meet the needs of our state's growing and increasingly diverse population. In spite of everything California has done in recent years to improve health care delivery, the state will face a shortfall in the next decade of 4,100 primary care clinicians and 600,000 home care workers and will only have two-thirds of the psychiatrists we need." Other findings published by the California Health Care Workforce Commission include:
  - Millions of Californians still don't have access to quality health care — because of where they live, how much they earn, or the health conditions they face.
    - Seven million Californians, the vast majority of them Latino, black, and Native American, live in Health Professional Shortage Areas — a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers.
    - Some of the fastest-growing regions of the state, such as the Inland Empire and San Joaquin Valley, have half as many doctors per resident as major metros like the Bay Area.
    - In the Northern and Sierra regions, one in five adults say they find it difficult to get the care they need.

        - For people who rely on the safety net, these challenges are even greater — with just over half as many doctors accepting Medi-Cal as those who accept private insurance.
        - Access to care is a major obstacle for those suffering from mental illness or drug and alcohol issues.
    - Today's health workforce doesn't current reflect the diversity of our state's population.
        - Given all of the cost associated with training, it's no surprise that the majority of medical students in California come from families with incomes in the top 20%.
        - Latinos are now nearly 40% of California's population, but only 7% of doctors.
        - More than seven million patients have limited English proficiency and could benefit from access to multilingual providers. Yet, according to one study, the state has only 20% as many Spanish-speaking doctors as it needs.

Described further in its 2019 report,[32] the California Health Care Workforce Commission recommends the following three strategies to address these and other health workforce challenges.

- Strategy 1: Increase opportunity for all Californians to advance in the health professions.
- Strategy 2: Align and expand education and training to prepare health workers with the right skills in the right places to meet California's health needs.
- Strategy 3: Strengthen the capacity, effectiveness, well-being, and retention of the current health workforce.

- **Special Populations**

Finally, Behavioral Health Action recognizes there are a number of important **special populations** that should be considered by policy makers based on their high risk factors and current difficulties accessing adequate behavioral health and primary care services. Examples include, but are not limited to:

- Individuals with Dementia or Alzheimer's disease
- Individuals with Traumatic Brain Injuries
- Individuals with behavioral health issues in significant contact with law enforcement or have experienced incarceration
- Youth in the child welfare system
- Older adults

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Appendix. Current Coverage of Behavioral Health Care Services

Prevention & Early Intervention

The Affordable Care Act (ACA) includes "preventive and wellness services and chronic disease management" in its definition of the **10 essential health benefits** that must be covered by all Marketplace health plans at no cost to enrollees. Among these preventative benefits are the following free preventative services pertaining to behavioral health:

- Alcohol misuse screening and counseling for adults
- Domestic and interpersonal violence screening and counseling for all women
- Depression screening for adults
- Alcohol, and drug use assessments for adolescents
- Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Depression screening for adolescents beginning routinely at age 12
- Developmental screening for children under age 3
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits

The federal Substance Abuse Prevention & Treatment (SAPT) Block Grant is the largest source of substance use disorder prevention funding in the nation, enabling states to stop substance use disorders before they start. In California, these substance use disorder prevention activities are carried out exclusively by counties receiving SAPT block grant funding. States have flexibility, but the most common prevention activities include:

- **Information Dissemination**: Increase knowledge and awareness of the dangers associated with drug use (e.g., public education campaigns).
- **Education**: Build skills to prevent illicit drug use, including decision-making, peer resistance, stress management, and interpersonal communication (e.g., classroom-based curriculum, mentoring, parenting classes).
- **Alternatives**: Organize healthy activities that exclude alcohol and illicit drugs (e.g., sports, community drop-in centers, community service activities).
- **Problem Identification**: Identify individuals misusing alcohol and illicit drugs and assess whether they can be helped by educational services (e.g., student assistance programs, screening and referral services).
- **Community-Based Process**: Provide networking activities and technical assistance to implement evidence-based practices, strategies, and agencies (e.g., needs assessments, community training, developing/revising strategic prevention plans)
- **Environmental**: Establish strategies for changing community standards, codes, and attitudes toward alcohol and illicit drug use (e.g., compliance checks, DUI checkpoints, advertising restrictions).

Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots require participating counties to provide "Early Intervention (American Society for Addiction Medicine Level

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0.5)" services. Specifically, counties must "identify beneficiaries at risk of developing a substance use disorder or those with an existing substance use disorder and offer those beneficiaries: screening for adults and youth, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage."

The Mental Health Services Act is California's largest source of mental health funding available to prevent mental illness. The MHSA statutes require 20% of the annual revenues generated by MHSA personal income taxes to be used on Prevention and Early Intervention (PEI) programs. The goal of the Prevention & Early Intervention (PEI) component of the MHSA is reduce and prevent the suffering that can result from untreated mental illness. While all ages may be served, at least 51% of the PEI funds must be used to serve individuals who are 25 years of age or younger. While counties have flexibility on their approaches, the required PEI program areas described in PEI regulations[33] include:

- Prevention Program
- Early Intervention Program
- Outreach for Increasing Recognition of Early Signs of Mental Illness Program
- Stigma and Discrimination Reduction Program
- Suicide Prevention Program
- Access and Linkage to Treatment Program
- Program to Improve Timely Access to Services for Underserved Populations

Assessment and Treatment Planning

In California's **Drug Medi-Cal program**, "assessment" is a term pertaining to treatment needs as used within the context of performing an "intake" of a beneficiary. Specifically, "intake" is defined in California Code of Regulations, Title 22, Section 51341.1(b)(13), as follows: *"Intake" means the process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders utilizing the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association; and the assessment of treatment needs to provide medically necessary treatment services by a physician. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.*

In California's **Medi-Cal Specialty Mental Health** service system administered by counties, "assessment" is a covered service and is defined in California's Rehabilitative Mental Health Services State Plan Amendment (CA SPA 10-016) as follows: *"*Assessment" *means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.*

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Later in the Appendix is a more detailed description of the required components of each beneficiaries' assessment, as described in the county Mental Health Plan contract with DHCS.

Services and Supports

The federal Affordable Care Act includes rehabilitation services in its definition of the 10 essential health benefits that must be covered by all Marketplace health plans. The U.S. Centers for Medicare & Medicaid Services' "Glossary of Health Coverage and Medical Terms" describes rehabilitation services as follows: "*Rehabilitation Services - Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings."*[34]

Under **California's Rehabilitative Mental Health Services Medicaid State Plan Amendment (CA SPA 10-016),** According to 2018 State reports on the SAPT Block Grant, evidence based prevention strategies in the substance use disorder field have returns on investment of up to 18:1, meaning for every $1 invested in prevention, $18 are saved due to reduced medical costs, increased productivity in work and school, reduced crime, and generally better quality of life.[35] receiving Specialty Mental Health Services administered by counties. Rehabilitation is defined as follows: *"Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries."*

Covered **Medi-Cal Rehabilitative Mental Health Services** available through counties are:

- Mental health services (individual, group, or family-based interventions)
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis intervention
- Crisis stabilization
- Adult residential treatment
- Crisis residential treatment services
- Psychiatric health facility services

Medi-Cal Specialty Mental Health Services also include:

- Targeted Case Management: Comprehensive assessment and periodic reassessment; development and periodic revision of a client plan; Referral and related activities; and monitoring and follow-up activities.

- Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) Services for beneficiaries under age 21, including Supplemental Services (e.g., therapeutic behavioral services, therapeutic foster care, intensive home-based services)

Later in the Appendix are definitions of each of the above Medi-Cal rehabilitative mental health services.

The **Drug Medi-Cal program** covers the following outpatient treatments and therapies when prescribed by a physician:

- Outpatient drug free treatment services
- Intensive outpatient treatment
- Perinatal residential substance use disorder services (limited to facilities with 16 or fewer beds)
- Naltrexone treatment services
- Narcotic treatment program services (methadone)
- Detoxification in a hospital

Later in the Appendix are definitions of each of the above Drug Medi-Cal covered services.

The **Drug Medi-Cal Organized Delivery System (DMC-ODS)** pilot programs include all of the above standard Drug Medi-Cal services, as well as the following:

- Multiple levels of residential substance use disorder treatment (not limited to perinatal women or facilities with 16 or fewer beds)
- Case management
- Narcotic treatment programs expanded to include buprenorphine, disulfiram, and naloxone
- Withdrawal management
- Recovery services, to be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse
- Case management
- Physician consultation
- Partial hospitalization (optional)
- Additional medication-assisted treatment (optional)

Later in the Appendix are definitions of each of the above DMC-ODS covered services.

