California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

AGENDA (Revised 10-6-2023)

October 17, 18, 19, and 20, 2023
Embassy Suites by Hilton San Francisco Airport Waterfront
150 Anza Boulevard, Burlingame, CA 94010

Notice: All agenda items are subject to action by the Council. Scheduled times on the agenda are estimates and subject to change. If Reasonable Accommodation is required, please contact the Council at 916-701-8211 by **October 10, 2023** in order to meet the request. All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.

COMMITTEE MEETINGS

Tuesday, October 17, 2023

2:00pm	Performance Outcomes Committee

Wednesday, October 18, 2023

8:30am	Executive Committee
10:30am	Patients' Rights Committee
11:00am	Children/Youth Workgroup (working lunch)
12:00pm	LUNCH (on your own)
1:30pm	Workforce and Employment Committee
1:30pm	Legislation and Public Policy Committee

Thursday, October 19, 2023

8:30am	Housing and Homelessness Committee
8:30am	Systems and Medicaid Committee
12:10pm	Reducing Disparities Work Group (working lunch)
12:10pm	Substance Use Disorder Workgroup (working lunch)

Thursday, October 19, 2023

COUNCIL GENERAL SESSION **Room:** Embassy Ballroom
Conference Call (listen only) 1-669-900- 6833
Participant Code: 848657

1:30 pm **Welcome and Introductions**
Deborah Starkey, Chairperson

1:40 pm **Approval of June Meeting Minutes** **Tab I**
Tony Vartan, Chairperson-Elect

1:45 pm **Implicit Bias Training**
Dr. Carole McKindley-Alvarez

2:45 pm **Public Comment**

2:55 pm **Council Priorities Discussion** **Tab K**
All Council Members

3:25 pm **Break**

3:40 pm **CARE Act Implementation Update (Cohort 1)**
Tony Vartan, MSW, LCSW, Stanislaus County Behavioral Health Director
Veronica Kelley LCSW, Chief, Mental Health and Recovery Services
Orange County Health Care Agency

3:55 pm **Committee Report-Outs**

- **Performance Outcomes**: Susan Wilson, Chairperson
- **Patients' Rights**: Daphne Shaw, Chairperson
- **Executive**: Deborah Starkey, Chairperson
- **Workforce and Employment**: Vera Calloway, Chairperson
- **Housing and Homelessness**: Monica Caffey, Chairperson
- **Systems and Medicaid**: Karen Baylor, Chairperson
- **Children/Youth Workgroup**: Vandana Pant (interim)
- **Reducing Disparities Workgroup**: Uma Zykofsky
- **Substance Use Disorder Workgroup**: Javier Moreno

4:50 pm **Public Comment**.

5:00 pm **Recess**

Public Comment: Limited to a **3-minute maximum** to ensure all are heard.

Mentorship Forum for Council members, including Committee Chairpersons and Chair-Elects, will occur following Thursday's General Session in the same room.

Friday, October 20, 2023

COUNCIL GENERAL SESSION **Room:** Embassy Ballroom
Conference Call (listen only) 1-669-900- 6833
Participant Code: 848657

8:30 am **Welcome and Introductions**
Deborah Starkey, Chairperson

8:45 am **Health and Human Services Agency Update**
Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, California Health and Human Services Agency

9:30 am **Department of Health Care Services Update**
Tyler Sadwith, Deputy Director, Behavioral Health, CA Department of Health Care Services

10:05 am **Public Comment**

10:20 am **Peer Empowerment Partnership (PEP) Grant Update** **Tab K**
Andrea Wagner, California Association of Mental Health Peer-Run Organizations

10:40 am **Break**

11:00 am **Bridge to Treatment** **Tab L**
Andrew Herring, MD

11:55 am **Closing Remarks**
Deborah Starkey, Chairperson

12:00 pm **Adjourn**

Upcoming Council Meetings Schedule

January 17-20, 2024: Courtyard San Diego Old Town

April 16-19, 2024: Holiday Inn Sacramento Downtown - Arena

June 18-21, 2024: Southern CA, TBD

October 15-18, 2024: Embassy Suites by Hilton Milpitas Silicon Valley

TAB I

California Behavioral Health Planning Council
General Session

Thursday, October 19, 2023

Agenda Item: Approval of June 2023 Meeting Minutes

Enclosures: Draft June 2023 Meeting Minutes

Background/Description:

Attached are the draft June 2023 meeting minutes for member review and approval.

California Behavioral Health Planning Council (CBHPC)
General Session Meeting Minutes
June 15-16, 2023
Draft

CBHPC Members Present Day 1:

Karen Baylor
Stephanie Blake
Monica Caffey
Vera Calloway
Erin Franco
Jessica Grove
Veronica Kelley
Steve Leoni*
Barbara Mitchell
Catherine Moore
Javier Moreno
Dale Mueller
Elizabeth Oseguera
Vandana Pant
Deborah Pitts
Marina Rangel
Daphne Shaw
Walter Shwe
Deborah Starkey
Tony Vartan
Cindy Wang
Susan Wilson*
Uma Zykofsky

*=Remote Appearance

CBHPC Members Absent

John Black
Erika Cristo
Christine Frey
Noel O'Neill
Darlene Prettyman
Joanna Rodriguez
Arden Tucker

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 24 of 30 Council Members present.

Opening Remarks

Veronica Kelley addressed attendees:

Welcome to Orange County. We are the third most populous county in the state and the sixth most populous county in the United States.

On this slide you see the 2010 Census versus the 2018 Census. There is a slight shift.

The highest population receiving services is Latinos at 46 percent, followed by Caucasians, white folks at 23 percent, and the other 19 percent because a lot of folks are identifying differently.

Our Asian/Pacific Islander population is about eight percent with the biggest group being Vietnamese.

Our African/American population is at four percent and our Native/American population is minute.

We have 55 adult programs and 38 are county operated.

We have a 24/7 access line. We have adult mental health clinics that are open access meaning anyone can come in for services.

We are currently going through a reorganization right now, so our org chart needs to be updated.

A list of different service providers in Orange County was discussed.

Orange County is super conservative. Conservative does not necessarily mean white folks; however, we are very conservative.

The cost of living in the County is 51 percent higher than the national average. Our homes cost 157 percent more than the national home price.

The median home price in the County is 1.1 million dollars. Our median rent is $3,523 a month.

The impact on people suffering from homelessness is huge.

We have many competing programs, and this can be a challenge.

Our Board of Supervisors is super-invested in behavioral health. This gives us the opportunity to enhance our systems.

The big challenge in Orange County is not gang prevention but substance abuse.

Our County reorganization is also providing opportunities for improvement.

I have a 25 percent vacancy rate in our workforce which is mainly clinical people.

Approval of April 21/22, 2023 Meeting Minutes (Action)

Chair-Elect Tony Vartan asked Council Members if there were any corrections needed to the minutes. (No corrections were voiced) The Minutes were approved as submitted.

Public Comment

Steve McNally made public comments.

Bill Stewart commented on the ad hoc committees established by the Orange County Board of Supervisors. He wanted to know if the committees were mental health or behavioral health committees.

Veronica Kelley answered that the ad hoc committees were behavioral health committees. They are very focused on the SUD issues and the fentanyl crises that the County has.

CARE Act Updates (This item was taken out of order)

Stephanie addressed the attendees. My role here is to give a quick update and then give the floor to Ronnie and Tony to talk about implementation.

Your packet is really comprehensive. I do appreciate the fact that your executive director is a member of our CARE Act Working Group. Ronnie is also part of the Working Group.

The CARE Act Working Group is an oversight body providing guidance on the initial implementation of CARE. We wanted people on that body who were opponents of CARE because we thought it was critical to have differing views represented.

This act is the law now and we have to implement it. It is important that our Working Group is made of a diverse group of people.

We have a variety of different types of providers who are going to be working with this population.

We also have a number of housing experts as well as equity and social justice advocates.

In addition to that, we have partners who are from our implementation side of the house.

This is really a very large group. We have over 30 members now.

The group is starting to focus on what their areas of focus are. I think the group will exist for five full years. Areas of focus will change as implementation proceeds.

DHCS is the technical assistance provider. Major areas of focus to begin with should be training and technical assistance, data and evaluation, and services and support.

It is important that the ad hoc working groups have the important perspectives all coming together to bring ideas forward.

The reason for the ad hoc working groups is to create more opportunities for engagement.

I would like to have some folks from this body involved and engaged with us.

There are going to be some interesting program and policy challenges that are systemic and not specific to care.

We have continued concerns about workforce shortages, lack of available housing and concern that there is not enough funding to process the petitions and to do some of the investigation work.

We have been focused on developing the Data Dictionary and working on the evaluation and the reporting requirements.

Hopefully, our engagement with potential consumers will be successful and voluntary. We would like to have people get access to services in a way that they never have been able to before.

We are working on a number of communication tools. We have heard that having a standard set of state tools to communicate would be helpful.

A lot of misinformation is still out there in terms of who is eligible and more concerning would be the process itself.

The CARE Act does not have any additional authority because we did not change the LPS Act.

Sometime this week Senator Umberg posted new language to SB 35. SB 35 is the technical cleanup bill for CARE.

Tony stated that the Cohort 1 process is a work in progress. We are trying to iron out operational challenges.

Cohort 1 counties can talk to one another and exchange ideas. Recommendations regarding challenges can be given to the Department as far as where the gaps are at what needs to be looked at.

At the county level we have our Steering Committee meetings and those happen regularly. We also have working committees that do the behavioral health modeling or designing the treatment and the processes.

The second one is on the justice side with the court, and it looks at the justice and court part.

We have definitely designed a treatment process where we have a known assessment team design that will be there. It is kind of the front door to the court and our justice partners.

We have a team of professionals to ensure that we are doing the initial work when that referral comes in.

The team that we have designed to do the work with this population consists of different layers. We have a team built on an assertive model care on a one-to-eight ratio. Our intensive team will have a one-to-15 ratio and a supportive team.

We did these three layers because the needs of individuals are going to be different, the level of function is going to be different, and it will allow us to wrap around a lot services initially and then step individuals up and down to different layers as we are working with them.

This is the process that we are focusing on. Each county has their own expectations.

We are an AOT county, and we know that initially there will be a lot of referrals. We are preparing for that and making sure that we can get into those referrals and really do the work.

As time goes on in regard to AOT we see a trending down of the referrals. So that is kind of our projection based on the data review.

Veronica stated that in Orange County our team is our presiding judge who oversees all of the Superior Court in the County, the judge who has been appointed for CARE who also is our assisted outpatient treatment judge. This judge is familiar with the population and the disease that we are trying to treat.

We also have our CEO of the courts who oversees the processes and all the paperwork, all those things that happen in the courts.

We have the coordinator of the self-help counter in the courts because people will go there to file the paperwork for care and they are going to need to know how to fill out the paperwork, what it means and all of that.

We have our Public Defender. The Public Defender met with all of the legal aid affiliates in the County and none were interested in providing this level of representation. Disability Rights is also present in our work groups, so they know what we are doing.

We have County Counsel who represents the legal rights at the County and then my staff and I for behavioral health.

We are really working with our court because the court trusts us. We have a good relationship and we have been doing collaborative courts for over two decades. They

understand the difficulty of some of the diseases that we treat and that it takes a while for people to trust us.

