California Behavioral Health Planning Council (CBHPC)
General Session Meeting Minutes
January 18-19, 2024

CBHPC Members Present Day 1:

Susie Baker
Karen Baylor
John Black
Jason L. Bradley
Monica Caffey
Veronica Kelley
Steve Leoni*
Barbara Mitchell
Catherine Moore
Javier Moreno
Donald Morrison
Dale Mueller
Jessica Ocean
Noel O'Neill
Elizabeth Oseguera
Vandana Pant
Marina Rangel
Danielle Sena
Daphne Shaw
Diane Shinstock (for Jessica Grove)
Walter Shwe
Maria Sierra
Deborah Starkey
Bill Stewart
Arden Tucker
Tony Vartan
Susan Wilson

*=Remote Appearance

CBHPC Members Absent

Stephanie Blake
Kimberly Chen
Erika Cristo
Erin Franco
Deborah Pitts
Darlene Prettyman
Uma Zykofsky

Staff Present: Jenny Bayardo, Naomi Ramirez, Justin Boese, Ashneek Nanua

Welcoming and Introductions

Chair Deborah Starkey called the meeting to order, welcoming Council Members and leading self-introductions. A quorum was achieved with 27 of 34 Council Members present.

Approval of October Meeting Minutes (Action)

The October 2023 meeting minutes will be reviewed and approved at the April 2024 Quarterly Meeting.

Mental Health Block Grant (MHBG) Overview

Jose Lepe, Maria Ruiz, and Victoria Mansfield from Imperial County Behavioral Health Services addressed attendees:

Imperial County is in a rural area approximately two hours east of San Diego. It is considered a small county and 85% of the population identify as Hispanic/Latino. The county has the highest unemployment rate and the highest poverty rate.

Imperial County Behavioral Health Services is dedicated to empowering individuals, families, and the community to improve their health and Wellness by providing education, preventative care, and quality treatment. Their vision is to provide inclusive, equitable and exceptional community-based mental health and substance use treatment. The staff from Imperial County provided overviews of three programs that are funded by the Mental Health Block Grant (MHBG).

Vista Sands Socialization Program started in 1985 as a collaborative effort between Imperial County, local school districts, the County Office of Education, and Imperial County Behavioral Health Services. The main goal of this collaborative is to decrease the unnecessary hospitalization of children because treating children and families within their community gives the best outcomes and results. The program was designed to assist elementary school-aged children whose capacity to function at home, school, or in the community has been impaired by emotional or behavioral problems. The program has structured group activities that promote positive social and emotional growth. The original program is still located in El Centro, CA but was expanded to two main cities in Imperial County due to its success. The three programs are co-located at three different elementary schools, and they serve children from all Imperial County school districts. The goal is to work in collaboration with parents and teachers to provide support and consistency to the children. MHBG funds are used for supplies, rent, office supplies, skill building activities, and a percentage of staff's allocation. For fiscal year 2023, the budget was $479,772.

The Youth Outcome Questionnaire (YOQ) and Parent Stress Index (PSI) are the performance outcome measurement tools used for the program. The YOQ is a 64-item report that indicates the total amount of distress a child or an adolescent is experiencing. It measures their interpersonal distress, somatic distress, interpersonal relations, critical items, social problems, and behavioral dysfunction. The YOQ is given to children before they start the program and then after they graduate successfully from the program. The PSI is 120 questions that focus on child characteristics, parent characteristics, and situational demographic life stresses. In fiscal year 2023 kids entering the program in El Centro on average started with a 63 YOQ score, and they ended on average with 26. In El Centro, the average PSI score was 72 and the post

was 68. This data shows there was a 36% decrease of YOQ scores, which indicates that the total amount of distress the child is experiencing has decreased once they completed the program. It also shows cumulatively that the average for the PSI decreased in all programs by 72% and that indicates that the stress between the parent and the child significantly decreased at the end of the program. This data is reviewed on an annual basis and the outcomes are reported to the Imperial County Office of Education Administrator, Superintendents, and members of the Special Education Local Plan.

The MHBG assisted with the implementation of the Portland Identification and Early Referral Program (PIER) program. For the fiscal year 2022-23, the MHBG First Episode Psychosis (FEP) grant provided $220,901. This funding was used to train staff on evidence-based practice in relation to FEP and to obtain necessary equipment for implementation of such services. The PIER model is an evidence-based model that focuses on early detection and intervention of the pre-psychotic (prodromal) phase of a developing psychotic illness. It is a researched and validated model that identifies and treats adolescents and young adults who are at risk of developing a mental illness associated with psychotic symptoms. It is designed to prevent the progression of mental illness, consequently preventing the individual from an admission to an institutional setting. PIER is designed for adolescents and young adults between the ages of 12 and 25.

The county is doing community outreach and educating the community about the early signs and symptoms of pre-psychosis. When an individual experiencing early symptoms is identified, they are referred for the PIER program. Once the individuals are referred, a Structured Interview for Prodromal Syndromes (SIPS) assessment is conducted to assess if the young person is in the prodromal phase. The third component is the treatment. Family psycho-education is conducted which includes groups with the individual that is having pre-psychotic break and with their family members. Supported education and employment, and a very low dose of medication as indicated by the psychiatrist are also provided. The program is evaluated through Structured Interview for Psychosis (SIPs) assessments, weekly multi-family group surveys, Global Assessment of Functioning, Basis -24, YOQ, and Outreach and Engagement Logs. Since the start of the program in 2017, 56 assessments have been conducted. Out of those assessments 39 met criteria to receive services. Obstacles encountered include the expensive cost of training for the PIER model and a high turnover in the staff.

The Dual Diagnosis Set Aside Program is an approved linkage to treatment under the Drug Medical Organized Delivery System (DMC-ODS). The program provides service coordination for adults with serious mental illness and a substance use disorder (SUD) that has resulted in functional impairment which substantially interferes with and/or limits one or more major life activities. This requires that services be specifically tailored for individuals with a dual diagnosis. The MHBG funding is utilized to provide direct services such as, but not limited to screening, care coordination, and therapy. The funding covers a percentage of direct services and staff allocations for 5 direct staff (3 behavioral therapists and two mental health rehabilitation technicians). The program's

goals are to enhance motivation and engagement strategies using evidence-based interventions to motivate, engage, and encourage clients with co-occurring SUD and mental health disorders to adhere to treatment. The county has been working closely with its justice partners and the courts to receive significant referrals. They expanded their efforts to reduce homelessness or at risk as homelessness status of clients with co-occurring conditions. They are seeking to expand their recovery housing and decrease the number of hospitalizations, emergency room visits, or psychiatric holds of clients with SUD and mental illness. They are currently working closely with their bridge hospitals and continue to provide care coordination for clients that need Medication Assisted Treatment (MAT).

Public Comment

None.

Proposition 1 Overview

Michelle Cabrera, Executive Director for the County Behavioral Health Directors Association of California (CBHDA), provided a brief overview of Proposition 1.

