California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

Comments on BHT Policy Manual-Module 1

Section 2.B.3 Eligible Populations

Align the definition of children and youth for all programs. While we support children and youth being defined as persons who are 25 years of age or under, we are concerned about the definition not being consistent for all programs. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is for children under age 21. Furthermore, there is not a transition age for substance use disorder programs which will now be covered under the Behavioral Health Services Act (BHSA). This lack of alignment in definitions will result in youth between these age gaps falling in and out of eligibility.

Add individuals who are screened and determined to be at risk of developing a substance use disorder (SUD) to the priority population for both children and youth, and adults and older adults since this population will be covered under the Behavioral Health Services Act. Additionally, the Council commends the Department for including individuals who are at risk of institutionalization in the criteria for adults and older adult. We recommend adding "at risk of institutionalization" to the eligibility criteria for children and youth also.

The definition of institutionalization should be broadened to include any type of inpatient, skilled nursing, long term settings; emergency department; residential treatment programs receiving a patch; jails; state hospitals. It is important that people who are in this wide range of institutions are eligible.

Section 2.C.1 The Behavioral Health Crisis in California Background

The CBHPC recommends that language for the lack of affordable housing and increasing homelessness be placed at the end of the list in the sentence, "*The crisis is exacerbated by many factors, including but not limited to the lack of affordable housing and increasing homelessness, the behavioral health workforce shortage, a youth mental health crisis, and a lack of culturally-competent care.*"

Section 2.C.2 Addressing the Crisis: A Population Health Approach to Behavioral Health

CBHPC recommends the adoption of a broad definition for "institutionalization" that aligns with the CalAIM Enhanced Care Management (ECM) Policy Guide's criteria. We respectfully request that DHCS revise the current definition to explicitly include

residential treatment programs for mental health or substance use disorders (SUDs), jails, prisons, state hospitals, acute locked units, and IMDs and residential care that receive a county patch for funding. This broader definition ensures a more inclusive and effective approach to providing care management for individuals transitioning from various institutional settings.

Section 2.C.3: **Statewide Population Behavioral Health Goals**
The CBHPC supports the notion that CalHHS will include health equity, defined as *the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations,* in each of the statewide behavioral health goals. We encourage the addition of clear language on how health equity will be incorporated under each goal. We recommend there be defined action steps for health equity goals in conjunction with the action items for each behavioral health goal.

Section 3 Integrated Plan
The CBHPC states that the planning and organization teams for the Integrated Plans must include an individual with lived experience on the team.

Section 3.A.3 Function of Annual Updates and Intermittent Updates
Stakeholders should be involved in the planning process more frequently than the annual and intermittent updates to ensure a sufficient stakeholder process. In addition, persons with lived experience as consumers or family members should be included. Some counties may opt out of engaging stakeholders in the annual plans since this policy says they “may”. DHCS should consider incentivizing stakeholder engagement.

Section 3.B.1 Stakeholder Engagement
The CBHPC recommends that DHCS publicly post a list of stakeholders involved in the planning process, with the primary stakeholders identified as individuals with lived experience of a mental health or substance use disorder, family members, and providers. The Planning Council would like to safeguard and protect the voice and choice of persons with lived experience in the Integrated Plan by ensuring that the input of individuals living with mental health and substance use disorder conditions are involved in development and implementation the plans. We recommend that best practices be added to the policy manual to emphasize the involvement of these individuals. The Council is willing to research and submit to DHCS examples of exceptional practices at varies counties in California. One suggestion to include client, family member and provider stakeholders is to assemble special focus groups with smaller subgroups for these individuals so they may participate in a more meaningful way.

Section 3.B.B.4.1 Planning Costs
Funds spent on stakeholder engagement should be targeted at persons with lived experience and family members to ensure they can participate fully in the integrated plan process. Many small counties in California face geographical challenges. Therefore, the CBHPC recommends that the state include planning costs for lodging and food in planning cost for travel and transportation for stakeholders. The CBHPC is

seeking clarification on whether travel costs need to be in compliance with California travel protocols or if there will be flexibility to meet needs such as food and lodging for stakeholders.

Section 3.C.1: Background
The CBHPC recommends the addition of language to reference peer services in the primary prevention examples in this section. Peer services are a significant asset in behavioral health prevention efforts. While Community Health Workers are notated, peers and other individuals with lived experience such as family members and caregivers are not included. The Planning Council recommends that DHCS explicitly list peers in the policy manual given their longstanding contribution to prevention. We must also ensure that peers are included in planning and implementation efforts for this section.