They are very open to giving us a little bit of additional time as the law allows, so that we can find somebody. Then we can begin the process of a relationship to help engage that person. If we do not do the engagement, we are not going to be effective.

The engagement will occur with our Public Defender as well as our clinicians.

We are trying to get between 20 and 40 visits to voluntarily activate somebody into treatment.

Our focus is to find out the individual's goals and help that individual meet them.

We are building our process off of assisted outpatient treatment. We have been doing this since 2014.

A full one-third of our AOT people voluntarily activated into treatment and did not have to go through the court process. This process is traumatizing for everyone involved.

We have been meeting with all of our partner agencies involved in these processes. We have to manage expectations to keep these processes based in reality.

We have over 200 programs. I need to make sure that potential clients get access to the particular program that will help them the most.

In addition to these programs, we have full-service partner agencies that specialize in hard-to-treat schizophrenia spectrum disorder.

Intensive family support is critical in treating this disease. Sometimes the disease does not result in what we would want as a family member.

There are many existing co-morbidities with these clients. Many folks have not found a medication that works for them, so they do not want to take the medication.

We are working on the cultural aspects of treatment. We might have a lot of folks who will be returning to their families. We worked with the CARE people on this.

Even if someone does not meet the criteria for CARE, there might be some services that they could benefit from.

In Orange County, our court is really focused on dignity. It is our job to do what we say we are going to do. It has been helpful to see what the other counties are doing.

Some counties are going to have a bigger struggle because they do not have the relationship with their courts. It is imperative that you have a good relationship with your courts.

We know that 30 percent of the people that we currently serve are living with schizophrenia spectrum disorder. We are estimating that we will get about 1400 petitions that meet criteria. We hope to activate a third of these people to voluntarily go into whatever level is appropriate for them.

Tony added that the important part of engagement is recognizing and continuing to elaborate that this process, the CARE Act, is another tool that we have to help our communities.

We need to continue to educate the public about what it is, and what it is not. Defining the criteria is very helpful.

The CARE Act paved the way for direct referrals to the court. This will give us an opportunity to engage more people.

If we engage more people early on, we see that this changes the process from referral to clinical evaluation, support, and graduation from this process.

We know about the workforce shortage, housing, and funding deficits. We do recognize that we need to have different levels of housing. In our county we have developed opportunities for transitional boarding care level for permanent support of housing as well as some prefabricated homes.

As well as we can prepare, there are still going to be some things that we don't know, that we may have not thought about. When the referrals pour in, we are going to have to start revisiting some of the items that may have not been projected initially.

Stephanie added that we are trying to get those communication tools out really soon. I expect and support counties customizing their communication tools. We need to be all on the same page and be crystal clear about, in particular, who is eligible for this program and doing good work to manage expectations.

We are a very big state, and we are going to need all the help we can get to make sure that people have accurate information. We want people to be well informed to avoid unnecessary petitions and wasting time and effort.

Tony stated that various opportunities to pass along good information has been very important. We've had good presentations in various settings and on various levels.

Stephanie added that DHCS has a website that is dedicated to information about CARE training. A lot of it is specific training for our Cohort 1 Counties that is more hands on.

Jenny stated that we have provided that to our Council Members. It should be in the tab. We will make sure everybody stays up to date with that.

Marina asked if a real-life example could be given envisioning this working pre-CARE Act and post-CARE Act. What would be the differences we would see? My understanding is that in order for this to work, they have to go through the court. What will this look like on the ground and what will be different?

Veronica mentioned that she was not sure what it is going to look like. The idea of offering services to a family when, perhaps, their loved one is no longer engaged in CARE and the CARE proceedings is what we are also talking about because we often deal with family members.

If a referred individual does not meet criteria, it is then an opportunity to offer them anything else that they might need. That is the beginning of an engagement with us.

Right now a person has to come to me in another way. They have to enter my clinic. I have to go out on a 5150 call. This will allow family members or friends to bring someone to our attention. This is not how our system currently works.

We are really mindful of equity issues on this. All counties have requirements for equity. We have to be addressing it. We have to look at services and who is being served.

Almost all counties have two categories with the highest levels of care and they are black and Native people. This is because they are not getting access to lower levels of care. We are really looking at this because oftentimes these people access our services via coercive care.

This will allow us to look at a lot of other data elements that we do not look at. It will give us more information about who is using our services.

The services we provide are for the MediCal population and people who have no insurance. So that will give us a lot of information. We are not sure how this is going to look. It could be totally different than AOT.

Tony added that regardless of how accessible and well organized any system is, there are always individuals who may or may not know about the process within that system.

There is an opportunity here that will educate. People have heard about the CARE Act and it may give a segment of the population another added resource that may be sooner than that conservatorship.

There will be those cases that could come to us early on. With this process this could be a benefit.

We may have some opportunities for diversion from either the justice system or conservatorship. We need to look at these as well.

Catherine asked, what are the other sources besides the families filing a petition? Our city is trying to clear the streets of all these encampments. There is some sense that the police are going to bring them in. Are there sources that are beyond just the family?

Once you get them in and they agree to something or it appears they have enough support to get to your full-service partnership – if you get as many people as you think you might in two or three months, and you are still trying to outreach to the people who diverted away from the court; are you going to run out of personnel?

When you talk about having people at different levels my concern is that you are trying to use some of the community things to involve people and now, they are switching levels. Where is the continuity for them? And how do you keep from losing them in that process?

Tony stated that the process for the CARE Court and CARE Act is a direct referral that authorized people can make. It is a much faster process to try to get some sort of response. From that perspective, it opens it up to the community and other interested individuals.

The different levels aspect focuses on the intensity of care that an individual may need. We want to make sure that we wrap around that intensity based on the individual's needs.

We have to design teams that can serve and treat those more complex or more complicated cases. We are going to start at a more intense level if the individual is intense. And they are probably going to stay there for a while.

Catherine stated that this answers the question in terms of – it's not going to be shifting really fast so that you exceed their level of trust in the system and the people that have talked to them.

My third part was about kind of the exhaustion avenue. You filled up and you have all these new outreaches, some of which went through CARE Court and some of which are diverted out. What do you see happening then?

Tony noted that Ronnie alluded a little bit to that. Not only the team that we have designed is there to provide the service and really do all the court reporting. There is a lot of reporting back and forth.

We also have access to all of our FSP teams and all of the other services that we can pull from. We know that we will be inundated initially by referrals.

Our backup process is, getting more resources from our existing services and systems of care and expanding to those. We are going to see that because as the process moves along, we will have to have more and more individuals taken care of.

Stephanie clarified that law enforcement is not allowed to be a petitioner. While first responders are allowed, it has to be a first responder who is working on a crisis team that has come in contact with this individual.

That was really important to us. I still hear it. I just want to be clear, even if you are a first responder, you have to be a certain kind of first responder. This has not necessarily been highlighted.

Adding to the list of potential petitioners would be somebody who is a public guardian or a conservator. The primary reason that we came up with this model is to prevent conservatorship and incarceration.

We will be spending a lot of time looking at data to see if this is actually working to do that. What we learned looking at those other states, is that the vast majority, almost 70 percent of the petitions, were actually coming from behavioral health providers. Most of them were the ones running the local, publicly-funded systems.

We feel pretty strongly that in California most of the petitioners will probably be behavioral health providers.

Vera from Los Angeles County stated, I am against the CARE Act. I believe that there are interventions that could have been tried through the peer support community.

My impression is that a lot of the people who were the driving force behind the CARE Act, a lot of family members are under the impression that – ah – now I can get treatment for my son or daughter or family.

However, a lot of those people do not necessarily fit the criteria and medical diagnoses for being a ward or detaining of the CARE Act or whatever you want to call them.

What about those people who fall through the cracks? Maybe they don't fit the medical diagnosis. What happens then? Will they just be released? What happens?

I am concerned about all those people who are going to be ensnared and don't fit the criteria, yet they will be traumatized.

I am also concerned about peer support professionals being put in the position of possibly being traumatized by trying to suggest someone participate in the CARE Act.

I don't know that we are prepared for the CARE Act if we don't have housing. There really is no housing. A lot of people believe, well, now we have the CARE Act, and we can get people off of the street.

They assume that everybody who is unhoused must be severely mentally ill, must meet the criteria, and it doesn't quite work out that way.

Stephanie commented that a judge will review the petitions. It is complicated and I would encourage you to look at the flow chart that is in the materials.

We worked really hard with a lot of different stakeholders to put protections in place to ensure that there wouldn't be a lot of petitions that would make it very far if the person was not somebody who would meet the criteria.

That is a critical role for the judge to play in their review before they even see the person. These are not people who are wards of the court. They are not detained in any way. They may have a court-ordered CARE plan if they go through the process. But there is no ability in the law to compel or require that person to show up in court.

There is so much education that we have to do. I would agree with you about what the public thinks. If the public is wanting to solve the homelessness crisis, CARE is not going to solve the homelessness crisis.

I have very publicly said that many times. We do think we will serve people who are unhoused. There will be plenty of people in CARE who may actually have housing.

Vera stated, I am concerned about the public perception because a lot of people see the CARE Act and believe it can get everybody off the street. It is a concern that advocates have as well.

Public Comment

Theresa Comstock noted that the last two speakers came from members of mental health boards. Bill Stewart is the Vice Chair for CalBHBC and also the Chair of the San Diego Behavioral Health Board.

And Andrea Wagner is on the Butte County Behavioral Health Board as well.

On behalf of CalBHBC we want to train our own members to understand the CARE Act. We want to train them on how to advise locally. We want to continue being a conduit of information.

Steve McNally spoke. These comments are my own. I thought the three speakers presented a compassionate review of the CARE Court.

I attended a presentation online in Los Angeles and maybe 12 percent of the people had any immediate consideration of getting involved with CARE Court.

I have lived this experience with my son who has schizophrenia and his relationships have been restored meaning that we all meet each other where we are at and appreciate each other.

I think there is an opportunity to make sure people understand. I do host NAMI support groups. Detoxifying families is really important.

Letting the person recover on their time is critical. This is what has worked for me.

A lot of people are still very confused about this and you have recognized that. It is not a difficult lift if you give us the materials and we present them in our communities.

Richard Krzyzanowski spoke. I am the Vice President of CMHPRO which is our statewide association of patient's rights advocates.

I was at the Patient's Rights meeting yesterday and heard Tony's and Ronnie's in-depth explanation about what they are doing in their respective counties.

I respect their desire to perform this very difficult task and walk this very difficult road.

I have a very hard time getting around my perception that however successful or good a structure you build; it still is built on a foundation of coercion.

To me, it is going to subvert all the good you do. When you are in court and you are being measured by criteria not of your own making, being told that you have to do things that are not your choice, you make them feel that it is an assault on their own dignity. And that is the feeling of being powerless.

Once you plant that seed, that is a memory that does not go away. That is something that you do not outgrow and leave behind.

I have a feeling, no matter your good intentions, you plant that seed in a person's soul – that is going to stay with them and that is going to work against all the good that you are trying to do.

Elizabeth Stone identified as a person with expertise in multiple, voluntary, and being unhoused and other experiences. I am from Ventura County.

I am astounded by what I heard today because it was explicitly said by two of the speakers that this is not about people who are unhoused. This is about treating people that are not being treated for schizophrenia spectrum diagnoses.

I do a lot of outreach to people who are unhoused. I was initially very concerned that it is anticipated that the majority of referrals will be from behavioral health departments. I am wondering, how are people engaged with behavioral health departments, but they are not getting the services they need; so what is happening with that?