She shared that two bills introduced in the last legislative session, SB 326 by Senator Eggman and AB 531 by Assembly Member Irwin, were placed on the March 2024 ballot as Proposition 1. There are provisions of SB 326 that were not contingent upon voter approval and are not going to be placed on the ballot. The provisions largely have to do with reporting on the millionaire's tax as well as some documentation reform alignment, aligning requirements around documentation reform in statute. There will be a transition period starting on January 1st of 2025 and going over the course of the next year until mid-2026 when all the provisions contained in the two bills will finally be in effect.

Michelle highlighted the piece of Proposition 1 that establishes a new behavioral health infrastructure bond. The key components of this were outlined in AB 531 which went through the legislature last year. Overall, this bond would authorize $6.38 billion as a general obligation bond, which is an important note. It's different from No Place Like Home which was financed with Mental Health Services Act (MHSA) funds. This bond is a general obligation and throughout the process, it was initially proposed as a housing bond, but very late in the session was updated to include treatment facilities including unlocked and locked behavioral health, treatment, and residential settings. The measure would set aside $1.5 billion for awards to counties, cities, and tribes for residential settings and the remaining funds would be more open. Many of the details still need to be worked out, but $1.5 billion has been allocated for veterans housing, close to $1 billion for supportive housing for individuals facing or at risk of homelessness with behavioral health challenges, and then $2.8 billion for treatment in residential facilities.

A high-level summary of what is included in Proposition 1/Behavioral Health Services Act (BHSA) as changes or reforms to the millionaire's tax are:

- It would establish a brand new 30% set aside of the millionaire's tax to fund housing, with a requirement for that housing to comply with statutory housing first requirements.
- It establishes the millionaire's tax as a new source of funding for substance use disorder services; creates a new structure for planning, data gathering, reporting, and accountability across all county's behavioral health funding streams.
- It is inclusive of realignment funds, block grants, and other sources of funding.
- There are significant changes to the Adult and Children's System of Care statutes that sit outside of the MHSA.
- The measure would double the state's allocation, so the amount of the millionaire's tax that goes directly to the state (not to counties) would increase from 5% to 10%.
- It would fund a new state-run workforce initiative.
- Prevention funds would be housed under the Department of Public Health.
- It would eliminate county-based prevention funding and establish new service and treatment requirements.
- Requires counties to engage commercial plans and managed care plans for contracting.
- Includes a variety of different exemptions for small rural counties.
- Requires the state to develop funding allocation for new county reporting and data collection.

Community Services and Supports (CSS) makes up the largest portion of MHSA funding with about half of that going to Full Service Partnerships (FSPs) and the other half going to General Services. 5% for Innovation (INN), and then Prevention and Early Intervention (PEI) is split up between the under-25 and over-25 population. The funding priorities would shift with the changes contained in Proposition 1. The biggest and most notable change is a new requirement for counties to pay for housing with the millionaire's tax funds. The other changes are that what used to be Community Services and Supports (CSS) would now be called Behavioral Health Services and Supports (BHSS) which includes Early Intervention funds which are now split between the under 25 (9.15%) and over 25 and population (8.7%), 35% for Full Service Partnerships, then 17.15% for the core services.

It's important to note that the chronically homeless would get a certain amount set-aside. The population is based on the federal definition, but the language in the legislation allows the state to weigh in on it. There's a cap on how much of that money can be used for capital developments and CBHDA was able to get an exemption for small rural counties to opt out of that with the permission of the Department of Health Care Services (DHCS) as early as 2026. CBHDA would be working with DHCS and CSAC to develop the levels of care for FSPs.

As mentioned, the State BHSA allocation goes up for the Workforce Initiative. There's also a $20 million per year set aside for the Mental Health Services Oversight and Accountability Commission to administer Innovation grants. Counties will be required to use BHSA funds for individuals with substance use disorders across the categories, and

the prudent reserves will be lowered from 33% of Community Services and Supports to 20% of all categories for medium and large counties, and 25% for small and rural. The prudent reserves requirements will have to be updated every three years instead of every five.

CBHDA did some modeling across individual counties last year. The General Services which fund a lot of outpatient services is where counties would have to make room for the housing and Innovation, which is of concern to counties. DHCS will have a much larger role in determining what evidence-based practices (EBPs) and Community Defined Evidence Practices (CDEPs) counties must use, establishing statewide metrics, approving capital funds, and transfers between the funding categories. They can also require a county to revise its three-year plans if it fails to address local needs or if they're not making adequate progress in DHCS' established metrics. DHCS will also have new sanctions authority related to the use of the BHSA.

Council Member Questions:

Catherine Moore asked:
"I was hoping you could remind us of the percentage of the overall mental health budget for most counties is accounted for by the mental health services funds. Also, you mentioned that one of the biggest hits is in General Services and that covers a lot of outpatient services. I was wondering what outpatient services we're looking at that aren't covered by Medi-Cal."

Michelle Cabrera responded:
"Counties are required to finance the non-federal share of Medi-Cal services for the most part, so we draw on all our behavioral health fund sources to provide that non-federal share.

The Mental Health Services Act funds typically account for roughly just over a third of the funds that we have in our system overall and half of the MHSA funds are used as a source of non-federal share. Other fund sources are the 1991 Realignment, 2011 Realignment, Substance Use Block Grant (SABG), a portion of the general fund, and then our substance use disorder (SUD) funds.

To pay for an outpatient service, we must draw from one of our existing eligible fund sources to put up a dollar to get a federal dollar."

Proposition 1 Panel Presentations- Randall Hagar

Randall Hagar, representative for the Psychiatric Physicians Alliance of California, addressed attendees. Randall shared that he represents psychiatrists, more specifically the Psychiatric Physicians Alliance of California. He represented psychiatrists for close to 18 years, and before that he was NAMI California's Legislative Representative and was on the steering committee for Proposition 63. He highlighted that his presentation would focus on the psychiatric perspective.

Psychiatrists come from training hospitals, which means that they see individuals in the most dire and acute manifestations of psychosis and other severe mental illnesses. Psychiatrists, as well as others, are acutely aware of how sometimes the thinness of the safety net in the community has led individuals into hospitals and into involuntary treatment. As the Mental Health Services Act evolved, they quickly noticed the effects of program funding and that the problems of persons experiencing homelessness and severe mental illness were not getting better. The State did not seem to be able to reduce the number of people on the streets even with an infusion of funds that started at $300 million a year and now has reached well over $2 billion.

The Mental Health Service Act was developed with the thinking that if there was not going to be a reduction in the homeless census or a reduction in folks that were going to jail who had a severe mental illness, then the State needed to reevaluate. The Psychiatric Physicians Alliance of California sponsored a series of bills to improve assisted outpatient treatment. Recently they brought forward legislation that added an additional period of certification under the 5250 statute. They also had legislation signed to have Full Service Partnership data collection and outcomes reporting. The Psychiatric Physicians Alliance of California has been intricately involved in the development of the Care Court legislation, and most recently with grave disability reform. Considering these recent legislative efforts, Proposition 1 was an opportunity to continue this work.

