Behavioral Health Transformation

Transformational Change in Behavioral Health: Early Intervention and Full Service Partnerships

Mental Health Services Oversight and Accountability Commission

Marlies Perez, BHT Project Executive
Department of Health Care Services

October 24, 2024

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MENTAL HEALTH FOR ALL

Housekeeping

- You may type your comments into the chat box throughout the presentation.
- Once we reach the discussion portion of our meeting, please raise your hand to speak and we will go in the order of raised hands.
- This is our opportunity to hear from you! We would appreciate your open and honest feedback during this discussion.

DHCS

Meeting Agenda

Early Intervention

- Overview
- Early Intervention Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices
- Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)

Full-Service Partnership (FSP)

- Overview
- Levels of Care, Assertive Community Treatment (ACT)/Forensic ACT (FACT), Individual Placement and Support (IPS) Model of Supported Employment, High Fidelity Wraparound (HFW)

Q&A

Resources

DHCS

Behavioral Health Transformation Milestones

Below are high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Started Spring 2024

Stakeholder Engagement

Stakeholder engagement including, **public listening sessions,** will be utilized through all milestones to inform policy creation.

Started Summer 2024

Bond BHCIP: Round 1 Launch Ready

Requests for Applications (RFA) for up to $3.3 billion in funding leveraging BHCIP.

Beginning Late 2024

Policy Manual and Integrated Plan Guidance

Policy Manual chapters and Integrated Plan guidance will be **released for public comment in phases**.

Summer 2026

Integrated Plan

New integrated plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle)

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

Early Intervention

DHCS

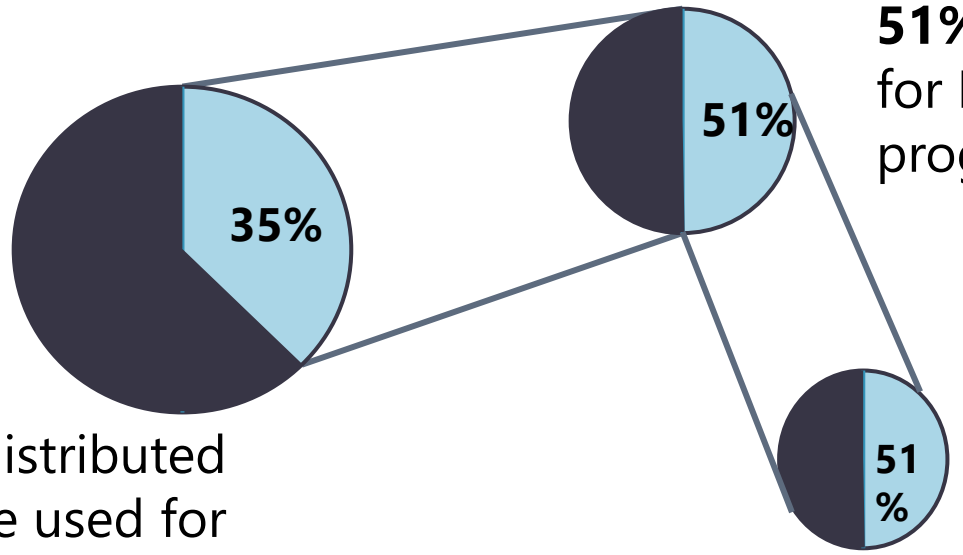
Today's Objectives

1	Review Early Intervention Funding Requirements
2	Understand Required Early Intervention Components
3	Overview of Biennial List

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

Early Intervention Legislative Funding Requirements



51% of BHSS funds must be used for **Early Intervention** services and programs

35% of the funds distributed to counties must be used for **Behavioral Health Services and Supports (BHSS)**

51% of Early Intervention funds must be used for **children and youth 25 years of age or younger**

Counties have the flexibility to transfer 7% of funds from BHSS into another funding category (FSP or Housing Interventions) for a maximum total shift of 14% into a single funding category.

DHCS

Behavioral Health Services and Supports

Per Welfare and Institutions Code (WIC) Section § 5892, Behavioral Health Services and Supports (BHSS) include the components below:

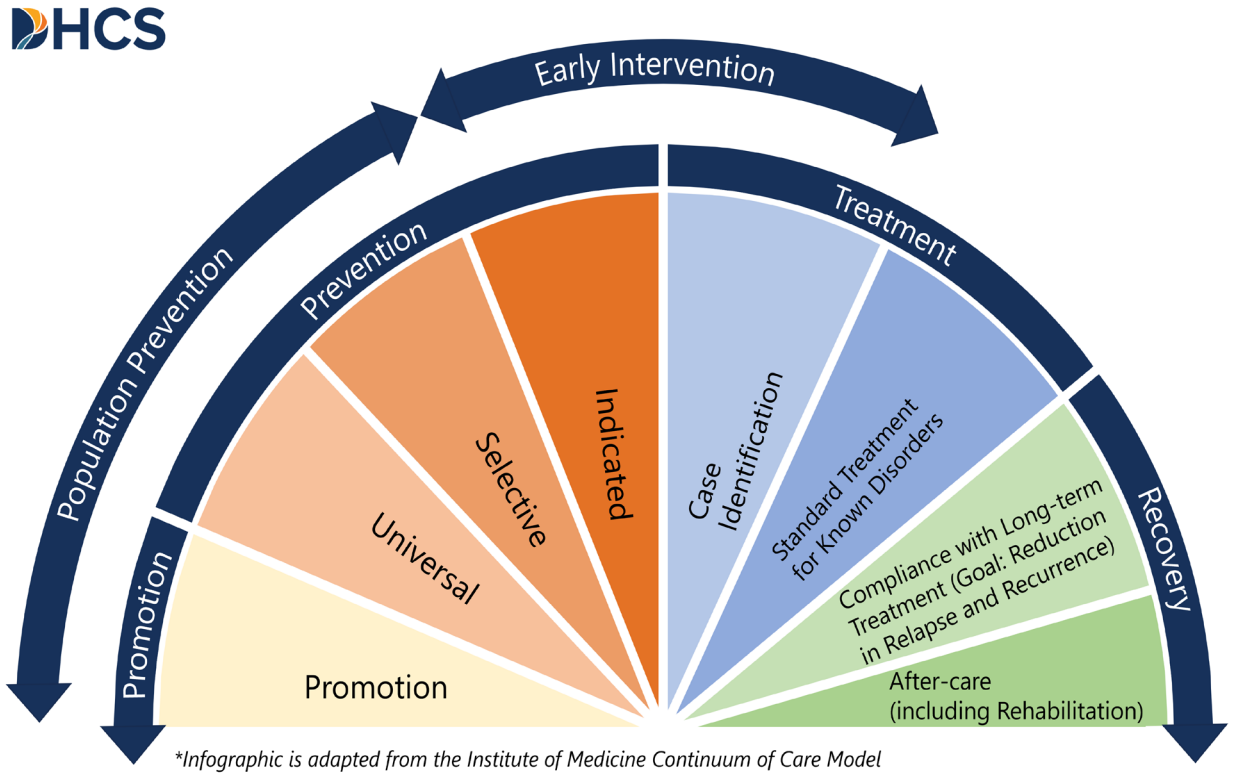
- ✓ **Early Intervention**
- ✓ Children's, Adult, and Older Adult Systems of Care
- ✓ Outreach and Engagement
- ✓ Workforce, Education, and Training
- ✓ Capital Facilities and Technological Needs
- ✓ Innovative behavioral health pilots and projects

Today's presentation will focus on Early Intervention.

DHCS

Defining Early Intervention, Target Populations

- WIC 5840(a)(1) defines Early intervention as those designed to prevent mental illnesses and substance use disorders from becoming severe and disabling.
- Early intervention would include indicated prevention case identification and early treatment and supports.
- Early intervention programs for children and youth are required to be designed to meet their social, emotional, developmental and behavioral needs (WIC § 5840(d)) along the continuum of care.



Infographic is adapted from the Institute of Medicine Continuum of Care Model

Early Intervention Funds for Children & Youth

The Behavioral Health Services Act strengthens prioritization of resources to serve children and youth with its dedicated allocation of Early Intervention funds.

51% of Early Intervention funds must be used for **children and youth 25 years of age or younger**

Early Intervention funds must **prioritize childhood trauma** through addressing the root causes of Adverse Childhood Experiences or other social determinants of health that contribute to early origins of mental health and substance use disorder, including strategies focused on:

- Youth experiencing homelessness
- Justice-involved youth
- Child welfare-involved youth with a history of trauma
- Other populations at risk of developing serious emotional disturbance or substance use disorders
- Children and youth in populations with identified disparities in behavioral health outcomes (WIC Sections 5840 and 5892)

MHSA to BHSA: BHSS Early Intervention Aims

SB 326 requires that Early Intervention programs focus on reducing the likelihood of certain adverse outcomes (WIC § 5840(d)).