Why would people feel a need to refer people to the program if they are already known and connected? I believe Stephanie just said that she believes the majority of people and their family members are already going to be housed.

I am going to throw out my housing questions because they seem to be irrelevant.

It is interesting to hear that the projections are being made from the AOT programs. I am also wondering about people engaged in treatment with AOT but where were they six months, a year later? What actually were the outcomes for enhanced quality of life for people?

Break

Council Member Reports on Conferences Attended

(This item was taken out of order)

Chair Starkey mentioned that she and Walter attended the NatCon Conference.

Susan stated that she attended the Children's Mental Health Conference. I presented a workshop on stakeholder engagement.

Many mental health workers attended the workshop. Not many youths go to the Children's Mental Health Conference.

A big question was, how do we take stakeholder information and do something effective with it?

We made a recruiting effort for Council Members at the Conference, and we were successful.

Walter stated that at the exhibit hall we had a table and tried to recruit people for the Council. Gabriela spent the most time at the table.

Catherine reported that she attended the National Psychiatric Organization meeting held in San Francisco.

Recently, the meetings have been focused on disparities and what to do about it and how to understand these things and how they come about.
Our organization and the AMA have just elected their first openly gay president. We are seeing a wider group of people represented.

Vandana stated that they attended a State of Reform Conference and some of us heard Jenny on the panel promoting the Planning Council and what we do. It was worthwhile hearing what is going on in the legislative arena.

Jenny attended the Forensic Mental Health Association Conference in April. It was a good opportunity to network with the agencies that we work with for the transition of our mental health population from prison to the community.

We had some interesting discussions providing education on our processes. We discussed pre-release processes specifically for our mental health population.

There was a very interesting presentation about marijuana. It was detailed and I learned more about marijuana than I needed to know. I enjoyed the presentation a lot and the rates of development of psychosis for those who use marijuana at earlier ages.

Uma had the opportunity in April to attend the Future of Mental Health Conference that happens nationally. It focuses a lot on emerging trends in mental health treatment and there is a significant focus on digital solutions.

We had a significant conversation around IOP programs moving into digital platforms.

Jenny stated that we sent several people in February from the Reducing Disparities Workgroup to this conference.

Uma informed the group that it was a conference really well worth it. It intersected nicely with some of the work that we are trying to do in our workgroup.

For the people immersed in this work, it may help us with our Performance Outcomes discussions because it a very data-heavy report.

Policy and Legislation Committee Report

Barbara reported that the Legislative Committee is now renamed the Legislation and Public Policy Committee. We have a lot of members in this committee.

We can never get through all the legislation. We are probably going to have to come up with a different method of prescreening legislation.

We had presentations on the state budget. We then had a presentation on the Mental Health Services Act by, David Pelon, the past president and CEO of Mental Health, Los Angeles.

David emphasized the value of employment as a social rehab value and as a wellness recovery value. He talked about looking at social rehab values.

We also had a lot of discussion about the MHSA modernization and had presentations from Mental Health America, California and REMHCO.

We tried to decide on a position on MHSA redesign. What we decided was that we would draft a letter and send it to the legislature about not taking a position for or against this but stating our concerns.

One of our big concerns is what was the process used to do this? Where were the voices of consumers and family members when this was done? MHSA is supposed to be a community process.

We really did not see that there was any kind of input into this MHSA redesign. What will probably suffer the most will be PEI-funded programs. Innovations programs will probably be eliminated.

There will also be cuts in projects such as Full Service Partnerships. They will lose money under this.

Many services that address diversity and equity in California, and many peer-operated services will have reduced funding.

There are also statewide mental health organizations that are drafting letters about their concerns. We hope to look at a draft within two weeks and climb onto that and we will also state our own concerns in our own letter.

There was some discussion about asking for a delay in a ballot measure on this. This is supposed to be in 2024 a ballot measure for Mental Health Services Act redesign and then also a ballot measure for a housing bond to go with this.

We discussed that we need to provide input before the ballot measure is designed. That will need to be decided probably by the end of this year.

Will we be in a position of fighting a state ballot initiative? That is an interesting idea.

There was some discussion of asking along with partner agencies to ask the governor to pull it off the 2024 ballot because it is too soon and you have not done outreach to get input from people on this.

Catherine stated that she was under the impression that the ballot language if it is going to come from the legislature, has to happen in the next few weeks. The timing of having an influence in the language through the legislature is a very short timeline.

Naomi stated that I am not aware of the ballot measure needing to be done in the next few weeks. You might be referring to us about C326 which is a bill that is accompanying this, and we don't know what is in it. We are hoping to get details within the next two weeks.

That bill would go through by September but separate from the ballot initiative.

It doesn't capture the language of the ballot initiative because it is coming from the legislature as opposed to a community petitioner?

Barbara replied that I think the legislature can put it on the ballot. You don't need a petition. They would have to pass it.

Barbara opined that this will have far-reaching implications if this goes through in the way we are seeing it at this point.

I presume that we are going to have an interim meeting of the Legislation Committee on this. Those meetings are open. We decided we would draft a letter with concerns and send it to our partner organizations who are also drafting a letter that we can sign onto.

Daphne did refer SB 519 to us. We said that we would look at that. It has to do with who might run jails other than the sheriff's office. We did not take a position on that.

We did take a position on a couple of bills. It is a lively committee, and we have lots of opinions. We will need to work out a method of pre-screening and going through legislation and having suggested positions on some of these.

Barbara added that the other thing that we talked about was to ask counties to provide us with information in relationship to the losses that will occur with this modernization. We wanted it to be patterned on the information how the Mental Health Association, the work that they have done and their presentation as this is what it is now, the way the money is split, the six versus the three.

If we could get this information from the counties, then we could do our own analysis in the Planning Council and then have that information to back up what we are thinking in terms of the disaster that we think is going to occur with some of these changes.

Committee Report-Outs

- **Performance Outcomes**

Susan reported that the Performance Outcomes Committee met on Tuesday afternoon before the conference started.

We were very Data Notebook oriented. I chair the Outcomes Committee. Noel is the Vice Chair.

Our Committee presented to the CMHACY Conference on the issue of stakeholder engagement.

We might offer this subject as a possible conference every year because our room was full to overflowing. The session ran a half hour longer than it needed to be.

People had many questions. We focused on the community planning process (CPP) part for the MHSA. It was timely because most of the mental health boards were holding hearings in May and June around the MHSA.

Our 2023 Data Notebook is about stakeholder engagement.

At our board meeting we talked about the Performance Outcomes measures, presentations that happened at our last meeting in April.

We discussed what our next steps might be. We discovered that there is so much information from those hours of presentations that we did not have time to talk about that and do the rest of the work that we had to do for the Committee.

So, we set up a meeting that we will do between now and the October meeting to digest some of that information and figure out what good valid next steps would be for the Planning Council.

We want to come to the leadership and the Executive Committee and all of you as members and say, these are some of the things that are really important. How do we go from here?

The whole Planning Council needs to be involved in further discussions on that.

We went through our Data Notebooks, and I will quickly discuss that.

We just finished our 2021 Data Notebook which was about racial and ethnic disparities.

This is the first year that we have done an executive summary of our Data Notebook. This reduces an 80-page report to a 10-page report.

The topic of our 2022 Data Notebook was the impact of covid-19. We got 53 counties to respond to our Data Notebook. That is an all-time high.

We talked about how to get the five that did not respond to respond?

And what are the big issues in the 2022 Data Notebook because we write recommendations. So, we are going to work on those recommendations.

The 2023 Data Notebook has just completed a preliminary draft. This one is on stakeholder engagement. This is a hard piece to get on paper.

We are hoping that it will go out in July or August as we get it to the final draft.

The 2024 Data Notebook talks about planning. We are going to change the structure of the Data Notebook a little bit.

We want to write a white paper about homelessness. We thought about reaching out to agencies we interact with and asking them what they want our relationship to look like and what can we do for you that would be more effective than what we are doing now?

- **Patient's Rights**

Daphne stated that they met yesterday. We only meet for two hours.

We began by receiving an update from the DRC, Disability Rights California on SB 43. It will probably be in committee next week.

The lawsuit that was put forth by Disability Rights California has failed. There is a lot of interest around LPS reform.

We had a CARE Act update. In the Governor's May Revise there were millions of dollars that went to the Judicial Branch and to the Department of Aging.

We did have a robust discussion around the CARE Act.

We discussed SB 519 because there have been issues with deaths and other things occurring in the San Diego Jail. County jails are run by the sheriffs. This bill would allow a possible change in that. The Board of Supervisors might have some authority over the jail. This would remove some of the control away from the sheriffs and hopefully bring about some transparency.

Our patient rights advocates have a very difficult time getting into the jails. We sent a request to the Legislative Committee to track this bill.

We had an update from COPR, the California Office of Patient Rights. They brought us information as to what activities are going on with county rights advocates.

We are to advise the Department of State Hospitals. We requested information on activities going on in the state hospital system. There have been difficulties in obtaining this information.

We will be establishing contacts with the state hospitals to let them know of our existence and in hopes of establishing a better working relationship with them.

We talk about influencing the ratio of patient's rights advocates in the counties. We talk about it and we accomplish nothing.

Patient's rights advocates spend the majority of their time doing certification hearings. This takes up most of their time. We have a lot of concerns in the future because already there are not enough PRAs in the county and if SB 43 goes through, that is going to increase the number of people who are LPS.

We found out that we had an audience member who was from KQED which is an NPR station in the Bay Area. She came to Orange County to talk with Veronica.

She recorded our meeting, and I am sure that some of our passionate discussions will be reviewed. She interviewed several people.

There is a lot of interest in this area of involuntary care. There was an article in, *The LA Times*, entitled; Forcing Treatment on Mentally Ill, Homeless People is a Bad Idea.

- **Executive**

Deborah reported that at the Executive Committee we did review the Council Membership and we have interviewed three different, potential members who were consumers and family members.

We have had a couple of tables at different events to bring in some more applications.

Regarding our logo and marketing materials – the file that we have is not digitally acceptable. We are working with the state to fix that and alter it a little bit. We will be showing that to the Council in October.

- **Workforce and Employment**

Vera reported that the meeting was very ambitious. We had our quarterly update from HCAI and they updated us on the WET (Workforce Education and Training) Five Year Plan.

We also had an update from CalMesa and DHCS on the current state of the MediCal Peer Certification Program.

It looks pretty promising, and they are just rolling out the specialties and training for the specialties. These are for the unhoused population, justice involved, parent and family members peers, and also the crisis workforce.

You have to be a state-certified peer already before you can embark on the training. And you can only participate in one training at a time.

We had a wonderful presentation on work models for the consumer workforce. We were given a lot more information about the IPS (Individual Placement and Support) Model, the Clubhouse Model; but we have not had, until yesterday, any examples of social enterprise models.

We had a presentation on this from REDF (Robert's Enterprise Development Fund) which is an investor based in San Francisco that has been around since 1987 and they are not focused specifically on behavioral health.

They are interested in developing social enterprise projects and have so far funded over 280 projects in 38 states and the District of Columbia. One of their partners is LA: RISE, which is the, Los Angeles Regional Initiative for Social Enterprise, which is a private/public partnership. So REDF partnered with LA RISE.

The populations served by LA: RISE are primarily unhoused, and justice involved seeking employment training.