The Psychiatric Physicians Alliance of California like the following about Proposition 1:

- It adds substance use disorders to the mix allowing the Mental Health Service Act to pay for folks who have a stand-alone substance use disorder.
- The housing opportunities afforded by both parts of the Proposition.
    - The lack of board and care beds negatively impacts the upstream to inpatient facilities.
        - The proposition would support the development and expansion of capacity for board and care beds in the community.
        - There's an opportunity to build more facilities for those in crisis and experiencing acute episodes.
- It adds accountability, which comes from getting data.
- The investment in the workforce.
    - 3% may seem small but it represents a critical opportunity.

The following is not liked about the proposal:

- Child psychiatrists and medical directors are very concerned about the loss of children's programming that may come about with the implementation of Proposition 1.

Randall highlighted that he has learned over the years that 90% of the success of any proposal is in the implementation work after that bill is signed. The Psychiatric Physicians Alliance of California will be working along with others to try to make this work as well as it can for our children and youth.

Proposition 1 Panel Presentations – Robb Layne

Robb Layne, Executive Director for the California Association of Alcohol and Drug Programs (CAADPE) addressed the attendees. Robb shared that he is a professional behavioral health advocate and the parent of an adult child with a serious mental illness. His son gave him consent to share about his condition during this presentation to help address the stigma of mental health disorders. A little over a year ago he experienced a psychotic break and has been on the road of recovery ever since. He has since graduated from his residential treatment program, been trained as a peer support specialist, and just recently passed his exam.

CAADPE advocates for quality patient care. Members provide substance use disorder services at over 600 sites throughout the state and constitute the backbone of California's publicly funded substance use disorder treatment network. Their commitment to fully funded, quality patient care, and advocacy or community-based treatment and prevention is the driving force behind their support for the modernization of the Mental Health Services Act.

CAADPE appreciates that Proposition 1 proposes a significant revision to the MHSA. Robb highlighted that the focus of the presentation is mostly on the expansion of the Behavioral Health Services Act scope to encompass treatment used for substance use disorder (SUD) and the financial opportunities provided.

The proposed change on SUD will be a welcome addition to help address the current epidemic of opioid misuse, homelessness, fentanyl poisoning, and drug related deaths. According to the Department of Public Health, in 2021 there were 6,843 opioid-related overdose deaths in California. Of those deaths, 5,722 were related to fentanyl. While homelessness and substance use disorders are not directly linked, research indicates that the trauma of experiencing homelessness can cause people to develop mental health complications and worsen existing behavioral challenges and coping behaviors like substance use. People who are homeless are at an elevated risk of experiencing substance use disorders, mental disorders, trauma, medical conditions, employment challenges, and incarceration.

In 2023 the Homeless Point in Time Count showed that 25% of the 181,399 people experiencing homelessness in California had a severe mental illness and 24% of them had a substance use disorder. He acknowledged that there are challenges quantifying data but stated that it was reported that one in five unhoused Californians who reported regular substance use wanted treatment, but they were not able to receive care. That is 20% of the community that is willing to receive help on their journey of recovery, but the funding, the structure of services, limited community affirming offerings, or many other reasons prevent their progress.

To further the need for additional funding, in the past, the population who had access to MHSA dollars was limited to the definition of mental health status eligibility. At most,

clients who had a co-occurring disorder could participate in MHSA programs. As a result, people diagnosed with a primary care substance use disorder were excluded from vital and innovative programs, early intervention, and community services. These restrictions were not only exclusionary, but lacked and continues to lack parity with existing mental health programming. This is critical because one in four adults living with a serious mental illness also has a co-occurring substance use disorder. This highlights the importance of providing treatment for both conditions. Additionally, for individuals released from California Department of Corrections and Rehabilitation (CDCR) in fiscal year 2018 and 2019, 52% of individuals released had identified substance use disorder. Research shows that incarcerating persons with mental illness counterproductive to the rehabilitation and makes the conditions worse. That undermines long term public safety and increases in recidivism. Today in California, over $100,000 is spent per person to incarcerate over 150,000 people who are mentally ill, and research shows that it's costly and counterproductive.

This proposition can prioritize treatment and not punishment for persons with mental illness. As the impact of Proposition 1 is considered, it becomes evident to CAADPE and its members that addressing the current issues also requires a comprehensive approach to community based mental health and substance use disorder services. The proposition not only seeks to reform incarceration practices, but it will also expand the community based mental health system and addiction services across the state and serve tens of thousands of people each year. By broadening the MHSA target population to include everyone within the behavioral health community, we can fundamentally change the way we provide care and create additional opportunities for California to draw down more federal dollars. Without additional funding, this proposal will structurally require cuts in other programs.

As a solution, CAADPE identified two ways to potentially fund this proposal to bring in additional dollars:

- Expand the use of MHSA to include substance use disorder services may incentivize more counties to participate in the Drug Medical Organized Delivery system.
    - Counties opted in would now be able to use MHSA funds as a match to draw down federal funds, thereby enabling them to provide more SUD services under the waiver.
- County's ability to use more flexible MHSA dollars for SUD services will free up 2011 realignment dollars that can be used as a local match to draw down additional federal dollars again.

CAADPE appreciates the Governor's effort to include SUD in the MHSA reform, but they do remain watchful about any provision that removes existing funding from successful and community-affirming programs. They know that these cornerstone programs are key to the journey of recovery for many people, and CAADPE believes that through collaboration and coordination, a new system of care can be developed without creating winners and losers. SUD services have been historically funded much lower than traditional health or mental health services. CAADPE supports a strategy

that adds additional funding instead of replacement. Supplementation will only result in these funds becoming a surrogate for reduced behavioral health funding when research has shown that investment in prevention will reduce the onset of negative effects of a behavioral health condition. Since its inception, the MHSA has supported a range of prevention and early intervention services that support the behavioral health system and prevent crisis and homelessness.

CAADPE is working with the administration and the Department of Health Care Services on the next phase of the Mental Health Service Act reforms, and once the proposition passes, they'll continue to lean into that process.

Break

Proposition 1 Panel Presentations –Adrienne Shilton

Adrienne Shilton, Vice President of Public Policy and Strategy for California Alliance of Children and Family Services addressed the attendees. The California Alliance represents non-profit community-based organizations across California that serve and support children and youth as well as families in public Human Services systems. Adrienne stated that the California Alliance doesn't have a position on the initiative, but they were involved in the amendments and advocacy with Senate Bill 326, which significantly amended the Mental Health Services Act.

Adrienne highlighted that she started working on the Proposition 63 campaign (Mental Health Services Act) in 2004, so she was around when the concept of expanding mental health programming in our state with a key emphasis on prevention and early intervention was first introduced. It always was in the drafters' dreams to one day change the paradigm of care in California. Rusty Selix, coined this term that the State was going to be moving from a fail-first system to a health-first system. The dream back then was that one day the State would be at a place where we could spend even more funding on prevention and early intervention to get ahead of the crisis, to even change the 80%, 20% split in the Mental Health Services Act to have 80% focused on prevention and early intervention programming.

The central reason children's advocacy groups including the California Alliance were so concerned when this proposal was first released in detail was because there was an elimination of prevention and early intervention components. It seemed that the State was moving back to this fail-first system by only focusing on the crisis (encampments to address chronic homelessness).

