California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

AGENDA

Revised 10-4-2024

October 15, 16, 17, and 18, 2024
Embassy Suites by Hilton Milpitas Silicon Valley
901 East Calaveras Boulevard, Milpitas, California, 95035

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 1, 2024,** 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 15, 2024

2:00pm	Performance Outcomes Committee

Wednesday, October 16, 2024

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

Thursday, October 17, 2024

8:30am	Housing and Homelessness Committee
8:30am	Systems and Medicaid Committee
12:00pm	**LUNCH (on your own)**
12:10pm	Reducing Disparities Work Group (working lunch)
12:10pm	Substance Use Disorder Workgroup (working lunch)

Thursday, October 17, 2024

COUNCIL GENERAL SESSION **Room:** Redwood/Maple/Cypress/Oak
Conference Call (669) 900-6833 (listen only)
Meeting ID: 814 8859 6918
Passcode: 545689

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

1:40 pm **Acceptance of April 2024 Meeting Minutes** **Tab D**
Tony Vartan, Chairperson-Elect

1:45 pm **Department of Health Care Services Update**
Paula Wilhelm, Assistant Deputy Director, Medi-Cal Behavioral Health, Deputy Director of Behavioral Health, CA Department of Health Care Services

2:15 pm **Public Comment on DHCS Update**

2:20 pm **10-MINUTE BREAK**

2:30 pm **Committee Report-Outs**

- **Performance Outcomes**: Susan Wilson, Chairperson
- **Patients' Rights**: Daphne Shaw, Chairperson
- **Executive**: Deborah Starkey, Chairperson
- **Legislation and Public Policy**: Barbara Mitchell, Chairperson
- **Workforce and Employment**: Walter Shwe, Chairperson
- **Housing and Homelessness**: Monica Caffey, Chairperson
- **Systems and Medicaid**: Uma Zykofsky, Chairperson
- **Children/Youth Workgroup**: Ashneek Nanua
- **Reducing Disparities Workgroup**: Uma Zykofsky
- **Substance Use Disorder Workgroup**: Javier Moreno

3:20 pm **10-MINUTE BREAK**

3:30 pm **Behavioral Health Transformation (BHT) Updates and Integrating SUD into BHSA** **Tab E**
Marlies Perez, Department of Health Care Services, BHT Project Executive

4:45 pm **General 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. We respectfully ask those not participating to exit the meeting space to allow for Council business to occur.

Friday, October 18, 2024

COUNCIL GENERAL SESSION Room: Redwood/Maple/Cypress/Oak
Conference Call (669) 900-6833 (listen only)
Meeting ID: 814 8859 6918
Passcode: 545689

8:30 am **Welcome Back & Announcements**
Deborah Starkey, Chairperson

8:40 am **Mental Health Services Oversight and Accountability Commission Update**
Tom Orrock, Deputy Director of Operations

8:55 am **San Francisco County Behavioral Health Services** **TAB G**
Hillary Kunins, MD, MPH, MS, Director, Behavioral Health Services and Mental Health SF, San Francisco Department of Public Health

9:35 am **Public Comment on San Francisco County**

9:40 am **20-MINUTE BREAK**

10:00 am **Substance Abuse and Mental Health Services Administration (SAMHSA) Update** **TAB F**
Carly Blemmel, SAMHSA, Behavioral Health Advisor, Region IX

10:40 am **Presentation Public Comment on SAMHSA Presentation**

10:45 am **Conservatorship in California** **TAB H**
Mike Phillips, Patients' Rights Committee
Alex Barnard, PhD., Assistant Professor of Sociology, New York University

11:45 am **Public Comment on Conservatorship Presentation**

11:50 am **General Public Comment**

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

12:00 pm **Adjourn**

2025 Council Meeting Schedule

January 14-17, 2025: Hilton La Jolla Torrey Pines
April 15-18, 2025: Lake Natoma Inn

June 17-20, 2025: DoubleTree Hotel Marina del Rey
October 14-17, 2025: Embassy Suites San Francisco Airport Waterfront

TAB D

California Behavioral Health Planning Council
General Session

Thursday, October 17, 2024

Agenda Item: Acceptance of April 2024 Meeting Minutes

Enclosures: Draft April 2024 Meeting Minutes

Background/Description:

Attached are the draft April 2024 meeting minutes for member review.