All of the programs have a behavioral health component given that these populations do have behavioral health issues.

We also heard from Downtown Women's Center which is an organization that has a social enterprise component, and they work with unhoused women in downtown Los Angeles, the skid row area.

Another organization, Homeboy Industries, as well as in Orange County, an organization called, Chrysalis, are part of that LA: RISE network.

They were invited because we felt they could give us a really good idea of the success of social enterprise for people who are unemployed or have difficulties gaining employment.

We had, The Village, which was a program of Mental Health America, that was very successful.

Of those employment models, the one that we have not tackled yet is entrepreneurship and people who are interested in perhaps becoming gig workers. Many behavioral health consumers may not be prepared to work full time or may have more creative interests.

Our Work Plan is pretty ambitious. We discussed our White Paper related to Medi-Cal, peer certification. We generally agreed that it is too soon to think about doing it. The implementation of peer certification is still relatively new. There are still scholarships available.

The specialties and the training for the specialties has not yet begun. We decided to postpone it and continue the discussion on the specifics of what information we might gather for a White Paper.

There are certain elements that we want to narrow down and become a little more specific about, while also not feeling the pressure of coming out with something.

- **Housing and Homelessness**

Jenny addressed the attendees. The Housing and Homelessness Committee had a few presenters and spent some time working on their work plan.

We heard from Cody who is the director of statewide policy for the California Interagency Council on Homelessness. He provided the Committee with an overview of what they do. They also talked about the Action Plan for preventing and ending homelessness.

He did get feedback from our Committee Members that they are going to use some of what he presented in their plan.

We also heard from Benny, and he shared about some of the issues around adult residential facilities.

The Committee had three goals that they talked about. One of the goals is prioritizing and looking at the different housing models. They want to look at the behavioral health modernization proposal and some of the housing funding.

We will be updating the Work Plan for the next time we meet. We may have an in-between meeting and in October we will start looking at potentially Housing First and some of the laws around that.

The group wants to look at the MHSA reform wanting to put about one-third of the money on housing and see what we might add to the full Council's position.

- **Systems and Medicaid**

Karen reported that we spent a heck of a lot of time this morning on payment reform and trying to understand the complexity of changing from a cost-based reimbursement to fee-for-service.

We started with DHCS on the policy level and then went to CBHCA to hear statewide, county level and then Ronnie and her team did a, how this impacts on the county level. And then we went to a provider level.

It is very complex. The Planning Council should continue to monitor this because there are going to be some hiccups. There are challenges regarding the EHRs, the need for training, how they are going to account for transportation, cash flow – there is just a ton of things that this will affect.

The one positive highlight was one of the providers said that they have already noticed a 50 percent decrease in the time that it takes to do documentation.

Uma added that we had some really good presentations today. They were very comprehensive and very thoughtful. We got to see the things that are challenging at each level.

It was really apparent that this was a really, really, big list and a very big effort. We had acknowledgement that because the timelines are so tight, providers did not get enough

time with their rates. Counties did not get enough time. There is a lot of concern about the rapidity of changes.

- **Children/Youth Workgroup**

Vandana stated that we decided to focus on something like three goals for the year.

Goal number one is to recruit more youth into the Workgroup. We've decided to look into organizations where youth are already engaged in policy and advocacy activities.

The second goal that we want to look at is aligning our work more closely with the Systems and Medicaid Committee. This links up with bringing young people from policy and advocacy groups. We want their input on our work and potential legislation.

The third goal is around basically increasing our learning around what kinds of programs are out in the communities and what we can do to help support community impacts and interventions.

We will be bringing this information back to the Council so that we can be current and see what is happening across the state.

In October we will invite the group from Stanford University with Santa Clara County which has created, allcove, which is a space/space, drop-in, youths center.

There is an initiative called Scout which is an upstream prevention-based, resilience-driven curriculum.

Vera asked if this would be a steering committee that would work with the youth workgroups or are we talking about Council Members?

Vandana answered that we haven't specifically talked about bringing in a steering committee. For now what we are focused on is inviting some youth become part of the Youth Workgroup so they can start to lead the discussions.

- **Reducing Disparities Workgroup**

Uma stated that we have a very active group consisting of seven or eight people.

We have been working on some questions that would be core questions that we would want any presenter to move the conversation on equity and the issues of disparities in care.

We will continue to work on this in the next meeting and hopefully have something ready by then.

We are working on an idea to move forward to the Executive Committee. We would like to find a way for the Council to see the film, *Color of Care.*

- **Substance Use Disorder Workgroup**

Javier presented the following: The Workgroup had the pleasure to have SAMHSA Captain Emily to participate in our meeting.

The Captain gave an overview of the work SAMHSA is engaging in to bring together mental health, SUD and physical health.

The Captain spoke about the certified Community Behaviroral Health Clinic as one example of how SAMHSA is supporting these efforts. These are community clinics that provide coordinated, comprehensive, behavioral health under one roof and one billing system.

They serve anyone with substance abuse disorder regardless of their ability to pay.

We had providers share their programs' efforts in combining mental health and SUD with physical health along with those presenting challenges.

A few of the challenges mentioned were, there are still nuances with billing and licensing having to navigate multiple billing systems, dual licensing requirements, and there still are concerns with navigating confidentiality rules.

One in particular is the inability to share the same space for a variety of services.

There are also tons of legal and compliance issues and inoperability issues.

We recognize that these barriers are not new. Historically, we have been aware of these barriers. The truth is that they still exist, and they still continue to present challenges. We are going to continue to look for opportunities to be able to promote and motivate some change.

The discussion ended with a continued commitment to try to identify what role, if any, that this Council plays in working through some of these challenges so that consumers can receive the care that they need without having to go and navigate several systems.

Hopefully, in the near future we will be able to provide some recommendations to the Council on what we can do to advocate on behalf of our consumers.

Recess

CBHPC Members Present Day 2:

Karen Baylor Stephanie Blake

Monica Caffey
Vera Calloway
Erin Franco
Jessica Grove
Veronica Kelley
Steve Leoni*
Barbara Mitchell
Catherine Moore
Javier Moreno
Dale Mueller
Noel O'Neill*
Elizabeth Oseguera
Vandana Pant
Deborah Pitts
Marina Rangel
Daphne Shaw
Walter Shwe
Deborah Starkey
Arden Tucker
Tony Vartan
Cindy Wang
Susan Wilson*
Uma Zykofsky

*=Remote Appearance

CBHPC Members Not Present Day 2:

John Black
Erika Cristo
Christine Frey
Darlene Prettyman
Joanna Rodriguez

Staff Present: Jenny Bayardo, Naomi Ramirez

Welcome and Introductions

Chair Deborah Starkey called the meeting to order, welcoming Council Members and leading self-introductions. A quorum was achieved with 25 of 30 Council Members present.

Uma addressed the attendees:

I wanted to take time to remember Angelina Woodberry who I have known a long time here in Sacramento County. I was a provider in the County, and she was a tireless advocate who dedicated her life to eliminating stigma as it applied to people with lived-experiences, children, families, and people of color.

I always found her to be extraordinarily gracious in the way she presented her perspective. She listened to everybody's perspective, but she never gave ground on fundamental values that she brought to her view. She was fearless.

I think she brought a lot to our Council, but she also brought a lot to the community. So, I just wanted to take a moment to honor her to respect the contribution she made to us and to remember her and her family and all her colleagues in Sacramento.

Her passing was sudden and many of us did not know about it. She was a very private person, and it is really important for us to remember her contributions.

Arden added that Angelina was a tireless and courageous woman in standing up for the rights of folks with mental illness and helping people to heal. I will miss her very much and I am sure I am not the only one.

Vera stated that we have been talking about creating professional organizations for peer specialists and anybody who has had peer specialist training including family members and people who are interested in becoming peers.

I already knew that if Angelina was working for them, that there was strength. I getting to know her through the Behavioral Health Planning Council, I always felt that she was, compared to me, the same person in the room.

You felt her presence and knew that she was thinking deeply about all of the issues and bringing it home to her community. She will be missed and I send my condolences to her family.

SAMHSA Update

Captain Emily Williams was recognized:

I would like for anybody who did not talk to me yesterday about this conversation, who can name all eight uniform services. When people see me in my uniform, they often say – who are you, what do you do?

We have the four everybody knows, the Army, the Air Force, the Navy, and the Marines. Sometimes people remember the Coast Guard. And then you have, the National Oceanic and Atmospheric Administration who has commissioned officers taking care of your weather. You have the United States Public Health Service which is what I am, and we take care of health care.

It started out as the Maritime Hospital Services for the Marines and the Navy. Now we have an eighth in the Space Force.

I appreciate the effort that you put into the work that you do.

SAMHSA and the Council have shared goals of ensuring that the mental health and wellbeing is a reality for everybody. We want to do that by improving access to mental health and substance use care.

SAMHSA is an organization that has grown exponentially in terms of staffing and funding increases.

We have been able to increase and continue funding for grant programs, support and services in support of helping more individuals to experience more positive outcomes.

The FY 2023 Consolidated Appropriations Act provided SAMHSA with a $7.4 billion budget which is a $970,481,000 increase over fiscal year 2022.

This means that the Administration really does recognize the need for behavioral health and mental health services across the country.

We are working to allocate those funds out through different discretionary grants, through state funding that we have to do. We support all levels in providing services that achieve the vision that people at risk for mental health and substance use conditions really receive care, thrive, and achieve wellbeing.

People of all ages and backgrounds are facing unprecedented mental health and substance use crises today. Nearly 1 in 4 adults 18 and older had a mental illness in the last year according to the 2021 National Survey on Drug Use and Health.

One in five adolescents had a major depressive disorder episode in the last year and of those, nearly 75 percent had symptoms consistent with severe impairment.

Nearly 1 in 3 adults had either a substance use disorder or any mental illness in the past year.

We also know that 12.3 million people age 18 or older had serious thoughts of suicide in the past year. Also, 3.5 million made serious suicide plans and 1.7 million attempted suicides.

CDC data shows that almost 107,000 Americans died due to drug overdose in 2021.

This is a dire situation, and we need to come together to work to improve the things that we are doing to support our communities.

We want to prioritize, preventing overdoses, enhancing access to suicide prevention and crisis care, promoting children in youth behavioral health, integrating primary and behavioral health care and using performance measures that include data and evaluation to inform the work that we do.

Prevention has a distinct role in all five priorities that we have. Currently, 85 percent of SAMHSA resources are dedicated primarily to prevention services focused on youth services and these benefits cross all the lifespan.

We are making a lot of headway in preventing overdoses and treating substance use disorders. This has happened through legislative changes and funding increases.

A lot of people get a little antsy when we start talking about harm reduction services because they think SAMHSA is providing pipes and tools for people to use drugs. That is not what it is.

We are working to use innovative and community-based harm reduction services that are working in your community.

One of the ways we are doing that is, try to finalize the Harm Reduction Framework which will be a national standard that should be released sometime at the end of this year, and it will be a national standard of harm reduction actually look like.

Harm reduction is also about reducing HIV, AIDS, hepatitis, and other communicable diseases. It is taking a public health model to improve the health of our nation.

Naloxone kits have been positive. SAMHSA has awarded more than $1.6 billion dollars through its State and Tribal Opioid Response Programs. And the SOR and TOR grant recipients have purchased more than 7 million naloxone kits, distributed about 6.5 million naloxone kits, and distributed nearly 100 million fentanyl test strips.