The California Alliance, with other partners in the children's advocacy community (Children Now, Children's Partnership, First 5 California, and the California Children's Hospital Association), worked together to negotiate for the final language in the bill. They were able to add:

- Early intervention back into the bill, which includes the set-asides for children and youth.

- A new prevention component that will be administered at the state level.
- Language clarifying that early intervention programs can include services for children and youth, including those populations that experience disparities in behavioral health outcomes.
- Eligibility criteria for children and youth that recognizes the importance of early intervention for youth who have experienced trauma.
- Language to prioritize children and youth in the Full Service Partnership component.

Looking ahead they can foresee the following challenges if this passes in March:

- There is a potential for some community-defined evidence practices being at risk of losing a key ongoing revenue source.
- There is no specific set-aside for homeless youth and families.
    - 25% of the current homeless population in California are families and unaccompanied youth.
    - It is a missed opportunity to prioritize housing families with children who are homeless, and system-involved, youth or unaccompanied youth.
- There is no specific language related to prioritizing youth and young adults in Full Service Partnerships (FSPs).
    - Data shows 48% of the FSPs now are serving youth and young adults.

Adrienne highlighted that there are opportunities for stakeholders to bring these issues out in the planning process in collaboration with others in terms of what should be prioritized locally in the final MHSA plan. The California Alliance looks forward to continuing advocacy on these issues if the proposition moves forward.

Proposition 1 Panel Presentations –Karen Vicari

Karen Vicari, Interim Public Policy Director for Mental Health America California (MHAC), addressed attendees. Karen shared that she personally identifies as a person with lived experience, the parent of a child with lived experience, and the sister of someone who is unhoused.

The bulk of MHAC's mission is to increase access to mental health services which is why they are opposed to Proposition 1. The changes to the MHSA under Proposition 1 would divert 30% of MHSA money over to housing services. It also takes an additional 5% of county money and gives it to the state for prevention activities and workforce activities. It also adds individuals with standalone substance use disorder as a population to be served under the MHSA.

Today under MHSA, 62% of funding is on non-Full Service Partnership Community Services and Supports, Prevention and Early Intervention, and Innovation. The BHSA as proposed has a total of 33% combined for all three of those buckets. This means 62% of county spending is now down to 33% for those key services. This includes an additional 5% off the top for statewide use. FSPs today are 38%, and they would go down to 33%. If counties take the flexibilities, the main services bucket will still be

reduced to 40% from the 62% it currently is combined. Services at risk include crisis respite; mental health urgent care; culturally specific services; outpatient clinics; consumer-run programs; peer support; Wellness centers; mobile crisis teams; jail service; and jail linkage services for people leaving jails.

She highlighted that recovery-oriented systems have peers employed throughout the system and they often have services that are not covered by Medi-Cal. Some of the basic principles of recovery-oriented services are hope, person driven, supported by peers, and culturally based. These principles are very different than a medical model system. MHAC fears that California is moving away from a recovery-oriented system of care instead of moving towards involuntary treatment.

Additional concerns include:

- Reduced local control under Proposition 1.
    - The community program planning process is only once every three years.
    - Prevention is only statewide and not county based.
    - Workforce efforts are statewide, not county based.
    - The spending buckets are more prescriptive than under the MHSA.
- The priority populations.
    - MHSA has always prioritized the unhoused and people with the most serious mental health conditions, however, that population is prioritized over almost everything else in Proposition 1.
    - Mild to moderate populations that are at risk of moving into the higher-need populations.
- It's a very volatile funding source.
- Civil rights concerns because involuntary treatment settings are going to be prioritized by the bond and the addition of standalone SUD.
- More than half of the permanent supportive housing money goes to unhoused veterans.
    - Veterans comprise about 6% of California's unhoused population.
- All involved parties should be at the table.

MHAC wants everyone with substance use disorder to receive services, but there's not enough money. There needs to be a way to add more money to the system rather than dividing up the same pie among more and more and more people.

Potential Solutions:

- The housing audit ordered by the legislature is needed to determine where the $40 billion that has already been invested to address homelessness was spent.
- Ensure that local continuums of care are building the housing that they need to build.
- Raise the millionaire's tax beyond 1%.

Proposition 1 Panel Presentations – Paul Simmons

Paul Simmons, Peer, addressed the attendees. He shared that he came into the mental health space about 10-12 years ago when his mentor Rusty Selix needed somebody to help in his office.

He highlighted that if Proposition 1 passes there will be a lot of decisions to make and many of the decisions will be made by the Department of Health Care Services (DHCS). He shared the following concerns if Proposition 1 passes:

- MHSA funding will drop 30% in total revenue plus the additional money going to the state and DHCS.
- Potential increase in involuntary care/locked settings.
- The bulk of this money is not going into permanent supportive housing, to make housing more affordable, or to build housing. It is being put into temporary holding facilities.
- More control and power is being given to DHCS.
- Accountability measures.
- The loss of decision-making through a community-based process with local community-based organizations and local counties that really know their populations and the needs of their populations.

Council Members Questions

Karen Baylor asked:
“Has there been any conversation about what happens if Proposition 1 passes and then there is no affordable housing in California and counties aren't able to spend that money?”

Michelle Cabrera responded:
“I'll just say on the policy side, there's a significant amount of secondary guidance that will need to be developed in order to implement the initiative should it pass. One of the concerns or questions that CBHDA raised during the policy development process around the housing set aside was that half of the 30% needs to be used for individuals who meet the federal definition of chronically homeless, which for many who work with county behavioral health populations, know is actually a higher bar than would be expected. If you spend 90 days or more in a treatment facility or incarcerated prior to going for housing, even if you spent the previous decades unhoused, you would still not qualify as chronically homeless. There was an amendment to give DHCS some wiggle room to be able to define that differently, but that definition has not yet been settled. For now, the straight read of the law would be that you would have to meet that definition of chronically homeless.” Michelle Cabrera stated that she shared Karen’s concerns that there are various restrictions that may have the net impact of making it more challenging for counties to purchase housing with BHSA funds than with the current MHSA funds. She added that there are outstanding questions that need to be answered in the secondary guidance policy conversations.

Barbara Mitchell asked:
“The main supporters listed for funding the Yes on Proposition 1 are the top funders of the State Building and Construction Trades Council of California and the California Correctional Peace Officers Association. The only health-related major funder listed is Kaiser Foundation Health Plans and Hospitals. The major opposition is from groups that either are representing peers or groups that represent unserved or underserved racial-ethnic communities in California or communities that serve LBGTQ clients. Do you have any thoughts on why there's this fairly large disparity between who is supporting and who is opposing? Do you have any concerns about that?”

Karen Vicari responded:
“I think my presentation says it all. There's some sort of agenda behind it and we don't see the agenda as improving care for people with mental health conditions.”

Randall Hagar responded:
“I'll just say real briefly that psychiatrists don't have any money to bankroll anything. We're supporters, we're out there publicly, but we're not able to fund or we would have.”

Catherine Moore asked:
“Is all the housing money only for behavioral health affected people or is it just across the board anybody who qualifies as homeless?” and “Where do you build out various structures such as a crisis house? Would that decrease the county's costs in terms of not having to pay rent?”
“Is there any advantage in the long run of having some of the brick and mortar costs taken away?”