Medi-Cal Managed Care Plans (MCPs) are required to provide the following outpatient mental health services to individuals with mild to moderate mental health conditions:

- Services Provided Within Primary Care Provider's Scope of Practice
- Individual and Group Mental Health Evaluation and Treatment (psychotherapy)
- Psychological Testing (when clinically indicated to evaluate a mental health condition)
- Medication Management (outpatient services for the purposes of monitoring medication therapy)

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- Outpatient Laboratory, Medications, Supplies, and Supplements (not including excluded medications)
- Psychiatric Consultation

Mental Health Services Act – Community Services and Supports includes the following wrap-around and therapy services: **Full Service Partnerships (FSPs)**. These programs may include the following "full spectrum" of mental health services:

Mental health services and supports including, but not limited to:	**Non-mental health services and supports including**, but not limited to:
1. Mental health treatment, including alternative and culturally specific treatments. 2. Peer support. 3. Supportive services to assist the client, and when appropriate the client's family, in obtaining and maintaining employment, housing, and/or education. 4. Wellness centers. 5. Alternative treatment and culturally specific treatment approaches. 6. Personal service coordination/case management to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services. 7. Needs assessment. 8. ISSP development. 9. Crisis intervention/stabilization services. 10. Family education services.	1. Food. 2. Clothing. 3. Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing. 4. Cost of health care treatment. 5. Cost of treatment of co-occurring conditions, such as substance abuse. 6. Respite care. **Wrap-around services to children**

<u>Long-Term Care, Supportive Housing, Residential Care</u>

The covered long-term and residential **Medi-Cal Rehabilitative Mental Health Services** available through counties are:

- **"Adult Residential Treatment Service"** are rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

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- **"Psychiatric Health Facility Services"** are therapeutic and/or rehabilitative services provided in a psychiatric health facility, other than a psychiatric health facility that has been certified by the Department as a Medi-Cal provider of inpatient hospital services, on an inpatient basis to beneficiaries who need acute care, which is care that meets the criteria of Section 1820.205, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings.

The **Drug Medi-Cal Organized Delivery System (DMC-ODS)** includes the following **residential** services:

- American Society of Addiction Medicine (ASAM) Levels 3.1 – 3.5 of Residential Treatment Services. [See the Appendix for definitions of these ASAM levels]
- Adults, ages 21 and over, may receive up to two continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365-day period. An adult beneficiary may receive one 30 day extension, if that extension is medically necessary, per 365-day period.
- Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30 days. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per year. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment. Nothing in the DMC-ODS or in this paragraph overrides any EPSDT requirements. Adolescent beneficiaries may receive a longer length of stay based on medical necessity
- If determined to be medically necessary, perinatal beneficiaries may receive longer lengths of stay than those described above.

Mental Health Services Act – Community Services and Supports (CSS) statutes permit counties to including the following types of **housing assistance** in their CSS programs (Welfare & Institutions Code Section 5892(a)(5) and 5892.5(a)):

- Rental assistance or capitalized operating subsidies.
- Security deposits, utility deposits, or other move-in cost assistance.
- Utility payments.
- Moving cost assistance.
- Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.

Supportive housing programs have been funded under the Mental Health Services Act and may be further expanded under the No Place Like Home Program recently authorized under state law and by voters in passing Proposition 2 of 2018. The definition of "**Permanent Supportive Housing**" under the No Place Like Home program has the same meaning as "**supportive housing**," as defined in Section 50675.14 of the Health and Safety Code: *"Supportive housing" means housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving his or her health status, and maximizing his or her ability to live and, when possible, work in the community.*

In California, the state Department of Health Services (DHCS), Licensing and Certification Division regulates **acute and long-term care health** facilities. In addition, the Department has regulatory responsibility for **psychiatric health facilities (PHFs)**, **mental health rehabilitation centers (MHRCs),** and **skilled nursing facilities with special treatment programs (SNF/STP)**. Community care facilities are regulated by the state Department of Social Services, Community Care Licensing Division.[36]