Access to Suicide and Prevention Crisis Care is a huge priority for SAMHSA. By improving the nation's efforts, we are helping people to thrive and to achieve wellbeing. Part of that comes through the implementation of the 988 Lifeline.

California has a robust 988 in-crisis care continuum of service. We need to do as much as we can to get the word out. Please take the resources I have on the back table.

We are taking a public health approach to the suicide prevention work that we are doing.

In 2024 the Biden/Harris Administration plans to issue a National Strategy for Suicide Prevention. This is an update and will move things to a more current level of access.

The Certified Community Behavioral Health Centers model is one that SAMHSA is embracing. It truly does provide wrap-around care for the most vulnerable people in our communities.

It allows for 24/7 crisis care and SAMHSA has released one million dollars each planning grant for communities who are interested in exploring the opportunity to become a Certified Community Behavioral Health Center community.

Evidence has shown that the Certified Community Behavioral Health Center approach works because it integrates mental health services, substance use treatment, and health care in one setting. There is no wrong door to come into care.

The CCBHC approach is demonstrating success. It is improving the social connectiveness and the overall, everyday functioning of people in our communities. They are decreasing hospitalizations and emergency room visits which also supports the workforce because we do not necessarily have the people to sit in the emergency rooms and wait.

Our workforce is one of the most important things we are working on right now and part of the CCBHC helps to address some of those workforce shortages but there are other ways that SAMHSA is working to make a difference.

SAMHSA has a lot of support to support your behavioral health workforce. We've done some co-sponsoring with HRSA (Health Resources and Services Administration) which runs all of your small community health center clinics across the nation.

HRSA and SAMHSA are both HHS agencies but oftentimes we have been a little bit siloed. Right now, we are working across government agencies to provide support for the workforce and workforce development.

There are many things going on with school-based services with peer support services, different trainings; the catch is, not every TTC offers continuing education credits.

SAMHSA is working to increase peer support because it increases our workforce. It increases community access, and it increases the community trust that people must have to come forward and say that they need support.

We have lots of Technical Assistance Centers, (TA) Centers. We have over 50 TA Centers in SAMHSA. They provide resources and/or training for the issues that are important to the community.

Trauma-Informed Approaches principles are widely practiced. Trauma is universal and it shapes the lives of individuals and families and communities. We are promoting recovery and resilience in the people impacted by trauma.

We have a FindSupport.Gov website that offers a lot of self-help and support for potential users. It is for the general public. It is not for clinicians. It is a tool that can help the general public as a person.

This website launched in May. It is continuing to expand every day. More self-help topics are continually being added and developed.

Questions

Arden commented that she would like to comment to enhance awareness and knowledge and hopefully inform changes that you can make in this crucial work.

As a suicide-attempt survivor, when queer and trans folks, especially black and brown, queer and trans folks reach out to these critical lifesaving services; are met with staff lacking training to give sensitive support, this is an issue in my community.

Captain Emily stated that SAMHSA has looked into this issue. We definitely acknowledge that queer and trans folks have a difficult time in reaching out which is why

when you dial 988 now, you can press 2 for a veteran specialist. There is another option for LGBTQ plus and trans folks to press for support.

SAMHSA also has some initiatives out because they do recognize that black and brown people do not get the same support and level of support in health care, including mental health and substance use care that other people get.

Steve Leoni spoke. I have been a consumer and advocate for many, many years. I spoke about the swinging pendulum with Emily before the pandemic.

My understanding is that due to federal legislation a few years back, SAMHSA was given a new Advisory Board. Your old Advisory Board used to look pretty much like the composition of this Council.

And the new Advisory Board at that time, because of that legislation, was all doctorate-level people, not even Master's-level people.

And somebody said, well – you have to have a consumer. So, they had one consumer in that whole Advisory Group and that had to be not a seasoned advocate, but someone who was currently in services with a doctorate-level person.

I was very alarmed for SAMHSA for the message that this might send downstream as to what was acceptable.

I am hoping that you can tell me that maybe that situation changed or what have you. If you could answer this in some way for me. Thank you.

Captain Emily replied that, I don't have an answer. I am not a part of the Council for SAMHSA. I do know that they actively recruit from each region. I do know that the names that I have sent up have not been people who are at that level that you say, the doctorate, the master – I have sent up names that are actually consumers.

I do not ever know who is actually selected. I will take this feedback to my leadership to make sure that it is included. I do not have an answer to say what the composition is.

Steve replied, I thank you for the sincerity of your answer and I am saying that even if my information is somehow wrong, the fact that it is alarming to some people out here should be something that you guys know.

Walter Shwe commented. I have a question about the Certified Community Behavioral Health Centers. What do you think about these centers?

Captain Emily stated that California has a bunch already. We have a lot of Certified Community Behavioral Health Centers. We have more than any other state.

I did not bring my list to say where everyone is located in California. They truly are located from the far north all the way down to San Ysidro. They are all across the state.

Captain Emily added that a lot of the CCBHCs are in partnership with the qualified clinics from HRSA because they have a requirement to provide medical care at the same time.

Most people who are strictly substance use and mental health services, do not have that access to be able to do that. And you also have to be able to have the ability to provide 24/7 crisis care.

FQHCs probably apply most frequently. It is open to other groups. It is open to some of the tribal communities. You would have to have a group of people who wanted to come to the table to support having a Certified Community Behavioral Health Center in their community.

Vera commented. Most people assume that the opioid crisis is still predominantly white and rural, but the face of the opioid crisis now is black people and in black communities.

The drug buprenorphine that is prescribed, is rarely prescribed to blacks. In fact, the prescriptions are half in terms of prescribing to black people and there are fewer prescribers in black communities.

This drug cuts the risk of opioid death by 50 percent. I rarely hear about opioid addiction in my community of Inglewood which is predominantly black and Hispanic.

Captain Emily replied that there is a program called, MOMS and it is a maternal child fatality and trying to reduce that. There is a MOMS event on Saturday. I literally just got an invitation to it. It is going to be in your community of Inglewood. It is addressing the crisis of maternal and fetal health in black and brown communities.

As far as prescriptions are concerned, I think that by removing the X waiver I think that you are going to see a better access to services across the continuum because SAMHSA does recognize that people of color are not having the same resources availability that white people have.

Catherine was wondering how SAMHSA is addressing the xylazine new contaminant for opioids that is so devastating to the people who survive opioid addiction?

I am assuming that the DEA renewals requires one get educated on buprenorphine which means that more people will be able to prescribe this and feel comfortable with it. A lot of people do not feel comfortable with it because of the history of this, “extra” education you had to do.

How do you look at our delivery system and how we try to push things out? How do you integrate to that? How do you become that?

Captain Emily said that SAMHSA is addressing xylazine and looking at best practices.

There is definitely some siloed information that goes out. One of the benefits in this region is that I am available to come to your counties and work with you.

I am here and always available regardless of the location of your county in the state.

You need to understand that I came into this position five months before the pandemic started. We spent the next three and a half years working from our homes. We did not do a lot of travelling.

Now that we are travelling, invitations to speak have definitely increased but because of turnovers in the counties – I need to do a better job of getting the word out that I am available and here.

Public Comment

Steve McNally from the Orange County Behavioral Health Advisory Board spoke as an individual.

Given that California now is putting funding into different agencies in the same locales, competing against each other, are there SAMHSA grants for cities? Are cities an eligible person to apply or do they always have to go through a county or a state?

Captain Emily answered, no – they do not. The discretionary grants that SAMHSA has sometimes say specifically for a state or a territory or a tribe. Many of the discretionary grants are open to community service organizations, to colleges, universities, cities, they definitely are not specifically for the state or a county.

Steve said that one of the reasons I like to attend a lot of different siloed events is you try to find where the champions are for different causes.

You have something that will potentially solve a problem, but I don't know if you have the trust for them to come to use it. This industry likes to plan a lot but no implement as much.

Can you white label SAMHSA products and put your name on it? You put them together so it appears that it is coming from the local entity plus you.

(Laughing) Captain Emily replied that – no, is the general answer. Anybody can apply for grants but, no, I cannot put my name on SAMHSA-prepared items. I can share that those resources are available and that I heartily endorse you looking and using them, especially when it comes to the resources on the SAMHSA website.

Jessica Grove with the Department of Rehabilitation commented. Can you point me in the right direction amongst those resources for materials to help practitioners

understand the benefit of not holding off on talking about employment until someone is, quote/unquote, recovered, stable?

When you came before you had mentioned the efficacy of including employment as part of the treatment plan and part of the treatment team. Any particular direction I should go for looking for materials that we can share out through DOR as well?

Captain Emily mentioned that off the top of my head I cannot pull something out and say, I have it – but I will get you something.

Department of Health Care Services Mental Health Block Grant Responsibilities

Waheeda Sabah addressed the Council and spoke about the Mental Health Block Grant Responsibilities.

Thank you for inviting me and one of the most important things for the Department of Health Care Services has been to bridge that gap we have had, that connection with the Planning Council and the Department.

The Department has gone through many reorganizations. It has been kind of difficult. Sometime historical knowledge gets a little bit lost. We want to make sure that we bridge that gap and have a stronger relationship with the Council.

The majority of our team members are teleworking. It is nice to see people face-to-face. This is really needed, and I need to hear your stories.

We are hear to let you know that your input is extremely valuable for the application that we submit to SAMHSA every year. This year we are doing a full application.

We oversee a majority of the SAMHSA federal grants. This includes the community and mental health block grants and also the substance abuse prevention and treatment block grants.

The discretionary grant is the State Opioid Response Grant and the majority of our substance abuse, prevention and treatment block grants and the mental health block grants – the majority of that money goes to the counties.

We also like to make sure that it follows protocol, the regulations, and we bridge that gap with the counties.

The State Opioid Response Grant does focus more on substance use disorders. Many members talked about the issues they are facing in their communities.

We are aware of the issues that are faced daily and we are trying to target that.

We have the Behavioral Health Workforce is one of our projects. We understand there is a shortage in the behavioral health community in general.

We also understand that we cannot separate substance use disorders and mental health disorders completely because there are a lot of co-occurring disorders.

What the State Opioid Response (SOR) does is create a lot of statewide projects rather than giving it directly to the counties. Sometimes, statewide projects allow us to target specific areas and specific projects.

Our media project is called, The Choose Change Campaign. You will see advertisements or radio spots talking about attitudes toward treatment. We want to look at it as a positive thing in changing your life.

We are also targeting the black and Hispanic communities. We are also focusing on youth and the homelessness population.

Thank you so much for inviting me here.

Questions

Karen noted page 3 on the application and stated that it is also at the very bottom of page 5 of 195; it says - 37 participating counties for the Supplemental County funding. And 37 has been the standard number forever.

I am curious as to what the Department is doing to expand that to all 58 counties.

Waheeda stated that when we receive the Supplemental funding this is ARPA or the CRSA grant. The CRSA grant is the Corona virus. I believe we had it for three years and then it extended to four years.

The reason that not all counties are participating in it is because there was time period where they can opt in to get the Supplemental funding.

If they opted in at that time we are not really opened up for them to opt in a later time because we have already allocated the funds.

We cannot expand that because it does have an expiration date. Our prime fund always continues. All 58 counties are participating in that.

Steve Leoni commented. I am a mental health consumer but also an advocate with 40 years of experience but not a whole lot of experience on the block grants.