Michelle Cabrera responded:
“There are various provisions in the proposition that require county behavioral health to use the BHSA housing set-aside for county behavioral health clients. Although they don't have to be Medi-Cal enrolled, they would need to prioritize FSP participants and prioritize those who are most severely impacted by their behavioral health conditions. Our understanding is that the funds in the set aside are not intended to address the whole of the population that includes that is unhoused, but rather folks with significant behavioral health conditions. On the potential opportunity that the infrastructure funding provides, of course, yes. It's great to have new funding come into the system to help build out new housing and treatment capacity. I think what we're trying to flag is not that there's a real benefit in having these funds earmarked and set aside for behavioral health, but the degree that all of the realignment and MHSA and other funds are already supporting existing programs and services. We look at the potential upside of new opportunities for medical match for example. We don't yet see in our analysis and modeling how that opportunity offsets the cost, and it's important to note some initiatives have one time infrastructure funding. The public does not want to invest public monies into something that that could be turned around and sold for profit or benefit. But that is a significant long term upfront commitment and there are not new funds that have been

specifically dedicated to support the full array of service and treatment capacity that will be needed to sustain that new capacity. So just a lot of unknowns is the short answer."

Walter Shwe stated:
"I want to thank Karen from MHAC for her presentation because I thought it got right to the heart of the matter. "

Susie Baker asked:
"What is the implementation timeline for building housing if this passes?"

Michelle Cabrera responded:
"It depends on what aspect you're thinking about. For example, we have Behavioral Health Bridge Housing funds close to almost a billion that has been provided to counties through applications. Those funds are being distributed right now meaning they were authorized last year and they're coming through on a rolling basis. I think it's important to keep in mind that in terms of success, there are some things that have already been put in place as one time funds for things like housing and infrastructure and then the bond measure comes later for additional needs that were not able to be funded through other initiatives. I think, just sort of stepping away from Proposition 1 for a second, it's important to realize that the population of individuals who experience homelessness in California is significant. The amount of funding set aside in the BHSA will certainly not be nearly enough to address the overarching homelessness issues. It's important from our perspective for the state to continue to make unique additional investments outside of redirecting current mental health funds to pay for housing for a subpopulation in order to continue to make progress on our broader ongoing persistent homelessness crisis. We really hope that the public understands that this this initiative certainly will not solve homelessness. It will hopefully help mitigate a portion of our client's needs. But again, there may be negative implications or ramifications for the array of services that Karen lifted up, which often times help to keep people stable and keep them from falling into homelessness when they're already in a fairly vulnerable position. So, lots of unknowns certainly as we move forward with this."

Public Comment

Richard Kryzanowski commented:
"A lot of you know me as Vice President the California Association of Mental Patients' Rights Advocates (CAMHPRA) and I've been a proud member of the Council's Patients' Rights Committee for many years. I really appreciate Paul's presentation. I've been involved with the MHSA and its implementation for many years. I was a fairly new consumer of mental health services and a brand new employee of Los Angeles County's Department of Mental Health. I was one of the very first people with the experience who they hired and their team. At that time, I got very involved in lending my voice and energy to the passenger Prop 63. When it became the MHSA, I was recruited to join the OAC's Client and Family Member Leadership Committee. I had a front-row seat for a lot of the travails and accomplishments of the MHSA and all that it had brought. I noticed two things and I think their great accomplishments California can be

very proud of especially mental health in California. First was the development of meaningful stakeholder input. That was done, not just by advisory committees, but seats at the table not only in Sacramento but locally. I was very involved in the community supports process in LA and Orange counties representing the disabled community LA and that's unusual. I think a powerful and important development of which we all can be proud. The other thing is a real awareness of an implementation of policies revolving around cultural competency, humility, and interaction with the many diverse communities of which we are all a part in which we are pretty much dedicated to serve. As Paul mentioned, when we lost our state Department of Mental Health, those two areas took a big hit and since then there's always been push back. We have been decreasing the importance of these elements. I'm not surprised though I'm distressed that these will be important casualties if the process if problem passes, which I fully expected to pass. I look forward to doing the work of trying to influence implementation. I think you got a taste of that just a few moments ago of where this door that's already open leads us to when somebody referred to us as our mentally. We are not your mentally. We don't want to be the babies that are thrown out with this particular set of water. Sure, the MHSA has always experienced pushback and has worked hard, but often to move forward despite, and perhaps even because of, the heartfelt disagreements and difficult conversations that have informed our processes. I don't want us to abandon the amazing achievements of which we rightfully can be proud. I hope we can continue to be proud."

Herald Walk commented:
"I'm chairman of the Imperial County Behavioral Health Board. I've been on it 23 years. I'm here with Mr. Benny Benavidez. I just want to speak briefly about the housing element. What we have in California is a real problem with constructing housing. My background is finance and management and I also sat on our local Planning Commission in our city for 12 years. I saw many housing projects killed because of CEQA. I am not saying CEQA is a bad thing, but certainly a lot of overkill. We've constructed housing in our area and there's so many restrictions and requirements on our housing. You've got to find a vacant lot for starters, and it's got to be near this and that. We ended up building our housing, which is very nice, it was right beside the railroad tracks, and they put up on the sound of the wall. But because all the restrictions and requirements, that was all we had. There's a lot that must be done to make it easier to build housing in suitable locations at a cost that is not atrocious. I don't see anyone from Sacramento, but it certainly must happen if we're going to house the homeless. Not to mention all the young people that want to buy homes today, there needs to be a lot done at the state level."

Steve McNally commented:
"I'm from Orange County. I'm on a local county board which has the Welfare and Institutions Code of 5604.2 and includes 59 electives. I appreciate all the presentations and all the hard work you do. There's a couple of things that really scare me as a family member who saw that it says schizophrenia has gotten tons of resources that are available. One that was brought up earlier was the calendarization of the implementation of the bond. How, how long will it take for any of that money to actually

hit the streets? There's so much that's unknown. Just like no place like home. We took MHSA money to get $2.8 billion for the future over the next 20 years up to 140 million, but $800 million went to expense, $2 billion went to actual housing and in our county, we added another $100 million out of MHSA on top of that. That's still not a waste, but we need their licensing money. We haven't been able to implement that in our county. It's difficult with the restrictions that were put on by the state. If you all could help us since some of you may be embarked from discussing this in public. How do we actually understand calendarization and implementation. The other thing that's come up in these meetings in the last couple days supplanting. You can't spend it for things that can be spent elsewhere. So much money has been spread around. Our managed healthcare plan is buying 6 bed houses for housing. That's a concern for me. What can be remedied when you have a proposition? I'm not sure how much faith community members have in the people that are going to be in charge of the remedies, given that we've already had all this accountability on the books. We just haven't actually done it or published it. I know I'm preaching to the choir to some degree, at least as far as being informed whether you agree with it or disagree with it. Few people in California have an understanding because so much of this was done in back rooms and a lot of the private negotiations. We don't know what everyone's agreed to. And we had two high level legislators voicing concern at this conference the last couple of days about how they felt that they were pushed and bullied to some degree. Those are my words, but they acted as if that's the way they felt. Thank you for all your hard work. Anything that you can provide that you have in a public domain that would allow people to understand what's going on, I think would be very helpful."