Home-based assistance is provided in California through the **In-Home Supportive Services (IHSS)** Program. IHSS is an alternative to out-of-home care, such as nursing homes or board and care facilities. Eligibility is limited to Medi-Cal beneficiaries who are living at home or in an abode of the individual's choosing. The types of IHSS services which can be authorized through include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Voluntary Crisis Stabilization, Hospitalization, and Transitional Care

The covered voluntary crisis and hospitalization **Medi-Cal Rehabilitative Mental Health Services** available through counties are:

- Crisis intervention
- Crisis stabilization
- Crisis residential treatment services
- Psychiatric health facility services
- Inpatient psychiatric hospitalization: Beneficiaries must have a covered diagnosis; cannot be safely treated at a lower level of care (except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications the individual either:
  1. Has symptoms or behaviors due to a mental disorder that (one of the following):
     a. Represent a current danger to self or others, or significant property destruction.
     b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
     c. Present a severe risk to the beneficiary's physical health.
     d. Represent a recent, significant deterioration in ability to function.
  2. Require admission for one of the following:
     a. Further psychiatric evaluation.
     b. Medication treatment.
     c. Other treatment that can reasonably be provided only if the patient is hospitalized.

Later in the Appendix are definitions of the above Medi-Cal rehabilitative mental health services.

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The **Medi-Cal** program offers as a **fee-for-service benefit, Voluntary Inpatient Detoxification** services provided in a general acute care hospital.[37] Medical criteria for this benefit includes:

- Delirium tremens, with any combination of the following clinical manifestations with cessation or reduced intake of alcohol/sedative: Hallucinations, Disorientation, Tachycardia, Hypertension, Fever, Agitation, Diaphoresis
- Clinical Institute Withdrawal Assessment Scale for Alcohol revised (CIWA-Ar) form score greater than 15.
- Alcohol/sedative withdrawal with CIWA score greater than 8 and one or more of the following high-risk factors: Multiple substance abuse; History of delirium tremens; Unable to receive the necessary medical assessment, monitoring, and treatment in a setting with a lower level of care; Medical co-morbidities that make detoxification in an outpatient setting unsafe; History of failed outpatient treatment; Psychiatric co-morbidities; Pregnancy; History of seizure disorder or withdrawal seizures
- Complications of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following factors: Persistent vomiting and diarrhea from opioid withdrawal; Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care

Additionally, the Drug Medi-Cal Organized Delivery System (DMC-ODS) includes the following crisis and hospitalization services:

- **Recovery services**, to be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. See the Appendix for additional details of this service.
- **Partial hospitalization** (optional), which is an ASAM Level 2.5 services featuring 20 or more hours of clinically intensive programming per week, as specified in the patient's treatment plan. These programs typically have direct access to psychiatric, medical, and laboratory services, and are designed to meet the identified needs which warrant daily monitoring or management, but which can be appropriately addressed in a structured outpatient setting. Services consist primarily of counseling and education about addiction-related problems. Providing this level of service is optional for participating counties. Service components include:
    - Intake
    - Individual and/or Group Counseling
    - Patient Education
    - Family Therapy
    - Medication Services
    - Collateral Services
    - Crisis Intervention Services
    - Treatment Planning
    - Discharge Services

The Medi-Cal Managed Care plans cover **Discharge Planning and Care Coordination** when a Senior or Person with Disabilities (SPD) is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning includes ensuring that necessary care, services, and supports are in place

in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. The minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

Every health insurance plan **through Covered California** covers **home health service** up to 100 visits per year.

Involuntary Care

Lanterman Petris Short (LPS) Act – Involuntary Detention, Evaluation, Treatment: California law allows police officers and certain mental health professionals designated by county mental health directors to take an individual into custody if they believe that, due to a mental health disorder, the individual presents a danger to self, danger to others, or are gravely disabled (i.e., unable to provide for their own food, clothing, or shelter). For up to a 72-hour period, individuals can be involuntarily detained and transported to an LPS designated facility while they are assessed by mental health professionals to determine whether they can be safely released, provided voluntary inpatient or outpatient services, or it is clinically appropriate to apply for a 14-day hold under Welfare and Institutions Code Section 5250 at the expiration of the 72-hour period. If the facility initiates a 14-day hold, a hearing will be held within four days where a hearing officer will either authorize the facility to continue to detain the individual or release them. Authorized detention pursuant to Section 5250 does not authorize the facility to provide treatment against the patient's will.