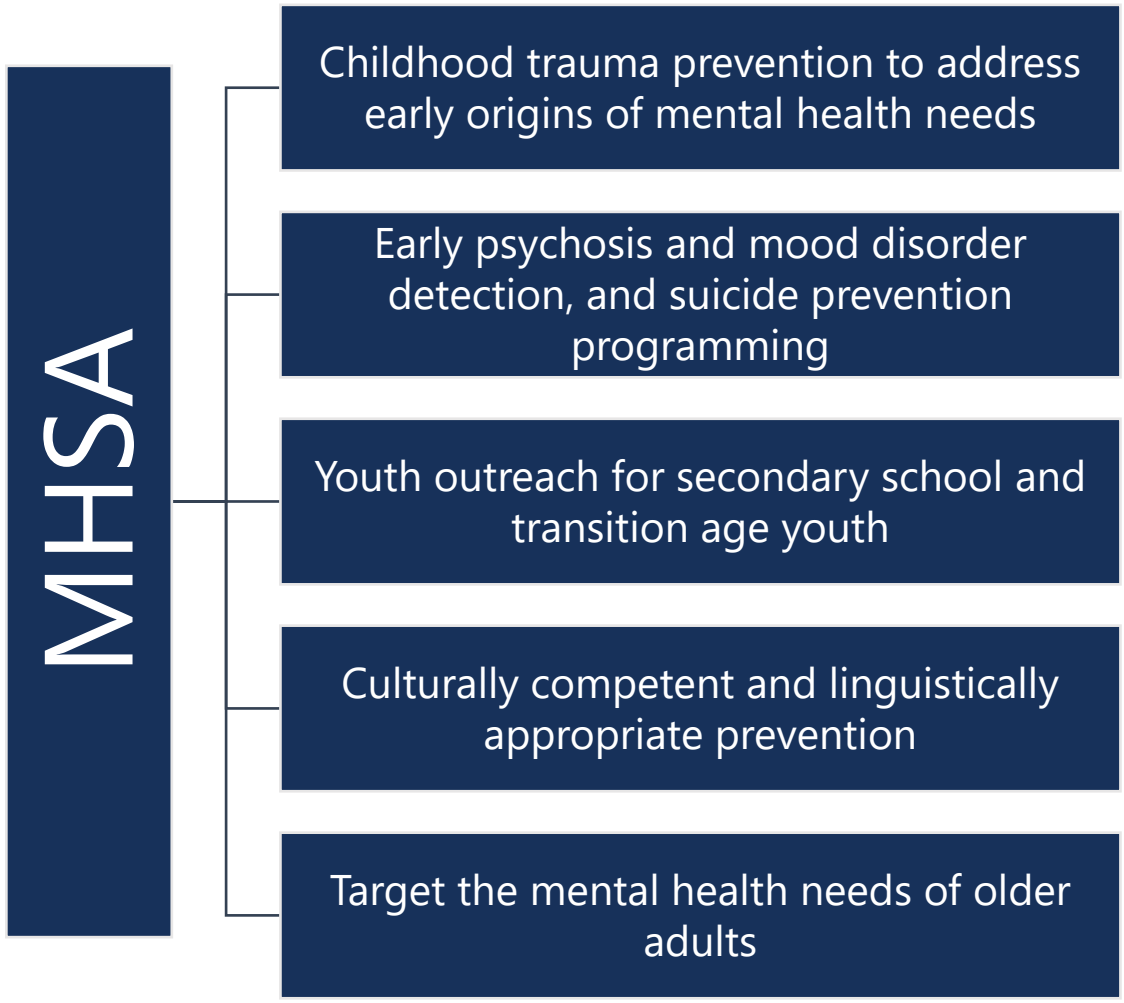
Suicide and **self harm****	Incarceration	School **suspension, expulsion, referral to an alternative or community school****, or failure to complete*	Unemployment	Prolonged suffering
Homelessness	**Overdose****	Removal of children from homes	**Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood****	

****Blue** represents additional goals for counties under the Behavioral Health Services Act

* Including early childhood 0 to 5 years of age, inclusive, TK-12, and higher education

DHCS

MHSA to Behavioral Health Services Act: Priorities for Use of Early Intervention Funds



Behavioral Health Services Act: Added Additional Priorities for County Early Intervention Programs:

- Target early childhood 0-5 years of age, including infant and childhood mental health consultation
- Advance equity and reduce disparities
- Programs that include community-defined evidence-based practices and mental health and substance use disorder treatment services similar to programs that have been effective and successful in the past
- Address the needs of individuals at high risk of crisis

Counties may add priorities for the use of their early intervention funds based on their community planning process.

DHCS

BHSA Early Intervention Program Components

BHSA requires that county Early Intervention programs be "designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health." WIC § 5840(a)(1)

BHSA requires that county Early Intervention programs include:

- Outreach
- Access and Linkage to Care
- Mental Health and Substance Use Disorder Treatment Services and Supports

The Early Intervention services provided should fall into one of these component categories.
*DHCS may include additional components (WIC § 5840(b)(4)).

DHCS

13

Outreach under Early Intervention

"**Outreach** to families, employers, primary care health care providers, behavioral health urgent care, hospitals, inclusive of emergency departments, education, including early care and learning, TK-12, and higher education, and others to recognize the early signs of potentially severe and disabling mental health illnesses and substance use disorders." WIC Section 5840(b)(1)

Outreach that may be funded under Early Intervention

- Outreach must be directed **toward priority populations[1], including older adults[2] and youth[3],** and outreach cannot be directed at an entire population.
- Outreach must have the goal of **identifying individuals** for **access and linkage to services and treatment and supports.**
- Outreach **must be able to connect individuals directly** to access and linkage programs or to mental health and substance use disorder treatment services and supports, should an individual wish to be connected to services.

1. WIC Section 5892(d) 2. WIC Section 5840.6(g) 3.WIC Section 5840.6(e)

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Access and Linkage to Care

Early Intervention programs **must contain a component that focuses on access and linkage to medically necessary care** provided by county behavioral health programs as early in the onset of these conditions as practicable.

- Access and linkage to care includes, but is not limited to:
  - Scaling of and referral to:
    - Early Psychosis Intervention (EPI) Plus Program
    - Coordinated Specialty Care
    - Other similar EBPs and CDEPs for early psychosis and mood disorder detection and intervention programs
  - Activities with a primary focus on screening, assessment, referral
  - Telephone help lines
  - Mobile response

DHCS

Mental Health and Substance Use Disorder Treatment Services and Supports

- This component includes mental health and substance use disorder treatment services and supports **that are effective in preventing mental health illnesses and substance use disorders from becoming severe**, and that have been successful in reducing the duration of untreated serious mental health illnesses and substance use disorders and assisting people in quickly regaining productive lives.
- This component must include services that are demonstrated t**o be effective at meeting the cultural and linguistic needs of diverse communities**.
- May include **services to address first episode psychosis and services that prevent, respond, or treat** a behavioral health crisis or activities that decrease the impacts of suicide.