Wrap-up

Deborah Starkey expressed gratitude for the presenters, public comments and all positions shared. She stated that the Council's role is to really look at and listen to different perspectives and review positions. She went on to say that the discussion was very informative.

Recess

CBHPC Members Present Day 2:

Susie Baker
Karen Baylor
John Black
Jason L. Bradley
Monica Caffey
Veronica Kelley
Steve Leoni*
Barbara Mitchell
Catherine Moore
Javier Moreno
Donald Morrison
Dale Mueller
Jessica Ocean
Noel O'Neill
Elizabeth Oseguera
Vandana Pant
Marina Rangel
Danielle Sena
Daphne Shaw
Diane Shinstock (for Jessica Grove)
Walter Shwe
Deborah Starkey
Bill Stewart
Arden Tucker
Tony Vartan
Maria Sierra
Susan Wilson

*=Remote Appearance

CBHPC Members Absent

Stephanie Blake
Kimberly Chen
Erika Cristo
Erin Franco
Deborah Pitts
Darlene Prettyman
Uma Zykofsky

Staff Present: Jenny Bayardo, Naomi Ramirez, Justin Boese, Ashneek Nanua

Welcome and Introductions

Chair Deborah Starkey called the meeting to order, welcoming Council Members and leading self-introductions. A quorum was achieved with 27 of 34 Council Members present.

CBHPC 2023 Highlights and Accomplishments

Jenny Bayardo, Executive Officer, highlighted some of the accomplishments of the Council from 2023.

The accomplishments shared include:

- The Legislation and Public Policy Committee took positions on 15 pieces of legislation.
- The Systems and Medicaid Committee responded to 8 Behavioral Health Information Notices and submitted 3 letters of recommendation to the Department of Health Care Services (DHCS).
- The Workforce and Employment Committee tracked the implementation of Senate Bill 803.
    - They regularly invited DHCS and the California Mental Health Services Authority (CalMHSA) to come to their committee meetings for ongoing implementation discussions.
- The Workforce and Employment Committee has been advocating for occupational therapists to be recognized as licensed providers for several years, which recently passed.
- The Patients' Rights Committee focused on Senate Bill (SB) 43 and Care Act implementation. They regularly have updates and stay up to date to make recommendations.
- The Patients' Rights Committee released the Patients' Rights Advocacy in California: Analysis and Recommendations report, which includes data they have been collecting since 2017.
- The Performance Outcomes Committee completed the 2021 Data Notebook report on Health Equity.
- The Housing and Homelessness Committee hosted Listening Sessions.
- The Council hosted seven Public Forums on SB 326.
    - The stakeholder input was used to inform the Council's Letter of Concern on SB 326.
- Council Members represented the Council at various conferences.
- We actively recruited to fill our consumer and family member vacancies by hosting exhibit tables at various conferences and events.
- The Council provided presentations across the state about the council to develop relationships.

Committee Report-Outs

Legislation Committee: Barbara Mitchell reported:

- Javier Moreno was elected as the new Chair-Elect of the committee.
- Council Members, Daphne and Karen provided updates on SB 43, which makes changes in conservatorship laws.
    - The committee intends on sending a letter to get involved in the implementation process following the April 2024 meeting.
- The committee reviewed the Council's Policy Platform and provided suggested revisions following the meeting. The revisions will be discussed at the April meeting.

- Gail Gronert, Director of Strategic Initiatives at CBHDA, provided an overview of the Governor's proposed budget.
- The committee discussed how Proposition 1 could impact various counties and state programs.
- The committee was prohibited from taking a position on Proposition 1 due to being advised that the Council can't use state resources to influence an election now.
- Assemblymember Corey Jackson and Senator Scott Wiener discussed their current priorities. Both have a broad knowledge about the behavioral health system it is an area of interest for them.

Performance Outcomes Committee: Susan Wilson reported:

- The committee completed the 2022 Data Notebook Overview report, which was on the impact of COVID on behavioral health.
- The 2023 Data Notebook, which is entitled Stakeholder Engagement, was discussed. To date the Council has collected the data notebooks from 38 counties and expect to receive 8 soon.
- 52 out of 58 counties responded to the 2022 Data Notebook.
- An application was submitted to present information from the 2023 Data Notebook on stakeholder engagement at the California Mental Health Advocates for Children and Youth (CMHACY) conference.
- The committee is planning a SB 43 Public Forum.

Patient's Rights Committee: Daphne Shaw reported:

- Deb Roth from Disability Rights California (DRC) provided their perspective on SB 43.
    - DRC has is issues around the use of hearsay information being able to be used to make the decision to 5150 individuals.
        - 56 of the 58 counties have chosen to defer implementation.
- Ronnie Kelley, Behavioral Health Director from Orange County and Tony Vartan, Behavioral Director from Stanislaus County provided an update on the Care Act implementation.
    - Orange County reported 46 referrals. Of those referrals 23 met the requirements. 15 were referred by family members, 5 were referred by hospitals and 16 of those in the individuals were unhoused. There are only three that currently have a court date.
- Mike Phillips and his team from the Jewish Family Services of San Diego provided a presentation about Patients' Rights concerns in Board and Care facilities.

Executive Committee: Deborah Starkey reported:

- The committee reviewed the Council's Membership.
- The committee decided the Council will continue to have hybrid committee meetings, but General Session meetings will be in person only.
    - Staff will revise the attendance policies.

- Naomi Ramirez provided an update on the Council's expenditures and allotments.

Workforce and Employment Committee: Ashneek Nanua reported:

- Walter Shwe was elected as the committee Chairperson.
- The Department of Healthcare Access and Information (HCAI) provided an overview of their data dashboards.
- CalMHSA also provided an update on the Medi-Cal Peer Support specialist certification benefit.
    - They released the certification exam in Spanish in December of 2023.
    - During first quarter of 2024 the continued education training provider application will open.
    - They are collaborating with the California Department of Corrections and Rehabilitation to provide the certification exam in institutions.
- DHCS provided an update on the peer certification.
    - They are updating any information notices and guidance for the implementation and developing updated Frequently Asked Questions documents.
    - They're continuing to explore the development of a unique identifier for the certification claims and then they are surveying counties on the implementation.
- The committee's been looking at different employment models and received presentations from the East Wind Clubhouse and Oasis Clubhouse.

Housing and Homelessness Committee: Monica Caffey reported:

- The committee discussed Article 34 which is on the ballot in November 2024.
- Sharon Rapport, the director of the California State Policy at the Corporation for Supportive Housing provided an update on rapid housing models and supportive housing.
- Hal Zawacki from the Substance Abuse Mental Health Services Administration (SAMHSA) gave an overview on the SSI/SSDI Outreach, Access, and Recovery (SOAR) program and provided data on disparities around those who receive housing in California.
- The California Department of Social Services provided an updated on the Community Care Expansion program.
- The committee decided the write a letter to SAMHSA regarding the definition of homelessness.