If at the end of the 14-day detention the treating professionals determine that an individual continues to be a danger to self, a danger to others, or gravely disabled, the authorized facility representatives may apply for one, of three subsequent holds: an additional 14 days for continued dangerousness to self, 180 days for continued dangerousness to others, or 30 days for continued grave disability (in counties where Welfare and Institutions Code Section 5270 has been adopted). Finally, an individual

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considered gravely disabled may be placed under LPS Conservatorship (described below).

Lanterman Petris Short (LPS) Act – Conservatorship[38]: An LPS Conservatorship gives legal authority to an adult conservator to make certain decisions for a person with serious mental illness (a conservatee) who is unable to care for him or herself. If asked, the court can give the LPS conservator the duty to take care of and protect the person (conservator of the person) and also the power to handle the financial matters of the individual (conservator of the estate). The conservator can give consent to mental health treatment, even if the conservatee objects, and can agree to the use of psychotropic (mind-altering) drugs.

The conservator can agree to place the individual with mental illness in a locked facility if a psychiatrist says it is needed and the hospital agrees to take the person, whether or not the conservatee agrees. The conservator can also decide where the mentally ill person will live when s/he is not in a locked psychiatric facility. An LPS conservator must have enough medical and social information before making decisions for the conservatee. And, the conservator must only take actions that are best for the mentally ill person. The LPS conservator can also make financial decisions for the seriously mentally ill person, like paying the bills and collecting a person's income.

Lanterman Petris Short (LPS) Act – Civil Commitment Placement: If a conservatorship is granted by a judge, the appointed conservator may place the conservatee in a medical, psychiatric, nursing, or other state-licensed facility, or a state hospital, county hospital, hospital operated by the Regents of the University of California, a United States government hospital, or other nonmedical facility approved by the State Department of Health Care Services or an agency accredited by the State Department of Health Care Services, or in addition to any of the foregoing, in cases of chronic alcoholism, to a county alcoholic treatment center. (Welfare & Institutions Code Section 5358)

<u>Current Assessment Requirements in County Mental Health Plan Contracts with DHCS</u>

a) **Presenting Problem**: The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
b) **Relevant conditions and psychosocial factors** affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
c) **Mental Health History**. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
d) **Medical History.** Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If

possible, include other medical information from medical records or relevant consultation reports;

e) **Medications**. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;

f) **Substance Exposure/Substance Use.** Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

g) **Client Strengths.** Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

h) **Risks.** Situations that present a risk to the beneficiary and/or others, including past or current trauma;

i) **A mental status examination**;

j) **A complete diagnosis** from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and

k) **Additional clarifying formulation information**, as needed.

Medi-Cal Specialty Mental Health – Rehabilitative Mental Health Services Definitions

Title 9, California Code of Regulations, Chapter 11, Subchapter 1. General Provisions, Article 2. Definitions, Abbreviations and Program Terms

- **"Mental Health Services"** means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
- **"Medication Support Services"** means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
- **"Day Treatment Intensive"** means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

- **“Day Rehabilitation”** means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
- **“Crisis Intervention”** means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.
- **“Crisis Stabilization”** means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.
- **“Adult Residential Treatment Service”** means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
- **“Crisis Residential Treatment Service”** means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.
- **“Psychiatric Health Facility Services”** means therapeutic and/or rehabilitative services provided in a psychiatric health facility, other than a psychiatric health facility that has been certified by the Department as a Medi-Cal provider of inpatient hospital services, on an inpatient basis to beneficiaries who need acute care, which is care that meets the criteria of Section 1820.205, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings.