I am trying to figure out if most of the block grant money goes to counties and they make decisions there, what is the role of this Council? I am trying to figure out what it is that we are doing that makes this an important task for us to do.

I am also confused about the timeline. It says - the next fiscal year. It is all due September first and the work we are doing today will be preliminary to comments done later in the summer, but we are not meeting again until October.

I thought you could answer both of those issues.

Waheeda replied to the question pertaining to the Council's role and responsibilities relating to the timeline.

Typically, we have an application that needs to be submitted every September. When SAMHSA opens the application for us to complete, it is not a very long timeline. We typically get about two months.

We are also trying to work with Planning Council to make sure that we receive your input. Historically, it has been difficult to get that input right away but most of the time we try to get that information and implement it into the application but one of the things that we have been doing lately working with Jenny and Naomi is that even if the application is delayed or opening up late – typically, most of the applications are not changing dramatically.

We kind of work based on last year's application and what we are foreseeing could be changed for the current year.

Regarding the Council's roles and responsibilities – what we are looking for is you guys are on the ground and you see what happens. You have to be able to tell us what is really happening, what kinds of communities are being affected.

I hope that answers your questions.

Steve stated, not entirely – with all due respect. With regards to the timeline – we have quarterly meetings, and we are meeting now in June. Our next quarterly meeting is in October.

This meeting today is supposedly preparatory to development and comment on the application itself and it says – for later this summer. But we will not be meeting again formally until October and that is the timeline, so you are saying you might want input in September sometime or late summer, whatever – but we will not be meeting until October.

I am just trying to make sure that is a doable timeline for your needs and the fed's needs.

Number two, I am still unclear about this whole application, maybe it will be made clear to me later. There are a lot of things in there made complicated by the fact that as you alluded to, we have almost 60 jurisdictions in California and every one of them is different.

I can tell you that this Council cannot cover all 60 and will not. Yet, we are asking to change verbiage that will do what. What will the changes do? Is it that we want to emphasize that counties should be doing this rather than that?

I just don't know exactly how, on the ground, this fits in. We have doing a lot of work and there are a lot of changes happening in California. It is very heavy-duty work. And now are taking an entire three hours to process block grant stuff which is, in terms of income for the counties, a very small piece.

I just want to know that our work is really worthwhile and exactly what that worthwhile is.

Jenny spoke to the timeline. This is an effort to try to get information to the Department early enough so that they can actually use it in their application process. We will still do an in-between meeting like we have done in the past when we have the actual draft from them to comment on. You will all get the information.

This is not replacing that. This is just an attempt to do a better job communicating early on so that your valuable feedback can be included in the application.

Steve thanked Jenny for the clarification.

Jenny added that after this agenda item we have Naomi who is going to talk a little bit more about our responsibilities to prepare us for the questions we are going to respond to in the afternoon.

Steve stated that, I understand some of our responsibilities in a general sense. What I don't understand is what this whole application plays with the counties. That is the missing piece for me.

I hear that the Department recognizes that the counties make a lot of decisions. What effect does this broader effort we are doing have on the counties? I just don't understand.

Jenny noted that this is what these conversations are for – to really learn more about what kind of input the Planning Council has and how we can put that in the application. We do not put information in for each specific county. That is something that California will actually review.

Our approach is to make sure that, based on the feedback that we receive, we package that up and we provide the general what we are trying to do as a state to SAMHSA. And then, as the Planning Council knows, what that application is and talking to counties and people, the members here – the counties are also able to get that information so altogether we are making that decision of what those applications look like in the county.

This will depend on the interactions that happen with the counties and their knowledge of what is in the application. It is just a collaborative effort of making sure the counties are doing what they want for what is really needed in the county.

The majority of the money does go to the counties but based on the feedback, we do create a lot of statewide contracts with the remaining funds. The Council has been telling us that this is really needed in the community as well.

Susan stated that years ago the Council was involved in evaluating some of the programs that were in the local counties. We felt that was a very valuable way for us to get information about what SAMHSA was funding, what the state was interested in, how the state was funding it, and that option has gone away.

I would be interested in understanding how you are evaluating those local programs and whether we can, once again, have a way of participating in that evaluation.

Waheeda responded and stated that we have been going through a lot of reorganizations. Our understanding is that historically, yes, the Council has been involved.

We have seen that due to the funds that we have received over the years, what the Department did was they started having a contract with UCLA to do this independent peer review. This was to take a little bit of a load off of the Department.

Our team is currently looking into what are the federal requirements about the DMHC's responsibilities but also the Council's responsibilities to be a part of this peer review. As we do the research, we will get back to Naomie and Jenny.

Deborah stated that we have early psychosis intervention programs in the state. We don't have a robust network of intervention psychosis. We had a block grant requirement for having five percent having to be spent on first episode programs.

Is there still a five percent requirement of the block grants?

Waheeda said that I cannot remember the specific number. I believe it is at five or ten percent. I would have to check that with our team.

Yes, that requirement is there. U.C. Davis does our first episode psychosis T.A. and are working on a specific model to make sure that everyone meets that FEP requirement.

We are in the process of seeing what this FEP model will look like. There is a distinction between early episodes psychosis and FEP, I know there is a distinction and there is a federal requirement to meet the FEP requirement.

Deborah stated that it was a discriminatory act for the federal government to require FEP funding and not allow for EIP. It was a political act on the part of our authorities at the time.

MHBG Overview CBHPC Responsibilities

Naomi presented the following: I am the SAMHSA liaison for the Planning Council.

The objective was to provide historical knowledge on the block grants. We wanted to explain how the funding is administered and to discuss what our role is.

States that receive the mental health block grants are required to submit an application and the application must include the state's plan, their evaluation of programs and services, and they need to conduct planning for the upcoming cycle.

Health and Human Services is under the Executive Branch. And within Health and Human Services is where SAMHSA is placed.

Within SAMHSA there are several different offices and centers.

In 2012, with the realignment of community mental health, DHCS assumed the responsibility and oversight of the Mental Health Block Grants and that is where we are today.

SAMHSA grants the block grants, DHCS administers and funds the money to the counties who then give it to direct providers.

The MHBG application includes two distinct parts, a Bi-Annual State Plan and a "mini application." They are released on alternate years. There is also an Annual Implementation Report.

We have been working closely with SAMHSA to try to bridge our relationship with the Department and find ways to make sure that the information that we provide for these components is useful and valuable.

The total amount of the 2022/2023 Fiscal Year Mental Health Block Grant was $107 million. The distribution amounts are listed on this slide.

The two categories of populations to be served are, Children With Serious Emotional Disturbances and Adults With Serious Mental Illness.

This list itemizes things that the block grant monies cannot be used for.

This slide itemizes the Council's role and responsibilities.

These five criteria must be included in the State Mental Health Plan. They include, Comprehensive Community-Based Mental Health Services Systems, Mental Health System Data Epidemiology, Children's Services, Targeted Services to Rural and Homeless Populations and to Older Adults, and Management Systems.

Jessica provided the Anticipated Required Sections for the 2023-2024 Application as listed on this slide.

We are aware of the Council's desire to participate in the MHBG Peer Reviews.

We would like to have your input on the programs you would like to see highlighted in the SAMHSA, MHBG Application.

Public Comment

No public comment was given.

Break

Department of Health Care Services Update

Tyler Sadwith addressed the attendees: There is a lot going on in behavioral health right now and in Medi-Cal in general.

We have 15 million Medi-Cal members and the majority of which are enrolled in managed care plans. We are strengthening the requirements for managed care plans beginning in 2024.

These are some new requirements for all plans going into effect next year:

There is a big focus on reducing disparities and improving equity, strengthening local linkages and cross-system collaboration and work between Medi-Cal managed care plans and their local, third-party partners.

There is a big focus on addressing social drivers of health and improving quality, improving transparency and accountability, and shifting towards value-based purchasing.

Agencies must post information about their subcontractor's activities.

Quality standards must now include minimum performance levels where plans will face monetary and financial sanctions if they don't meet quality performance measures.

There are new plans to become accredited by NCQA, a national health plan accrediting organization.

There is a big focus on population health management including transitional care services, working across social service systems, and ongoing implementation of enhanced care management community supports.

Ultimately, there will be a focus on closed-loop referrals as well. There will also be increased requirements for Memorandums of Understanding (MOU) with key partners who are not strictly a part of the health care system.

There will be a requirement to meet health disparity reduction targets established by the Department.

There are more engagement requirements with Medi-Cal members and with families.

There are also requirements for profits by Medi-Cal managed care plans to be invested in community infrastructure development.

There are specific requirements focused on the children's space about partnering with local education agencies and a big focus on expanding the knowledge and information and utilization of EPSDT benefits.

There is continued focus on improving the performance of the Medi-Cal program with respect to behavioral health including a lot of the CalAim policies that strengthen the interaction between the plans and our county behavioral health delivery system.

There is a requirement for medical loss ratio reporting by contractors. Plans have to spend a certain amount of the premium revenue that they receive on health care services.

There are more changes, and we encourage you to access them on our website.

In 2024, Kaiser will participate for the first time as a Medi-Cal managed care plan, prime contractor. Currently, the plan sort of subcontracts with Kaiser but now Kaiser will enter direct contracts with the state similar to other Medi-Cal managed care plans.

This will happen in 32 counties with an initial focus on those members who are currently enrolled in Kaiser or have been enrolled in this calendar year or have family members enrolled or are a foster care child or youth or a dual eligible.

The new MOU requirements are quite significant. In 2024 the Medi-Cal managed care plans will be required to enter into MOUs with a wide range of key local partners and entities that also provide care and services to Medi-Cal members.

There is a baseline MOU template that the plans will be required to use that delineate minimum requirements for policies and procedures and for organizational structure clarifying roles and responsibilities and a big focus on data sharing.

This is so the plans can coordinate care across systems with these other agencies.

There is a new requirement for every Medi-Cal managed care plan to have a foster care liaison. This is a new dedicated position within each plan to ensure effective cross-system coordination for children who are receiving foster care.

I will now discuss CalAIM and how some of the interventions are working.

These interventions or services include enhanced care management (ECM) as well as community supports.

There are different populations of focus for ECM. The four categories listed show you the enrollment per category from Q1 – Q3 of 2022.

In total, there are about 88,000 members who received ECM services during the first nine months of last year and this is growing.

Community supports are optional for Medi-Cal managed care plans to offer. Every MCP must offer ECM services to members who meet the population of focus eligibility criteria.

Community supports are on an opt-in basis and they are designed to meet social drivers of health like housing tenancy and sustaining services, housing navigation, medically-tailored meals and other services that are not ordinarily covered under Medi-Cal.

During the first nine months of last year you see the utilization numbers showing an uptick of housing tenancy and sustaining services and housing, transition and navigation services speaks to the key role that housing, safe and stable housing, plays in an individual's ability to have good health and good wellness.

The Department has conducted listening sessions across every region of the state and has worked closely with the plans and community-based organizations and consumers and members to hear and receive valuable feedback.

We have heard that there is a desire to standardize eligibility across different Medi-Cal managed care plans. We should streamline and standardize assessments, referrals, and optimization processes.

There is a need to expand the provider network. And there is a need to exchange data better as well.

I will touch on the key CalAIM behavioral health initiative that goes live in two weeks. This is the Behavioral Health Payment Reform.