Section 3.C.2: Behavioral Health Care Continuum
The CBHPC recommends the addition of the following items in *Table 3.C.1. Substance Use Disorder Care Continuum Service Categories, Definitions and Example Services*:

- Please list Case Management Services as an example of an SUD service in the Service Category for Outpatient Services, as Case Management was included in one of the levels of Full-Service Partnerships (FSPs) during the DHCS Listening Sessions.
- Please add Community Defined Evidence (CDEPs) as a Service Category. Given the focus on equity in the BHT, it is pertinent to include CDEPs as a best practice in service delivery to ensure they are included in the planning and implementation efforts.
- Please add Peer Recovery and Peer-Oriented Crisis Services as examples of SUD services in the Service Category for Crisis Services. Given the focus on equity in the BHT, it is pertinent to include Peer Recovery Services as a best practice in service delivery to ensure they are included in the planning and implementation efforts.
- Please list Crisis Call Centers as examples of SUD services in the Service Category for Crisis Services, as individuals experiencing an SUD crisis or are experiencing a co-occurring mental health issue may need support from call centers as a point of contact.
- Please add respite services as an example of SUD services in the Service Category for Crisis Services.

Section 7.C.4.1.1 Experiencing Homelessness and At Risk of Homelessness
CBHPC recommends that DHCS provide a clear definition of “enriched residential setting” in the policy manual. Although the manual references a public notice of intent dated June 14, 2024, which provides additional information about room and board in such settings, it remains unclear what constitutes an Enriched Residential Setting.

Section 7.C.4.1.3 People in Encampments
CBHPC suggests that DHCS provide a clear definition of “encampment”. The policy manual makes reference to a U.S. Interagency Council on Homelessness' report, which provides a general definition of encampment. We seek clarification on whether DHCS plans to adopt this definition, and if so, we propose its formal inclusion in the policy manual for clarity.

Section 7.C.8 - Flexible Housing Subsidy Pools
CBHPC recommends clarifying if housing subsidies are tied to a specific location or individual. To encourage more permanent supportive housing development, CBHPC advises that subsidies be project-based rather than individual-based to ensure they are used as a permanent rent subsidy for developers and only individuals who qualify under BHSA are eligible. The manual does not currently specifying if the subsidy remains in effect indefinitely, even if the tenant moves and is no longer homeless.

Furthermore, CBHPC recommends that rent subsidies should not be used in residential care homes, as there is no rent within this system.

Section 7.C.9 - Allowable Expenditures and Related Requirements
CBHPC believes residential care facilities and skilled nursing facilities should not be allowable under the housing funds, as these settings do not have rent structure and are considered treatment. Assisted living may be considered allowable only if there is a formal rent structure. Additionally, CBHPC recommends that Assisted Living and 'unlicensed room and board' be classified as transitional housing due to the absence of formal leases in these types of facilities.

Appendix A: A. Experiencing Homelessness
The CBHPC supports the adoption of an inclusive definition of homelessness in alignment with the CalAIM Community Supports guidelines because the revised definition considers individuals in institutions as experiencing homelessness, regardless of the length of their stay, and allows those who become homeless during their stay to qualify, even if they were not homeless before entering the institution.

Appendix A: B. At-risk of Homelessness
CBHPC supports the adoption of the updated definition of at-risk of homelessness. We view this definition as a significant improvement over the federal definition, as it includes individuals residing in motels who are self-paying, whereas the federal definition only considers those in motels funded by government or charitable organizations.

Appendix A: C. Chronically Homeless
CBHPC commends DHCS for expanding the definition of chronically homeless to include individuals exiting institutions, regardless of their length of stay or prior homelessness status. CBHPC is particularly mindful of the requirement that 50 percent of housing intervention funds be allocated to the chronically homeless population, and we believe this updated definition will help in achieving this requirement.

Upon examining the definition of chronically homeless in **Section 7 C.4.1.2** and **Appendix A: C. Chronically Homeless**, we have identified an inconsistency. Section 7 C.4.1.2 states that anyone who was chronically homeless before receiving Transitional Rent or staying in an Enriched Residential Setting, and is transitioning to Housing Interventions services, will be considered chronically homeless under Housing Interventions. However, Appendix A indicates that individuals do not need to have been chronically homeless before entry to be defined as such. CBHPC requests that DHCS address this discrepancy by aligning the definition in Section 7 C.4.1.2 with the definition outlined in Appendix A. We would be in favor of a definition that allows more institutionalized individuals to qualify under the chronically homeless definition.