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

CBHPC Members Present Day 1:

Susie Baker
Stephanie Blake
Monica Caffey
Erin Franco
Jessica Grove
Ian Kemmer (for Veronica Kelley)
Steve Leoni*
Lynne Martin Del Campo
Barbara Mitchell
Catherine Moore
Javier Moreno
Don Morrison
Dale Mueller
Jessica Ocean
Noel O'Neill
Elizabeth Oseguera
Vandana Pant
Deborah Pitts
Marina Rangel
Danielle Sena
Daphne Shaw
Walter Shwe
Maria Sierra
Deborah Starkey
Bill Stewart
Arden Tucker
Tony Vartan
Susan Wilson
Uma Zykofsky

*=Remote Appearance

CBHPC Members Absent

Amanda Andrews
Karen Baylor
John Black
Erika Cristo
Darlene Prettyman
Ali Vangrow
Sarah Poss
Karrie Sequeira

Staff Present: Jenny Bayardo, Naomi Ramirez, Justin Boese, Ashneek Nanua, Gabriella Sedano, Simon Vue, Peter Saechao

Welcoming and Introductions

Chairperson Deborah Starkey called the meeting to order. She welcomed Council Members and led self-introductions. A quorum was achieved with 29 of 37 Council Members present.

Approval of October and January Meeting Minutes (Action)

The October 2023 and January 2024 meeting minutes were reviewed and accepted with edits requested by Jessica Ocean and Steve Leoni.

Committee Report-Outs

Patients' Rights Committee: Chairperson Daphne Shaw reported that the Patients' Rights Committee received updates on SB-43 from Samuel Jain of Disability Rights California. The committee will continue to track the implementation of this bill, as well as any follow-up legislation, due to its impact on the patients' rights system. The committee continues to track implementation of the CARE Act and heard updates from Tony Vartan (Stanislaus County) and Ian Kemmer (Orange County). Melanie Roland from the Law Foundation of Silicon Valley presented to the committee on two pieces of patients' rights legislation they are seeking authors for. The first bill would ensure that people who are discharged from mental health holds are provided bridge medications and/or existing prescriptions upon request. The second would prevent the vehicles of people taken into custody for mental health treatment from being towed, and/or cover the negative consequences of their vehicles being towed. The committee will stay in communication with the Law Foundation regarding these potential bills.

Performance Outcomes Committee: Chairperson Susan Wilson provided updates on the 2022, 2023, and 2024 Data Notebooks. The Overview Report for the 2022 Data Notebook (Impact of the Covid-19 Public Health Emergency on Behavioral Health Needs and Provision of Services in California) has been published and the Executive Summary report will be finalized soon. Susan reported that the committee has collected 51 completed 2023 Data Notebook (Stakeholder Engagement) to date. Susan Wilson shared that members reviewed a draft of the 2024 Data Notebook, which focuses on Homelessness in the Public Behavioral Health System. The development on the survey questions and background information will continue with the goal of finalizing the document for distribution this summer. Lastly, Susan shared that in addition to the Data Notebook project, the POC will continue assisting with the planning and facilitation of public forum events similar to the panel and forum on Senate Bill 43.

Executive Committee: Deborah Starkey, Chairperson of the Council, shared that items discussed included Council appointments and the mentorship program. There are currently 2 vacancies, 1 Family Member/Parent of SED Child and 1 Direct Consumer. Written guidance has been developed for mentors and mentees that outline the responsibilities of each. The final version of the updated Council Priorities document was reviewed and will be posted to the Council webpage following the meeting. At this meeting members also received an update on the expenditures and budget from the Chief of Operations, Naomi Ramirez.

Legislation and Public Policy Committee: Chairperson Barbara Mitchell reported that the committee took 8 legislative positions. The committee is in support of Assembly Bill (AB) 2711, AB 2119, and AB 2995. The committee also supports Senate Bill (SB) 2411 in concept and members will continue to monitor and provide recommendations on the language to the sponsor of this bill. The committee opposed AB 2411 and SB 1238. Lastly, the committee decided to watch AB 1907. Barbara Mitchell shared that member discussed areas of concern regarding the Behavioral Health Services Act, which will be submitted to Council leadership. Amotion to request the Council send a letter to the Department of Health Care Services (DHCS), Housing and Community Development (HCD), and the Department of Veteran Affairs, requesting involvement in the development and review of regulations for Prop 1 was passed.