DHCS

Stigma and Discrimination Reduction

Required Programs within the MHSA PEI Component	Required Components for Behavioral Health Services Act Early Intervention Program		
	Outreach to recognize early signs of severe MH or SUDs	Access and linkage to care provided by county BH	MH & SUD treatment services/EBPs & CDEPs for Early Intervention
Prevention			
Early intervention		X	X
Outreach to recognize early signs of severe MH	X		
Access and linkage to treatment		X	
Stigma and discrimination reduction			

- **Stigma and Discrimination Reduction programs align with population-based prevention activities, which will be funded by other funding sources (including SAMHSA Block Grants, CDPH Behavioral Health Services Act funding, other prevention dollars).**
- CDPH will provide guidance on the Behavioral Health Services Act population-based prevention funding. DHCS is working collaboratively with CDPH on the guidance.
- Stigma and discrimination reduction activities aim to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness or seeking mental health services.

DHCS

Early Intervention Evidence Based Practices and Community-Defined Evidence Practices Biennial List

Biennial List Purpose

DHCS will develop a non-exhaustive list of Early Intervention EBPs and CDEPs biennially, in consultation with the BHSOAC, counties, and stakeholders.

DHCS proposes that the biennial EBP and CDEP list will be a reference tool for counties to determine which practices to implement locally.

This non-exhaustive list will include suggested EBPs and/or CDEPs that a county may implement.

If a county is demonstrating gaps in services or is struggling to meet performance measures, DHCS may require a county to implement a particular EBP or CDEP from the biennial list.[1]

1. WIC § 5840 (c)(5)

Sources for Evidence-Based and Community-Defined Evidence Practices

DHCS will leverage the following sources to identify EBPs and CDEPs:

- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Medicaid Section 1115 Demonstration
- The Children and Youth Behavioral Health Initiative (CYBHI)
- Family First Prevention Services Act (FFPSA)
- Early intervention EBP's identified by the Prevention and Youth Branch (ex: UCLA, National Registry of Evidence-based Programs and Practices, Blueprints Programs, Athena Forum, programs implemented through SUBG)
- Community-Defined Evidence Practices identified through the California Reducing Disparities Project (CRDP)
- Evidence-Based Practices Resource Center developed by the Substance Abuse and Mental Health Services Administration
- The Cognitive-Behavioral Interventions for Substance Use (CBI-SU) curriculum designed by the University of Cincinnati
- California Evidence-Based Clearinghouse for Child Welfare (CEBC)

DHCS

Considerations for Inclusion in Biennial EBP and CDEP List

EBPs: Levels of evidence (Well-Supported, Supported, Promising, Emerging).

CDEPs: Strong level of efficacy within specific communities based on their perceived positive outcomes.

Cultural evidence.

Populations served.

Risk and protective factors.

Program type (Universal, Selective, Indicated, Tiered).

DHCS

Full-Service Partnership (FSP)

Today's Objectives

1	Understand Full-Service Partnership (FSP) core components
2	Discuss FSP levels of care design

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

FSP Overview

Behavioral Health Services Act FSP Funding Requirements

» 35% of the funds distributed to counties **must be used for Full-Service Partnership (FSP) Programs**

» Per WIC § 5887(a)(2), counties with a population of less than 200,000 may request an exemption from certain components of the required 35% allocation of Behavioral Health Services Act funds for Full-Service Partnership (*Note: exemption process under development*)

» Counties have the flexibility to move 7% of funds to/from Full-Service Partnerships into another category (Housing Interventions or Behavioral Health Services Supports) for a maximum total shift of 14%.

SB326 on FSP Programs

**Orange: Focus of today's presentation.

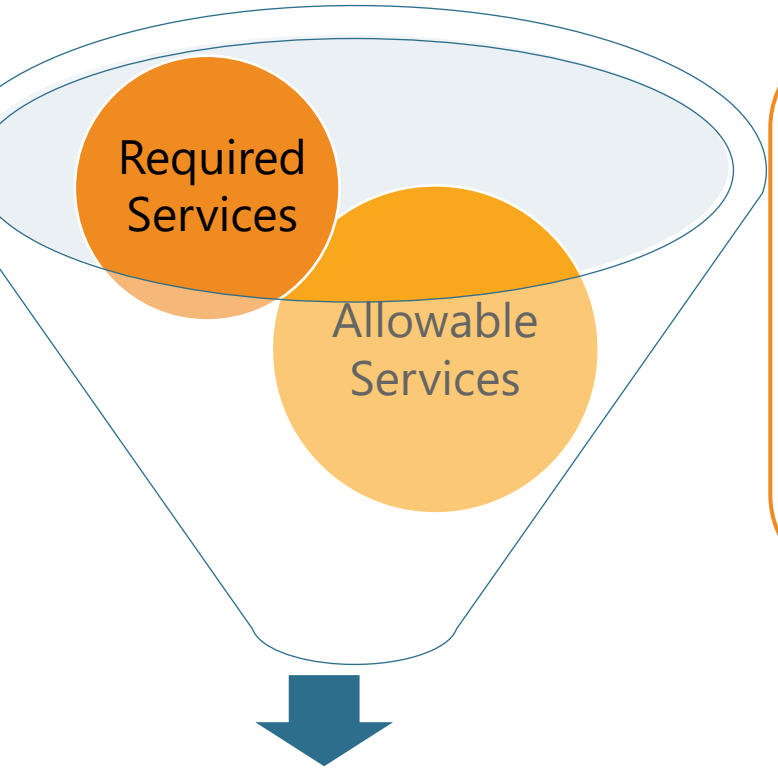
Per WIC § 5887, each county shall administer a full-service partnership program that includes the following services:

(a)(1) **Mental health services, supportive services, and substance use disorder treatment services.**
(2) **Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound****, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services.
(3) **Assertive field-based initiation for substance use disorder treatment services****, including the provision of medications for addiction treatment, as specified by the State Department of Health Care Services.
(4) **Outpatient behavioral health services**, either clinic or field based, necessary for the ongoing evaluation and stabilization of an enrolled individual.
(5) **Ongoing engagement services** necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services, including services to support maintaining housing.
(6) **Other evidence-based services and treatment models**, as specified by the State Department of Health Care Services
(7) **Service planning**
(8) **Housing interventions** pursuant to Section 5830.
(e) Full-service partnership programs shall have an **established standard of care with levels based on an individual's acuity and criteria for step-down**** into the least intensive level of care, as specified by the State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, providers, and other stakeholders.

DHCS

FSP Continuum

FSP programs are comprised of required and allowable services. FSP programs must make required services available as a condition of receiving Behavioral Health Services Act funding. Allowable services are additional services that may be offered and can be paid for using Behavioral Health Services Act FSP funds.



Required Services

- Required services are outlined in statute and must be included in FSP programs:
  - Mental health services, supportive services, and SUD services
  - Assertive field-based initiation for SUD
  - Outpatient behavioral health services for evaluation and stabilization
  - Ongoing engagement services
  - Service Planning
  - ACT/FACT** or FSP ICM
  - HFW**
  - Individual Placement and Support (IPS) model of Supported Employment**

Allowable Services

- Allowable services may be included in addition to, or in conjunction with, required services. They include, but are not limited to:
  - Housing Interventions*
  - Primary SUD FSPs
  - Additional EBPs
  - Outreach and engagement
  - Other non-clinical services

DHCS

*Housing Interventions pursuant to WIC Section 5830 must be funded through Housing Interventions funding. **Services eligible for small county exemption requests.

Relationship to Medi-Cal EBP Policy Design

- This presentation includes an overview of how required EBPs – ACT/FACT, IPS, and HFW – will function within FSP.
- FSP EBPs will mirror the Medi-Cal EBP benefits being developed through BH-CONNECT.
- Under BH-CONNECT, DHCS is partnering with a Center of Excellence to provide support related to fidelity monitoring, training, and technical assistance for FSP EBPs.
- FSP programs will also be expected to meet initial certification and subsequent fidelity monitoring standards as provided for in forthcoming Medi-Cal guidance.

Note: Preliminary EBP policy design presented for the purposes of BHSA are subject to final approval of Medi-Cal policy guidance.

DHCS

FSP EBP and Fidelity Timing

- Counties will be required to **implement** FSP EBPs – **ACT/FACT, IPS, HFW** – beginning July 1, 2026.
- Counties will also be required to implement **FSP-ICM and Assertive Field-Based SUD** by July 1, 2026.
- Counties will have **18-months** to complete a **fidelity review** for all EBPs (by December 31, 2027).
  - Fidelity reviews will be led by a **Center of Excellence (COE),** which will also provide **training and technical assistance** leading up to and following the fidelity review.
- Following the first fidelity review, counties will have **18 months** (by June 30, 2029) to come into compliance and demonstrate they are delivering FSP EBPs to **fidelity**.
  - The COE will continue providing training and TA as counties move toward delivering FSP EBPs to fidelity.
  - Additional fidelity reviews by the COE over this 18-month period will confirm whether the county is delivering FSP EBPs to fidelity.

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

Exemptions

FSP Exemptions for Small Counties

Per statute, small counties may request an exemption from FSP program requirements.*

WIC § 5887(a)(2):

(a) Each county shall establish and administer a full service partnership program that includes the following services:

(2) Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound**, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services. **Counties with a population of less than 200,000 may request an exemption from these requirements. Exemption requests shall be subject to approval by the State Department of Health Care Services.** The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on **reasonable criteria for those requests and a timely and efficient exemption process.**

For the FY 2026 Integrated Plan, all small counties will be exempt from:

- **Meeting fidelity requirements for ACT/FACT**, but must still provide FSP ICM; and,
- **Meeting the fidelity requirements for the IPS model of Supported Employment and/or HFW**

Note: DHCS believes that there are very few circumstances where exemptions from the IPS model of Supported Employment and/or HFW would be warranted given the flexibility of the models and ability of individual practitioners to deliver IPS and HFW).

DHCS

**Note:* This exemption does not apply to Field-Based SUD or FSP ICM ***Note:* Counties will still be required to offer HFW through Medi-Cal under EPSDT*

Criteria for 2029 FSP Exemptions for Small Counties

- Starting in 2029, the following exemption criteria would apply:
- Counties may cite **one or more of the following criteria** when requesting an exemption to ACT/FACT and/or the fidelity requirements for IPS and/or HFW:
  - Limited **workforce**, including providers
  - Limited **need** (e.g., small number of individuals in or eligible for the program to support the required staffing for fidelity)
  - **Other considerations** subject to evidence requirements and DHCS review
- Requests for exemptions must include:
  - **Documentation** demonstrating that one or more of the criteria for exemption are met (e.g., workforce data, county demographic data, etc.)
  - For exemption requests from IPS and HFW fidelity, counties must include a description of how they will **modify EBP requirements** (e.g., substitute LPN for RN requirements) and **plans to move toward meeting FSP EBP fidelity requirements**.