Systems and Medicaid Committee: Karen Baylor reported:

- The Committee's focus for the meeting was on the No Wrong Door Policy implementation.
- Seneca, Pacific Clinics, and the Department of Health Care Services provided their perspectives on the implementation.

Children and Youth Workgroup: Vandana Pant reported:

- The workgroup has been focused on trying to increase youth engagement and has 2 youth committed to being part of the workgroup.
- The California Alliance of Child and Family Services (CACFS) shared their current focus and spoke in detail about the challenges faced by foster care youth.
    - Transition ages for foster care youth are 18, which coincides with most people being in high school.
    - The next transition point is at 21, which coincides with a lot of people being in college.
    - There is an opportunity to work on legislation to shift those transition points so that we're not burdening youth.
- CACFS also shared about the diverse programs that they're offering in the communities to engage youth more actively.
- The Department of Health Care Services provided an overview of their current initiatives focused on youth and demonstrated their new youth mental health platforms.
    - Soluna is free to any young person ages 12 to 25 in California. It provides education, information, self-engagement, and directly connects young people to coaching.
    - BrightLife Kids is for parents or caregivers and kids 0-12 years old.
- The Mental Health Services Oversight and Accountability Commission provided an overview on their efforts to engage many more youth in their activities and discussed opportunities for collaboration with the Council.
    - One of the ways they discussed collectively addressing stigma and bringing advocacy communities for young people is through the screening of Ken Burn's *Hiding in Plain Sight* film.

Reducing Disparities Workgroup: Ashneek Nanua reported:

- The workgroup reviewed a list of priorities that was previously created.
- Central focus of the meeting was on making sure that the language the Council uses throughout its work is reflective of the community that we're talking to and how they identify.

Substance Use Disorder Workgroup: Noel O'Neill reported:

- Psychologist, Dr. Laura Rossi who is the owner and operator of an opioid treatment center in Oceanside provided an overview to the workgroup.
    - She discussed different medications that might be used, including Methadone and Suboxone, and Naltrexone
    - She emphasized that medication is really effective, but only when there is also intensive support for the consumer, so counseling is key to success.

Department of Health Care Services Update

Michelle Baass, Director of the Department of Health Care Services (DHCS) addressed the attendees. Michelle provided updates on the California Advancing and Innovating Medi-Cal (CalAIM) program, California Behavioral Health Community-Based Organized

Networks of Equitable Care and Treatment Demonstration (BH-CONNECT), and Children and Youth Behavioral Health Initiative (CYBHI).

CalAIM is a multiyear effort to transform the delivery of care to Medi-Cal members. The focus of the initiative is to meet members where they are and to take advantage of the connections community-based organizations have with Medi-Cal members. The goal is to get into the community and utilize community-based providers that haven't traditionally been part of the healthcare delivery system. Components of CalAIM include:

- The No Wrong Door approach for members to access behavioral health services quickly and easily, regardless of where they show up to seek care.
    - Members can receive the needed mental health services prior to a diagnosis being established regardless of whether they seek service through the Medi-Cal Managed Care Delivery System or the county behavioral health system.
- Modernization of the reimbursement for Medi-Cal behavioral health service providers.
    - Under the payment reform, the Department is moving from a cost-based reimbursement toward an alternative payment model that rewards value and not necessarily volume and better quality of care and outcomes for members.
- The criteria to access specialty mental health services using a trauma informed approach for children and youth under the age of 21 has been streamlined.
- The screening tools for mental health services has been streamlined to help determine the appropriate delivery system for members seeking mental health care.
- Behavioral health care benefits have been expanded for members, including peer support services, which is in 50 of the 58 counties.
- The Department is working closely with the 988 call centers to support the launch of the new national 988 hotline for crisis care.
- Contingency Management Service is being implemented.
    - This is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder to support their path to recovery.
- The Enhanced Care Management serves as a core coordinator of all services for certain populations of focus who are eligible.
    - Provides coordination with community supports related to social needs such as health housing supports, sobering centers, and medically tailored meals.

October 20th, 2023, the Department submitted the BH-CONNECT 1115 waiver to the federal government. This waiver would expand access and strengthen the continuum of community-based behavioral health services to Medi-Cal members living with serious mental illness and serious emotional disturbance. BH-CONNECT aims to expand Medi-Cal service coverage, drive performance improvement, and support the implementation for key interventions that have been proven to improve outcomes for members. The

initiative is intended to assist those experiencing the greatest inequities including children and youth involved in the child welfare system, individuals with lived experience in the criminal justice system, and individuals at risk of or experiencing homelessness.

Components of BH-CONNECT include:

- Standardization and scaling of evidence-based models so Medi-Cal members with the greatest needs receive upstream field-based care delivered in the community.
    - This will avoid unnecessary emergency department visits, hospitalizations, and stays in inpatient and residential facilities. Additionally, it will reduce involvement with the criminal justice system.
- Proposal for activity stipends for children and youth in the child welfare system. The stipends could be used for extracurricular activities, music lessons, sports, and other activities to support children in the child welfare system, as well as a prevention measure.
    - This would be an incentive program that brings together the managed care delivery system, the county behavioral health system, and the child welfare departments to support better outcomes.
- Expansion of Medi-Cal coverage for evidence-based services to include assertive community treatment, forensic assertive community treatment, coordinated specialty care, first episode psychosis care, supportive employment funding for community health workers, and the Clubhouse Model.
- Establishment of Centers of Excellence to offer training and technical assistance to providers to support the implementation of these types of evidence-based services and programs.
- Incentive dollars for counties to strengthen their infrastructure to be able to improve performance, improve quality, and reduce disparities in behavioral health access and outcomes.
- Proposal to cover transitional rent for up to six months for certain eligible high-needs members.
- $2 billion behavioral health workforce proposal to increase the pipeline of the behavioral health workforce.

On January 16, 2024, two apps for California families with kids, teens, and young adults ages 0 to 25 were launched. The launch is part of the CYBHI. These are free apps regardless of insurance. They provide one-on-one life support with a professional Wellness coach, a library of multimedia resources, wellness exercises, and peer communities moderated by trained behavioral health professionals, professionals to ensure appropriate content and safety. The Department worked with over 300 youth in the design and development across the state and asked questions about the kind of functionality needed to ensure these applications meet the needs of diverse populations across the state.

Council Members Questions:

Bill Stewart asked:
“Is there a budget or a strategy plan for media to promote the apps?”

Michelle Baas responded:
“Yes. They were just launched this week and the developers of the apps will have a rollout strategy to ensure robust communication working with our schools, families, and youth to ensure they know about this.”

Catherine Moore asked:
“Is there a parent component to the app for younger kids?”

Michelle Baas responded:
“Yes. The app that is for children zero to 12 is also for parents and caregivers.”

Steve Leoni stated:
“I'm Steve Leoni, a consumer-related advocate, originally from San Francisco, now Sacramento. I've been at this stuff for over 30 years and there was something that went through in the early 1990s from the federal government and it was an option in Medi-Cal that was taken up by the state of California called the rehab option, which allowed for visits in the field outside an office or location. It seems to me like that was already happening 30 years ago. I'm not sure that field-based care, I don't see how they fit together or why field-based care is an innovation. Just thinking about the opportunities for how and where care and services and support can be delivered.”