Currently, our county behavioral health delivery system in Medi-Cal is reimbursed through a cost-based reimbursement system. Reimbursement is limited to the lesser of cost or charges.

What this means is that if providers are able to develop an innovative way to deliver care or to find efficiencies that result in savings, they are disincentivized to do so because they would be paid less for doing that type of better work.

For all of us to have better data about what types of services are provided, Medi-Cal Behavioral Health is moving away from a cost-based reimbursement model to a fee-for-service payment model.

This goes live on July 1. There are three components to this specifically. They are: Reimbursement Structure, 2. Financing Mechanism and 3. Providing Billing.

The Department has been working extremely closely with counties on making these changes and making all of this information available to our providers and to all of our partners.

There is a comprehensive repository of learning opportunities, training materials, technical assistance tools that provide information to counties, to providers and to others that provide services.

There is a fee schedule, and this is a fee schedule of rates that are paid from the state to the county. After that, the county then will enter into negotiations with every single contracted provider to develop and enter into negotiated, provider-specific rates.

The Department sets county-level rates that are then used as a basis for negotiated rates.

CMS requires that Medi-Cal payment rates be economic and efficient. We have to justify and show how we develop rates.

There are things that will not change, including the responsibility and, more importantly, the opportunity and the possibility and the flexibility where providers negotiate and develop specific arrangements with counties.

The Department does not enter into provider/county negotiations. We simply set rates at the county level.

Behavioral health payment reform does not change what is covered under Medi-Cal or how individuals are able to access covered services.

The Department has done readiness testing working with counties to submit shadow claiming and tests of their systems and updated billing information.

There is a wealth of information available on our website. Feel free to dig in and roll up your sleeves and email us if you have any questions.

We plan to submit our BH-Connect waiver to CMS later this year which will expand community-based behavioral health care coverage and key resources for members with behavioral health needs in Medi-Cal.

We used to call it the California Behavioral Health Community-based Continuum Demonstration. That old name is very accurate in describing the goals of the waiver.

While the name is new, the vision, the goals and the approach for the waiver remain the same.

We know how important it is to have these key resources available in our community for everyone who needs them.

We had specific recommendations around expanding the crisis care continuum which is underway. Targeted populations included children and youth with serious emotional disturbances or substance use disorder including children and youth who have involvement with child welfare and juvenile justice.

There was also a key focus on ensuring that evidence-based practices and community-defined practices are available and standardized across the state where appropriate.

This waiver expands the full continuum of care and it also takes advantage of federal flexibility to cover short-term, in-patient and residential care in facilities that have more than 16 beds.

This slide shows how all the components of the waiver fit into the full continuum of care.

We did post a concept paper. We received excellent feedback from the Planning Council. We received over 200 comments in general.

Based on the feedback we received we made three key updates.

- We are pursuing a new request to draw down significant federal funding to expand the behavioral health workforce.
- We have revised the timeline for counties that want to opt in and take advantage of the IMD flexibility.
- We are now proposing to cover the Clubhouse Model as an optional service.

We do plan to post the Draft Waiver Application for public comment next month.

There will be a formal public comment period and we will take the feedback and incorporate it into the Final Waiver Application that we will submit to CMS in the fall.

Questions

Catherine stated that it appears to me that when you did the initial presentation about the entire Medi-Cal is that most of the people that we are interested in are all eligible for enhanced care management if I heard you correctly.

Tyler mentioned that there is a big landing page on our website for enhanced care management. There are seven specific populations of focus.

Generally speaking, Californians with Medi-Cal who do have significant behavioral health conditions – it is likely that there is an ECM pathway.

It is the severely mentally ill who have higher needs than just the average.

Vera stated that I am very excited about the employment development and looking at the Clubhouse Model.

I would ask you to look at public/private partnerships. REDF, Robert Enterprise Development Fund which is based in San Francisco and they have partnered on over 280 projects in 38 states plus the District to Columbia.

They are in partnership with LA County, and they are into social enterprises. This would give potential clients different options.

DHCS has the Behavioral Health Stakeholder Committee and you also have your Primary Stakeholder Committee. I would request that you consider the fact that now we have the California Association of Care Professionals and they are working towards becoming independent.

Our membership is made up of peer specialists, certified and not-certified, including family members and people who have specialties in justice involvement, crisis care, and we are interested in the peer workforce.

If you could consider putting us on that Stakeholder Committee, I would really appreciate it because I noticed that there are other professional associations on that Committee as well.

Tyler was thanked for his presentation and he acknowledged such.

MHBG Application Input/Roundtable

Jenny gave instructions regarding this agenda item and the participants followed the directions given.

Closing Remarks

Chair Starkey thanked everyone for their participation. We will see you in San Francisco.

Adjourn

There being no further business Chair Starkey adjourned the meeting at 11:57 a.m.

TAB J

California Behavioral Health Planning Council
General Session

Thursday, October 19, 2023

Agenda Item: Council Priorities Discussion

Enclosures: CBHPC Priorities Crosswalk

January 2021 Council Member Priorities Summary

Welfare & Institutions Codes related to the CBHPC

Background/Description:

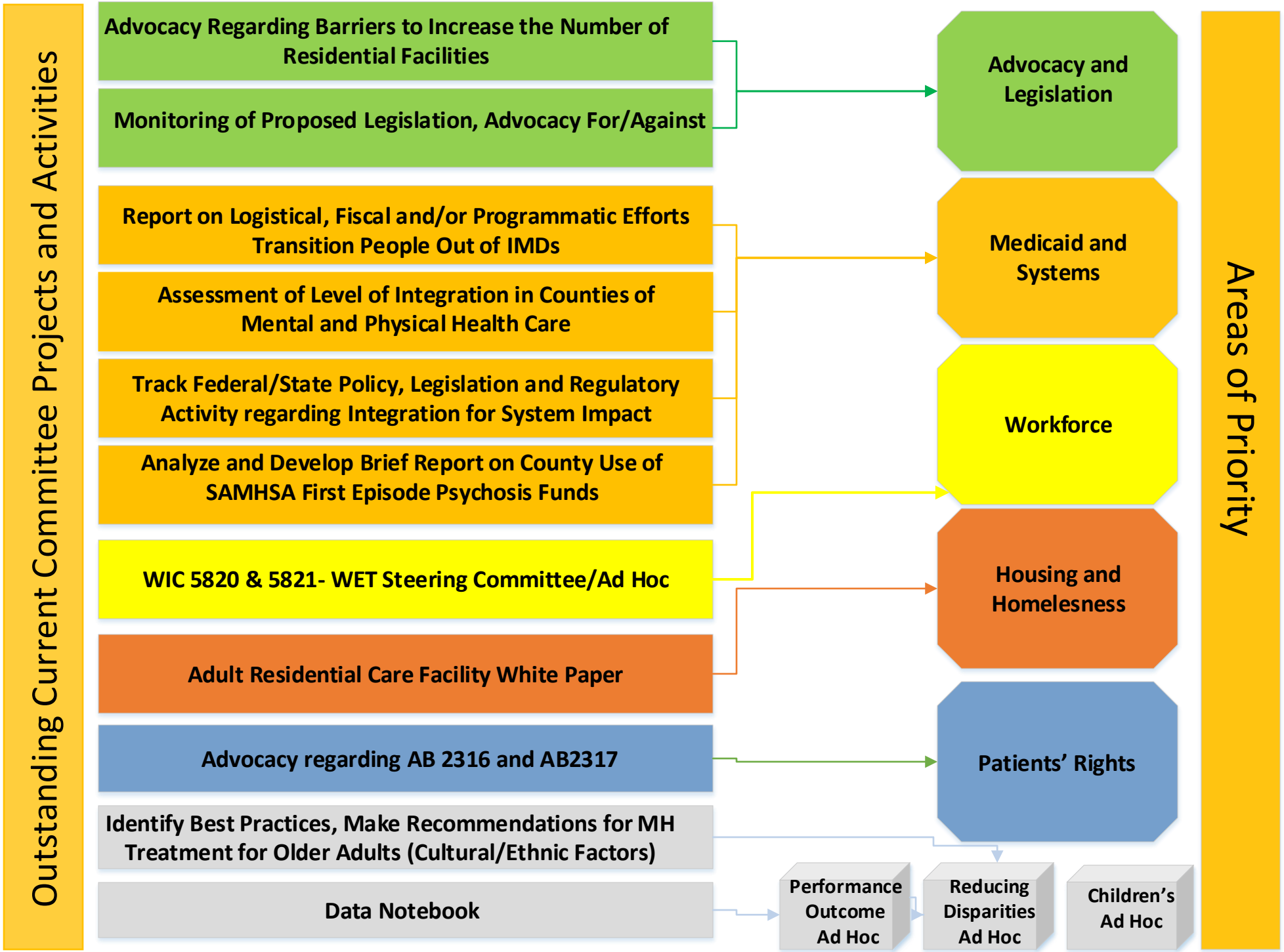
In 2018 the Council evaluated committee projects and identified key priority areas of focus. Council committees were restructured around these priority areas to represent the committees we currently have, which include Performance Outcomes, Patients Rights', Legislation and Public Policy (formerly Legislation), Workforce and Employment, Housing and Homelessness, and Systems and Medicaid. Ad-hoc work groups at that time included Reducing Disparities and Children & Youth.

During the January 2021 General Session, Council members shared their priorities for the CBHPC committees and/or for themselves. In April 2021 the Executive Committee reviewed and discussed the summary of priorities to identify areas of focus for the Council. These themes were worked into committee work and General Session agenda items.

The Executive Committee continues to regularly review and discuss the Council's roles and mandates to ensure committee activities align with the mission, vision, and guiding principles of the Council.

The purpose of this agenda item is to review Council priorities in order to update council documents and identify areas of focus for 2024.

California Behavioral Health Planning Council Proposed Priorities Crosswalk



Executive Summary

Children/Youth

Go upstream to ensure children, TAY, and families have access to and receive mental health services when and where they need them. Ensure mental health education is provided in schools from kindergarten up and school staff are equipped to identify and refer. That the transition of youth into the adult system is smooth and doesn't result in falling through the cracks.

Housing/Homelessness

Two main priorities identified are 1) affordable housing for older adults and 2) address the loss of licensed residential facilities and the financial issues preventing more facilities from serving individuals with serious mental illness.

Council Work

Strengthening the Council's collaboration and relationships with DHCS and SAMHSA ranked highest. Next was ensuring Council work in the committees integrate the Equity Statement into practice, address disparities, complete quality projects and goals that continue to raise the Council's visibility and voice.

Direct Service Issues

The CalAIM implementation provides us a great opportunity to decrease documentation and paperwork requirements, improve reimbursement processes, create standardized assessment tools and quality measures and to increase access and effectiveness in services delivered. But before that happens, the system will need to transition into post-pandemic environment and support successful service delivery strategies while phasing out those that created barriers for persons needing direct services.

Peers

Year 2021 will be the year of the Peer. The implementation of the Peer Support Specialist Certification Program must be done with Peers, for Peers, and by Peers. The training and validity of the process must be supported by peers as well as having peers in the workplace as managers, supervisors and including workplace preparation that promotes peer career ladders/lattices all the way up to leadership.

Workforce

Need to keep the workforce engaged and growing or we cannot deliver any of the things that we would like to do. By having the CSU and UC systems add mental health to curriculum, can create potential pipeline for a diverse workforce. And also think about career ladders/lattices and attracting people that have specialties, eg, LGBTQAI, and older adults, etc.