DHCS

FSP Levels of Care

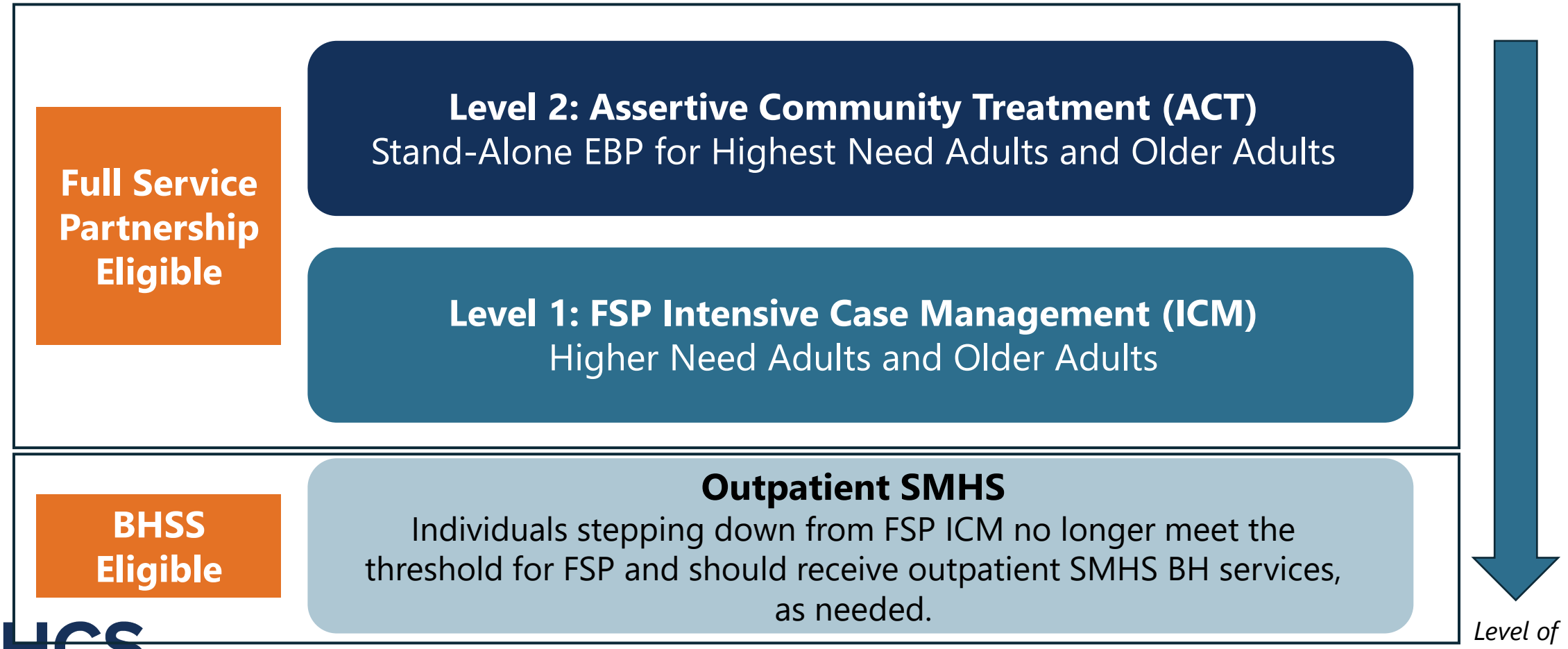
Adult FSP Levels of Care

- To meet new BHT requirements, DHCS has begun developing a **straw model for the Adult FSP standards of care** with levels based on an individual's acuity and criteria for step down.
- Since ACT is a required service and an evidence-based practice (EBP) for those with the highest acuity, **we propose that ACT be the highest level of care** for an adult in the FSP program.
- **DHCS proposes developing a standardized step-down level from ACT, using known terminology, FSP Intensive Case Management (ICM),** which will capture individuals who may not meet ACT eligibility criteria, but still have significant behavioral health needs and can benefit from FSP supports. Many of California's current FSP programs include more than one level of care; this Behavioral Health Services Act policy will improve standardization across the state.
- WIC § 5892(k)(8)(A) defines adult and older adults as those 26 and older. For the purposes of FSP programs, **the Adult FSP is for those 26 and older as well as Transitional Age Youth or younger, if determined to be clinically and developmentally appropriate.**

DHCS

Adult FSP Levels of Care Framework

The framework includes two levels of coordinated care for adults and older adults with ACT as the highest level and a step-down level from ACT, that we are calling FSP Intensive Case Management (ICM).



ACT Service Components

FSP ACT programs must mirror the service components outlined in the Medi-Cal benefit and be made available to non-Medi-Cal members who receive FSP and are clinically eligible for the highest level of care. FSP funding can be used to cover additional non-clinical supports that are not covered by Medi-Cal, as needed.