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Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) Service Definitions

California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 4. Scope and Duration of Benefits

a) **"Case management" services in the DMC-ODS** are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
b) **"Crisis intervention"** means a face-to-face contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.
c) **"Group counseling"** means face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served. Group counseling shall be conducted in a confidential setting, so that individuals not participating in the group cannot hear the comments of the group participants, therapist or counselor. A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.
d) **"Individual counseling"** means face-to-face contacts between a beneficiary and a therapist or counselor. Individual counseling shall be conducted in a confidential setting, so that individuals not participating in the counseling session cannot hear the comments of the beneficiary, therapist or counselor.
e) **"Intensive outpatient treatment (IOT),"** formally called Day Care Rehabilitative services, includes intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure.
f) **"Medication Services"** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.
g) **"Naltrexone treatment services"** means an outpatient treatment service directed at serving detoxified opiate addicts who have substance use disorder diagnosis by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.
h) **"Narcotic treatment program"** means an outpatient service using methadone and/or levoalphacetylmethadol (LAAM), directed at stabilization and rehabilitation of persons who are opiate addicted and have a substance use disorder

diagnosis. For the purposes of this section, “narcotic treatment program” does not include detoxification treatment.

i) **“Outpatient Drug Free (ODF)”** services are treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure.

j) **“Physician consultation services**” in the DMC-ODS includes DMC physicians’ consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations

k) **“Perinatal residential substance use disorder services program”** means a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnoses. Each beneficiary shall live on the premises and shall be supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services for pregnant and postpartum women. Supervision and treatment services shall be available day and night, seven days a week.

l) **“Recovery Services in the DMC-ODS** include outpatient individual or group counseling; recovery monitoring and coaching; peer-to-peer services and relapse prevention; linkages to life skills, employment services, job training, and education services; family support, linkages to childcare, parent education, child development support, family/marriage education; support groups; and ancillary services, linkages to housing assistance, transportation, case management, individual services coordination.

m) **“Residential Treatment Services” in the DMC-ODS** can be provided in facilities with no bed capacity limits. The length of services ranges from 1 to 90 days, with a 90 day maximum for adults and 30-day maximum for adolescents per 365-day period; unless medical necessity authorizes a one-time extension of up to 30 days per 365-day period.

n) **“Withdrawal management” in the DMC-ODS** includes at least one of the five levels of withdrawal management services according to the American Society of Addiction Medicine (ASAM) Criteria, when determined by a Medical Director or LPHA as medically necessary, and in accordance with the beneficiary’s individualized treatment plan. Medically necessary habilitative and rehabilitative services must be provided in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

American Society of Addiction Medicine (ASAM) Levels 3.1-3.5 of Residential Treatment Services in the DMC-ODS

https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

a) ASAM Level 3.1

Called Clinically Managed Low-Intensity Residential Services, this adolescent

and adult level of care typically provides a 24 hour living support and structure with available trained personnel and offers at least 5 hours of clinical service a week. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour living support setting.

b) **ASAM Level 3.3**
Called Clinically Managed Population-Specific High-Intensity Residential Services, this adult only level of care typically offers 24-hour care with trained counselors to stabilize multidimensional imminent danger along with less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

c) **ASAM Level 3.5**
Called Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults, this level of care provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Patients in this level are able to tolerate and use full active milieu or therapeutic communities. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

Medical Necessity Criteria for Medi-Cal Reimbursement of Psychiatric Inpatient Hospital Services

Title 9 California Code of Regulations Section CR § 1820.205

(a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)-(2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IVE (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Tic Disorders
(E) Elimination Disorders
(F) Other Disorders of Infancy, Childhood, or Adolescence
(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
(I) Schizophrenia and Other Psychotic Disorders
(J) Mood Disorders
(K) Anxiety Disorders

(L) Somatoform Disorders
(M) Dissociative Disorders
(N) Eating Disorders
(O) Intermittent Explosive Disorder
(P) Pyromania
(Q) Adjustment Disorders
(R) Personality Disorders
(2) Both the following criteria:
(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:
1. Has symptoms or behaviors due to a mental disorder that (one of the following):
a. Represent a current danger to self or others, or significant property destruction.
b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
c. Present a severe risk to the beneficiary's physical health.
d. Represent a recent, significant deterioration in ability to function.
2. Require admission for one of the following:
a. Further psychiatric evaluation.
b. Medication treatment.
c. Other treatment that can reasonably be provided only if the patient is hospitalized.
(b) Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:
(1) Continued presence of indications that meet the medical necessity criteria as specified in (a).
(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
(3) Presence of new indications that meet medical necessity criteria specified in (a).
(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

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