Misc

Other very important aspects of the BH system were mentioned including suicide prevention, crisis response lines, patients' rights, stigma and discrimination, formerly incarcerated individuals and structural racism leading to racial disparities.

Council Member Priorities in Key Areas

Children/Youth

(3) the health and welfare of children

enhancing child abuse mental health services

making sure youth and children are getting the services they need from the state level on down.

have consumers support around children specifically related to transitional needs.

(3) focus on mental health education in schools starting in kindergarten, the majority of the students are asking for help. We need to start health education of the youngest ages all through high school

transfer from County children services to adult services they fall through the cracks, especially right now, I don't know how to fix it or how to face, address it the right way

recommending a mental health training specific component to their curriculum specifically for children so we are trying to bring the training into the schools sometimes it is optional mandatory but perhaps in a couple of years this will be more integrated as a norm of the system. If we get started quickly.

to enhance youth services and services for young people in schools,

go upstream, focus on children and tay

with families in the COVID situation, creating friction and a lot of stress, I have a child with depression that dropped out of university

Wish we could have a new appointment from the Department of Education with an emphasis on children and transitioning, particularly on health, and transitioning children into adult services.

Housing/Homelessness

really be involved in a method of resolving the structural problems of adult residential care homes.

my goal for housing. In particular older adult housing, there is a tremendous shortage of older adult housing

(3) funding for ARFs

I am also interested in the older population across the state which is hardly mentioned in our committee meetings, and I know that locally a lot of our seniors and folks that are receiving mental health services are sometimes losing their housing due to rents being raised and things like that, they become one of the homeless at age 65 or 67 or 68. So those populations of the elders are facing these economic situations are very important,

two is identify the crises in the residential facilities

to target the most immediate concern and see if we can make some changes whether it is making contact through community members or whatever legislators, to get immediate resources to adult residential facilities

Misc

Continuum of care for ethnic communities, *Expand engagement and outreach*

(2) Suicide prevention and 988 effort

Monitor Patients' Rights, don't diminish during pandemic

I see a lot of different endeavors happening across the state that I believe separates that community that's reentering the broader community from incarceration, there are moves we can make such as having peer support specialist role for that community, and in one particular County those community health workers have been a great asset, and I see that being a wonderful model to tap into if that was rolled out efficiently at all the other counties

outing structural disparity in the system

there is a lack of awareness of mental health in general. So we can increase that awareness and actually have mental health as a component in the rollout we will create some challenges as far as the stigma attached

Council Work

how to get our voice out to where it needs to be heard

We also have integrating council equity statements. Which I hope everyone will be working on, we did mention it as a council when we began the meeting today

collaborating closer with SAMSHA with the federal rules when it be. See what the federal rules want to be

Strengthen Council and DHCS

the inequity dashboard that the council track progress so we can have input across the board

work on strengthening the connection between the Council and the DHCS

support committee work plan goals

that the committee will have a dual role to look at continuing the efforts around individuals seeking employment and making sure that individuals seeking employment have the best opportunity possible and they continue to work on the peer issues in the training issues for staff

I really want to work to see that the Council continues to function effectively as it has, and that our profile is increased, the people know the hard work that the committees are doing and some of the outcomes that you have arrived at

that our outcome committee addresses racial and other inequities."

I really want to get to know the councilmembers. I'm a new member I know many of the council members from earlier parts of my work, but really want to get to know the different work and the different perspectives that people have

Direct Service Issues

how we are going to transition back in person to mental health services and have this discussion about is it going to be a hybrid, are we to offer both, is to be clinicians choice? Figure out how to best support a transition back to services,

the extent of consumer care throughout the community needs to be addressed meaning that initial contact really begins at the community level so that we understand this and don't limit it to the system itself but to know that in the scope of serving the communities that there is outreach and referral to the system, to look at new and innovative ways of doing that to engage the community.

Decrease documentation and increase services

assessment tools as being invaluable from a patient standpoint and expediting services to the clients

I am glad to see that we have standardized tools being developed and that the quality measures across the counties are being standardized.

big moment for CalAIM, for the first time to really reduce paperwork burdens, and also improve the quality of service to people we serve, these things go together. This is like a decade's long project, but this is a moment we can really influence and impact that.

(4) CalAIM implementation

Peers

(5) pursuing the success of the peer specialist rollout, and exploring barriers

Peer support, I think there is a role in our clinics, in our programs that we need more of a presence, how are we to get more people on board in a short period of time

I also want to speak out for the peer certification and be clear that the training is relevant in that it is provided by peers to peers, and the validity of the process is supported at the peer level as well, and we talk about having peers in the workplace that we appear as managers, managers that are not related to peers, that we have a structure that increases peer management and peer leadership and also peer employees.

(2) Peers as supervisors and workplace preparation

Workforce

to keep nurses engaged in the workforce in a healthy and secure, in the right way -- that is part of reaching the overall goal of the Council because without the workforce we cannot deliver any of the things that we would like to do

have CSU and UC add mental health to curriculum

we need career ladders. I am thinking right now upward career ladders but also lateral. Because the people that have specialties, eg, LGBTQAI, and not every care specialist is able to connect with all those groups.

WELFARE AND INSTITUTIONS CODE – WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5961.5]

PART 2. THE BRONZAN-MCCORQUODALE ACT [5600 - 5772]

5664.

In consultation with the County Behavioral Health Directors Association of California, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Behavioral Health Planning Council, and the California Health and Human Services Agency, county behavioral health systems shall provide reports and data to meet the information needs of the state, as necessary.

5750.

The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the County Behavioral Health Directors Association of California and the California Behavioral Health Planning Council.

(Amended by Stats. 2017, Ch. 511, Sec. 10. (AB 1688) Effective January 1, 2018.)

5772.

The California Behavioral Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health and substance use disorder programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health and substance use disorder systems, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health and substance use disorder services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health and substance use disorder programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on the performance of programs annually to the Legislature, the State Department of Health Care Services, and the local boards, and to post those findings and recommendations annually on its Internet Web site.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance in delivering mental health services is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health and substance use disorder issues and the policies and priorities that this state should be pursuing in developing its mental health and substance use disorder health systems.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health and substance use disorder services.

(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.

(i) In conjunction with other statewide and local mental health and substance use disorder organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.

(j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.

(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health and substance use disorder systems, and to report its findings to the Legislature, the State

Department of Health Care Services, local programs, and local boards, as appropriate.

(l) To suggest rules, regulations, and standards for the administration of this division.

(m) When requested, to mediate disputes between counties and the state arising under this part.

(n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.

(o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Behavioral Health Planning Council, subject to the approval of the Department of Finance.

(p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Behavioral Health Planning Council, subject to the approval of the Department of Finance.

(q) Notwithstanding subdivisions (a), (c), (e), (g), and (i), in the event that the State Department of Health Care Services determines that California's Community Mental Health Services Block Grant funding pursuant to Section 300x et seq. of Title 42 of the United States Code is in jeopardy due to the California Behavioral Health Planning Council's noncompliance with the requirements specified in Public Law 102-321, the State Department of Health Care Services shall notify and consult with the California Behavioral Health Planning Council, and the California Behavioral Health Planning Council shall make the changes necessary to comply with federal law.

(r) The Legislature finds and declares that the amendments made to subdivisions (a), (b), (c), (e), (g), (i), and (k) by the act that added this subdivision are consistent with Section 5892.

(Amended by Stats. 2017, Ch. 511, Sec. 15. (AB 1688) Effective January 1, 2018.)

PART 3.1. HUMAN RESOURCES, EDUCATION, AND TRAINING PROGRAMS [5820 - 5822]

5820.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Behavioral Health Planning Council, shall identify the total statewide needs for each professional and other

occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(e) Each five-year plan shall be reviewed and approved by the California Behavioral Health Planning Council.

(Amended by Stats. 2017, Ch. 511, Sec. 17. (AB 1688) Effective January 1, 2018. Note: This section was added on Nov. 2, 2004, by initiative Prop. 63.)

5821.

(a) The California Behavioral Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Behavioral Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

(Amended by Stats. 2017, Ch. 511, Sec. 18. (AB 1688) Effective January 1, 2018. Note: This section was added on Nov. 2, 2004, by initiative Prop. 63.)

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98]

CHAPTER 7. Basic Health Care [14000 - 14199.76]

14045.17.

The department shall solicit stakeholder input that may include input from the Office of Statewide Health Planning and Development, peer support and family organizations, mental health services and substance use disorder treatment providers and organizations, the County Behavioral Health Directors Association of California, and the California Behavioral Health Planning Council in implementing this article. Consultation shall include regular stakeholder meetings. The department may additionally conduct technical workgroups upon the request of stakeholders.

(Added by Stats. 2020, Ch. 150, Sec. 2. (SB 803) Effective January 1, 2021.)

TAB K

California Behavioral Health Planning Council
General Session

Friday, October 20, 2023

Agenda Item: Peer Empowerment Partnership (PEP) Grant Update

Enclosures: None

Background/Description:

The Peer Empowerment Partnership (PEP) is a CAMHPRO program that is funded by the Department of Health Care Services (DHCS) and administered by Advocates for Human Potential (AHP) as part of the Behavioral Health Workforce Development.

Peer Empowerment Partnership (PEP) was created by a Department of Health Care Services (DHCS) grant to CAMHPRO to assist in implementing SB803: Peer Support Specialist Certification Act. CAMHPRO has extended the PEP program until the end of 2023.

Following extensive work to promote the passing of a peer support certification bill, CAMHPRO created PEP, a statewide effort to support the rollout of SB803, honoring and amplifying the peer perspective while embracing and uplifting peer support as a mental health and substance use treatment specialty profession.

PEP ensures that the peer perspective is part of implementing peer certification. Peers, or people with lived experience with mental health, in dialogue with policy leaders, shape the expansion of the peer support specialist workforce. PEP's regional trainers provide peer perspective to the Department of Health Care Services (DHCS), CalMHSA, county-level administration, and individuals regarding the process of peer certification as it develops.

Additional Resources:

- What is PEP Video
- Department of Health Care Services Peer Support Services Website

TAB L

California Behavioral Health Planning Council
General Session

Friday, October 20, 2023

Agenda Item: Bridge to Treatment

Enclosures: None

Background/Description:

Andrew is the Chief of Addiction Medicine at Alameda Health System and attends in the emergency department, in a low-barrier addiction medicine “Bridge Clinic” and on the Addiction Medicine consult service at Highland General Hospital in Oakland. Dr Herring is a founder of the Mariposa Wellness Center in Watsonville, CA, The Street Level Health Project in Oakland, CA, and CA Bridge–the largest effort in the US aiming to integrate emergency department crisis care into a comprehensive continuum of care for substance use disorders. His current research with the National Institute of Drug Abuse and the Patient Centered Outcomes Research Institute focuses on opioid and methamphetamine use disorders, co-occurring mental health disorders, and optimization of transitions of care for high-risk individuals. Andrew is an assistant clinical professor at the University of California, San Francisco. He conducted health policy research as a Fulbright Scholar in Central America. He is board-certified in emergency medicine, addiction medicine, and pain medicine. Andrew graduated from Harvard Medical School and completed residency in emergency medicine at Highland General Hospital.

Chief of Addiction Medicine, Alameda Health System
Assistant Clinical Prof. University of California, San Francisco