- ✓ Assessment
- ✓ Crisis Intervention
- ✓ Employment and Education Support Services
- ✓ Medication Support Services
- ✓ Peer Support Services
- ✓ Psychosocial Rehabilitation
- ✓ Referral and Linkages
- ✓ Therapy
- ✓ Treatment and Planning

DHCS

Forensic ACT Requirements

- FACT is ACT tailored to Justice-involved individuals.
- Counties may adapt their FACT model based on local resources and needs (e.g., more populous counties may have dedicated FACT team, smaller more rural counties may integrate FACT within their ACT teams)
- ACT teams meet the FSP requirement to include FACT if:
  - Counties have dedicated FACT teams; **OR**
  - At least one ACT team member has lived experience; **OR**
  - All ACT team members complete FACT training.

DHCS

Overview: Intensive Case Management (ICM)

- ICM is a service that is well known and documented in the literature.
- ICM includes a **comprehensive set of community-based services** for individuals with significant behavioral health conditions.
- Compared to standard care, ICM has been shown to improve general **functioning, employment and housing outcomes, and reduce length of hospital stays**.
- ICM does not have set fidelity criteria like ACT but generally **combines the principles of case management** (assessment, planning, linkages) with **low staff to client ratios**, **assertive outreach**, and **direct service delivery**.

Sources:
1. Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. Intensive case management for severe mental illness. Cochrane Database of Systematic Reviews. 2017, DOI: 10.1002/14651858.CD007906.pub32
2. Schaedle, R.W., Epstein, I. Specifying Intensive Case Management: A Multiple Perspective Approach. *Ment Health Serv Res* 2, 2000. https://doi.org/10.1023/A:1010157121606
3. Meyer, P., and Morrissey, J. A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. Psychiatric Services. (2007). https://doi.org/10.1176/ps.2007.58.1.121

DHCS

Who Might FSP ICM Serve?

- Individuals receiving FSP ICM may include **members who were receiving ACT and have been clinically determined to be ready for a step-down** level of care
- Individuals may also enter an FSP program **needing a moderate to significant level of support** but do not meet the qualifications for ACT
- Individuals living with **co-occurring SMI/SUD** are eligible to receive FSP ICM
- Individuals ages 18-26 or younger who are **not connected to children's services**, if determined to be clinically and developmentally appropriate

DHCS

FSP ICM Service Components

FSP ICM participants may need some or all of the same services components as ACT.

- ✓ Assessment
- ✓ Crisis Intervention
- ✓ Employment and Education Support Services
- ✓ Medication Support Services
- ✓ Peer Support Services
- ✓ Psychosocial Rehabilitation
- ✓ Referral and Linkages
- ✓ Therapy
- ✓ Treatment and Planning
- ✓ Housing supports

Note: *This list is not exhaustive. Additional services may be provided on an as needed basis.*

A Note on Permanent Supportive Housing:
Pairing intensive behavioral health services like ACT and FSP ICM with permanent housing is a recommended best practice for achieving long-term housing stability.

DHCS

FSP Levels of Care for Children/Youth

- DHCS will require HFW for children/youth as an EBP, so that it is delivered with fidelity in each county.
- HFW subject matter experts/research do not support defining multiple levels of care in this scenario, given that HFW service design enables flexibility to adjust the level of intensity according to an individual's needs.
- SB 326 does not prohibit counties from establishing FSP programs for children/youth that include multiple levels of care based on intensity of mental health or SUD needs. However, DHCS will not require counties to develop multiple, dedicated levels of care for FSP for children/youth.

DHCS

Overview: High Fidelity Wraparound (HFW)

HFW is a **team-based** and **family-centered evidence-based practice** that includes an **"anything necessary"** approach to care for children/youth living with the **most intensive mental health or behavioral challenges**. HFW is regarded as an **alternative to out-of-home placement for children with complex needs,** by providing intensive services in the family's home and community.

» HFW centers family voice and decision-making in developing a care plan to reach desired family outcomes by providing a structured, creative, and individualized set of strategies that result in plans/services that are effective and relevant to the child, youth, and family.

» HFW is delivered by a **HFW Facilitator**, who leads a team through a prescribed process, which is both flexible and responsive to child and family-identified strengths and needs.

» At its core, high fidelity is defined as **adherence to the four phases of the HFW model:**

Phase 1: Engagement and Team Preparation	Phase 2: Plan Development	Phase 3: Implementation	Phase 4: Transition

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

HFW Service Components

HFW must mirror the service components outlined in forthcoming Medi-Cal guidance.

Basic HFW Medi-Cal service bundle includes:

- ✓ HFW Facilitation and Coordination
- ✓ Child and Adolescent Needs Survey (CANS) Administration
- ✓ Individualized Care Planning, including Safety and Crisis Planning
- ✓ Caregiver Peer Support

Additional services (as needed) through Medi-Cal, e.g.:

- ✓ Therapy
- ✓ Youth Peer Support
- ✓ 24/7 Support (mobile crisis)
- ✓ Intensive home-based services
- ✓ Caregiver Respite

Flexible Funds are a **vital component of HFW,** and inclusive of anything deemed necessary by the HFW team, **that are <u>not</u> Medi-Cal billable**.

HFW facilitation occurs within the context of a <u>Child and Family Team</u> (CFT) and HFW Providers must refer to other services part of the intervention, including FSP services that may be particularly beneficial for Transitional Aged Youth (TAY), such as housing supports and the IPS model of supported employment.

All eligible children/youth will receive the basic HFW Medi-Cal bundle, but not all will need to receive every additional service.

DHCS

Individual Placement and Support (IPS) Supported Employment

DHCS

Overview: Individual Placement and Support (IPS)

Over 60% of clients with severe mental illness want to work, but less than 20% are employed.[1] The IPS model of supported employment is an evidence-based intervention that engages people with severe mental illness in finding and maintaining *competitive* employment or education *of their own choice*.