Susan Wilson asked:
“Can you share with us the names of the two sites that you have developed for the youth?”

Michelle Baas responded:
“Both can be accessed on calhope.org.”

Substance Abuse and Mental Health Services Administration (SAMHSA) Update

Captain Emily Williams provided a SAMHSA update to attendees. Highlights from the updated include:

- California’s SAMHSA funding for Fiscal Year 2023 is $621,088,471.
- Since rolling out the 988 Lifeline, the line has answered nearly 5 million contacts.
    - Nearly 2 million more than the previous 12 months.
    - The average speed to answer decreased from 2 minutes and 39 seconds to 41 seconds.
- Future goals of 988 include:
    - Launch of a national technical assistance center for crisis services.
    - Establish the BHCC Suicide Prevention Coordinating Committee (SPCC) 988 Workgroup.

        - Mechanism to drive the coordination of crisis care services across Health and Human Services.
    - Finalize an evaluation model for crisis services nationwide.
    - Continuing to connect all people to community-based services such as mobile crisis care, stabilization centers, etc.
- The 2024 National Strategy for Suicide Prevention was released.
- The Garrett Lee Smith and Tribal Statute were updated to remove the age floor enabling activities for youth and young adults up to age 24.
- Funding opportunities include Zero Suicide, National Strategy for Suicide Prevention, and Native Connections.
- The Certified Community Behavioral Health Clinic Certification criteria was updated in March 2023 to include:
    - Increasing coordination with 988 and crisis systems.
    - Improving psychiatric rehabilitation supports, with new requirements around supported employment, social inclusion, and finding and maintaining housing.
    - A focus on populations facing health disparities in quality improvement plans.
    - Requiring addiction medicine staffing.
    - An emphasis on prescribing buprenorphine and coordinating with OTPs provision.
    - A provision of intensive outpatient services for SUD.
    - An added focus on harm reduction.
- The National Model Standards for Peer Support Certification was developed as a new resource to support the workforce.
- An Overview of the Impacts of Long-term COVID on Behavioral Health report was released.
- FindSupport.gov was launched to assist individuals access care.

Arden Tucker asked:
“What extra effort and outreach is being done to reach young people of color? “

Captain Emily responded:
“We have an Office of Behavioral Health Equity. It’s our responsibility as an agency to be better and we're trying to be better. Everything we put out including grants are looked at by the Office of Behavioral Health Equity before being published to make sure it is inclusive of all the populations that we serve.”

Catherine Moore asked:
“Are there grants to help establish that continuum of care from the 988 lines?”

Captain Emily responded:
“Every year we have different grants that come out as discretionary grants.
One of those grants that is available now is the Certified Community Behavioral Health Clinic, which we're going to talk about that after the break.”

Certified Community Behavioral Health Clinics Panel Presentation

Captain Emily, Mario Zayas and Doctor Priti Ojha provided a panel presentation on San Ysidro Health's (SYH) Certified Community Behavioral Health Clinics. Highlights from the presentation include:
The Goal of Certified Community Behavioral Health Clinics (CCBHC) are to:

- Improve health outcomes, well-being, and patient satisfaction.
- Address health disparities for equity.
- Maintain high quality and efficiency.
- Improve staff satisfaction to prevent burnout.

- SYH's initial SAMHSA grant was for May 2020-April 2022
- SYH was awarded an Improvement and Advanced Grant for September 2022-September 2026
- CCBHC's framework is recovery and wellness-oriented; trauma-informed; evidence-based; patient-centered; and team-oriented.
- SYH's CCBHC's staff includes 6 Psychiatrists; 9 Therapists; 9 Case Managers; 4 Registered Nurses; 2 Peer Support Specialists; 3 CCBHC Call Center Reps; and 2 Data Analysts
- The CCBHC serves vulnerable populations including:
  - Moderate to severe mental illness
  - Substance use disorders
  - Multiple medical co-morbidities
  - Refugees/asylees
  - Survivors of human trafficking
  - Peripartum patients
  - Collaboration with HIV and Gender- Affirming Medicine and Sexual Health programs
- The total number of patients served is 1,244 and the total number of encounters is 23,184.
  - 65% of the patients are female, 35% are male and 54% are Hispanic.

Public Comment

Richard Kryzanowski stated:
"I wanted to offer my thoughts about what we've been wrestling with as a body about Proposition 1 and the Council prohibition from taking a position and lobbying. I worked in the field, we were mandated to be objective and also have to convey information that we were passionate about, but we couldn't take any steps to actually say "I feel this, or I advocate for this." We have the privilege both in committee and in General Session to hear first-hand a lot of really good information from experts on both sides of this issue. This is something that is not available to many people. I'd say it was a real privilege to be able to hear that and engage with these people. I think it would be a shame for all that information to stay locked away in our meeting minutes and other kind of official documents of that source. I am suggesting that the Council consider producing more public-facing documents that summarize the people and entities we heard from. The intent and aspirations of those components of the proposition, and then the main

concerns we heard from all the various communities we're connected with. I think it would be a great public service and it will allow us to share some very crucial and timely information with a much wider audience beyond these."

Denise El Amin stated:
"I am a Behavioral Health Commissioner for Santa Barbara County. I live in Solvang, CA. I'm amongst the six blacks there. I came into this meeting, and I have found out a lot of things that I had no idea existed. We need to have more black people black people into this group. I'm speaking to you as a black person and if I've never heard of this, how can I bring somebody in when I have no knowledge of it. Wednesday, I asked a friend to come with me because I'm trying to get more commissioners of color on this thing because it's not, it's not correct. It's all Caucasians and they stay on the committees for 10 to 20 years and it's just not fair. It's called systemic racism. She came and I had no idea, and I had no idea what she was going through. She spoke at the panel, and she told them that her mother, who was 66 years old and was a veteran, lives in Santa Maria and she had a mental health crisis issue. Someone in that county gave her a bus ticket to Los Angeles County and then she became homeless. The family had no idea where their mother was for over a year. They found their mother on one of the streets smoking and they arrested her. She was in jail for one year. That's when the family knew that their mother was still alive, and she wasn't homeless. She was now in jail. I'm really upset because this is a black woman, and this has to be stopped. You have to treat each and everyone the same. This should not happen to anyone. I'm here because it shouldn't happen to anyone. I don't know what I would do if my child or my mother or my father. Please think about the people and not the assistance."

Steve McNally stated:
"I support Richard's comments. As soon as you post the videos from the meeting, they will be available for public view. The media can see pros and cons. There's not a lot of pros and cons out there for Proposition 1. I find it's nice to network different people once you find like-minded people so that you can bring the case studies of success other places. It's just a matter of individuals make a difference, and each individual also decides why they can't make it happen in their arena when it can happen. Thank you."

Closing Remarks

Attendees were reminded that General Session meetings are live streamed on the Council's Facebook page.

Adjourn

Chairperson Deborah Starkey adjourned the meeting at 11:54 a.m.