- The IPS model uses a strength-based approach to support individuals living with serious mental illness[1] **find and maintain employment**, which plays a crucial role in their **recovery and integration into the community**.
- Supported Employment can be **integrated into other FSP services** such as ACT, HFW and CSC for FEP, to offer a comprehensive approach to recovery that addresses both clinical and functional needs.
- BHT Supported Employment programs will align with the evidence-based IPS model and **mirror the Medi-Cal benefit** being developed through BH-CONNECT[2].
- Compared to traditional vocational rehabilitation approaches, IPS has demonstrated **higher rates of competitive employment for individuals with behavioral health disorders**.[3]

[1] IPS Employment Center, 2024
[2] Under BH-CONNECT, Supported Employment will be available at county option in the SMHS **and** DMC/DMC-ODS delivery systems
[3] Recent research has also demonstrated the effectiveness of the IPS model in supporting individuals living with SUD gain employment (Marsden et. al, 2024)

DHCS

IPS Principles

- IPS is an important part of **psychosocial rehabilitation**, providing structure, purpose, and social connection to reduce isolation and combat stigma for individuals with SMI.
- The evidence-based model is designed to help individuals with serious mental illness **find and maintain jobs as part of their recovery and is based on 8 core principles**[1,2]**.**

IPS Core Principles

- Zero Exclusion
- Competitive Employment
- Rapid Job Search
- Systematic Job Development
- Integrated Services
- Benefits Planning
- Time-Unlimited Supports
- Worker Preferences

[1] IPS Employment Center, 2024

[2] There are other evidence-based models of Supported Employment for individuals with I/DD to get and keep competitive integrated employment in the community.

DHCS

Assertive Field-Based Initiation for Substance Use Disorder (SUD)

DHCS

Working Definition

Assertive field-based initiation for substance use disorder treatment services

Outreach, engagement and initiation of treatment for substance use (e.g., alcohol misuse, stimulant misuse, opioid use) disorder **particularly medications for addiction treatment (MAT) in any low-barrier setting**, such as on the street, in homeless encampments, drop-in centers, in hospital emergency departments (ED) **to reach people wherever they are**.

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

Assertive Field-Based Initiation for SUD Treatment Services Requirements

Counties will be required to **strengthen**, **expand existing**, and/or **stand-up** the following three services/models:

1. **Conduct ongoing, data-informed targeted outreach** to BHSA eligible individuals with SUD needs
   - May be performed by Mobile Field-Based teams (below) or delivered via other models
2. **Mobile Field-Based Programs**
   - Mobile teams that conduct **field-based** outreach and provide or facilitate **access to MAT,** and other treatment. Services are for populations at higher risk of overdose and provided in locations with higher rates of overdose and need (e.g., outreach/medicine programs)
3. **Open-Access Clinics**
   - A "**walk-in**" service delivery model with **low-barrier MAT access** (e.g., telehealth models, Bridge Clinics) that can connect individuals to **other supports**

DHCS

Assertive Field-Based Initiation for SUD Treatment Services Requirements

The key goals of these requirements is to **increase access** to MAT and directly provide or facilitate **rapid access** to all FDA approved MAT**.**

- **Rapid MAT access** means:
  - County field-based programs are **expected** to work towards ensuring **same day MAT access**
  - To help meet this standard, field-based programs can **have MAT prescribers on staff or refer** to buprenorphine providers, Federally Qualified Health Centers (FQHCs), Indian Health Clinics, and Narcotic Treatment Programs (NTPs)
  - Counties can utilize **telehealth models** to ensure access to MAT

DHCS

*The information included in this presentation may be pre-decisional, draft, and subject to change.

FSP Integration With SUD

Expectations for the Behavioral Health Services Act

1. Counties must conduct assertive field-based initiation; and
2. FSP teams must be capable of supporting individuals living with co-occurring mental health and substance use conditions.

NOTE: *SB 326 does not prohibit counties from establishing FSP programs for individuals with primary SUD diagnoses (i.e., without co-occurring significant mental health needs), however, counties are not required to develop new, dedicated Levels of Care specific to SUD, or FSPs that are exclusively for SUD (apart from implementing new, field-based initiation of SUD care requirements). DMC-ODS is intended to cover a comprehensive continuum of care for SUD.*

DHCS

Resources

Behavioral Health Transformation Website and Monthly Newsletter

Explore the Behavioral Health Transformation website to discover additional information and access resources.

Please sign up on the DHCS website to receive monthly Behavioral Health Transformation updates.

Infographics and FAQs

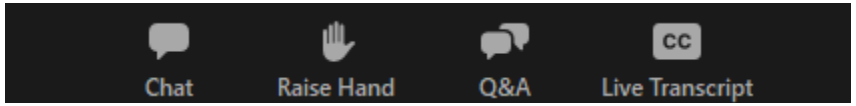
Explore our infographics and FAQs for additional insight in the Behavioral Health Transformation on the Behavioral Health Transformation website, along with this public listening recordings, once available.

Questions and Feedback

Please send any other questions or feedback about Behavioral Health Transformation to BHTInfo@dhcs.ca.gov.

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Feedback
(Please Use Q&A Feature)



Questions?

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Thank You

For Questions

BHTinfo@dhcs.ca.gov

DHCS