Workforce and Employment Committee: Walter Shwe shared the success of the committee's advocacy efforts resulting in the approval of Occupational Therapists as Licensed Mental Health Professionals in the Specialty Mental Health Services System and Licensed Practitioners of the Healing Arts in the Drug Medi-Cal Organized Delivery System. Walter then reported the committee had an update from the Department of Health Care Access and Information (HCAI) on their behavioral health programs and the development of the Certified Wellness Coach (CWC) Benefit. Walter shared that the committee engaged in a robust discussion with Turning Point Community Programs and peer-run community-based organizations such as the Consumers Self Help Center and Project Return Peer Support Network regarding the challenges and opportunities to bill Medi-Cal for certified Peer Support Specialist services. The committee had presentations from the California Department of Rehabilitation (DOR), Butte County Department of Behavioral Health, and vocational rehabilitation programs, Caminar and Dreamcatchers Empowerment Network about efforts to support individuals with employment and productive role engagement.

Housing and Homelessness Committee: Chairperson Monica Caffey reported that Simon Vue is the new staff person for the committee. She shared that the committee heard multiple presentation. The first presentation was on Senate Constitutional Amendment 2, which would repeal Article 34 from 1950. Marlyn Sepulveda, Chief Operating Officer of the Hope Cooperative provided a presentation on their shared permanent housing. The committee received updates from Hal Zawacki, Assistant Regional Director for Substance Abuse and Mental Health Services Administration (SAMHSA). Teresa Comstock, Executive Director for the California Local Behavioral Health Boards and Commissions (CALBHB/C) provided and overview on Senate Bill 2411 and the members decided to monitor the bill. They also discussed that they sent a letter to SAMHSA regarding their interest in broadening the Federal definitions on homelessness to include people who have been in institutions more than 89 days, including prisons, jails, locked behavioral health facilities, and other residential treatment programs.

Systems and Medicaid Committee: Chairperson Uma Zykofsky reported that the meeting focused on older adults. The committee received an overview on the Master Plan for Aging as well as California Department of Aging (CDA) programs and services

for older adults with behavioral health needs from Stephanie Blake. The members engaged in a robust discussion with Dr. Ryan Quist, Behavioral Health Director for Sacramento County, on the older adult system of care programs and needs. Genelle Cazares, Executive Director for El Hogar, shared El Hogar's programs for older adults such as their Full Service Partnership, prevention and early intervention (PEI) program, and evidence-based depression intervention program. Genelle Cazares was joined by a senior graduate from the PEI program, SeniorLink, shared her experience and successes from engaging in the program. The committee also reviewed and approved the SMC Work Plan for 2024-2025.

Children/Youth Workgroup: Council Staff Ashneek Nanua reported that the workgroup had a 30-minute screening of the *Hiding in Plain Sight* documentary followed by a group discussion. The group is interested in planning a larger screening of the film with a panel presentation. The members agreed that the event will need to be very structured with a specific purpose and call to action, in addition to resources being included throughout the event.

Reducing Disparities Workgroup: Workgroup leader Uma Zykofsky reported that Anna Bolanos from the Department of Public Health Office of Health Equity provided a presentation about the work of the Office of Health Equity. The information will be posted on the website. Uma also shared that Monica Caffey was appointed to the Black Health Equity Advisory Group (BHEAG).

Substance Use Disorder Workgroup: Workgroup leader Javier Moreno reported that the workgroup reviewed the steps the Council has taken to date to integrate substance use disorder (SUD). Additionally, the Sacramento County Alcohol and Drug Advisory Board joined the meeting and was happy to see SUD included in the Council's Policy Platform. The committee developed the following recommendations:

- Identifying ways to address some of the licensing and certification issues that some providers are experiencing, including continued variances and audit findings which differ between non-medical and medical providers.
- Raising business and clinical standards to continue to weed out some of the bad SUD providers that provide subpar care.
- Ensuring that there's a greater stakeholder engagement with the development of regulations.
- Seeking parity between the private and public sector SUD providers.
- Ongoing community education on SUD related topics in an attempt to bring awareness to SUD related issues and in an effort to remove any existing stigma.

Public Comment

None.

Break

Department of Health Care Services Update

Paula Wilhelm, Interim Deputy Director of Behavioral Health at the Department of Health Care Services (DHCS) addressed the attendees. Paula shared that she joined DHCS in December of 2022 as Assistant Deputy Director for Behavioral health, working with Tyler Sadwith who has since moved into the Medicaid Director role. Prior to coming to DHCS, Paula worked for approximately 5 years with the County Behavioral Health Directors Association (CBHDA) Before that she worked in the public behavioral health system as a graduate student at the Senate Office of Research writing a paper about the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Paula updated the Council on the Behavioral Health Transformation (BHT), Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-Connect), and the Health Equity Roadmap.

Paula also announced that DHCS is continuing to support Elevate Youth California (EYC) to bolster community-based and tribal organizations whose work prevents young people from using drugs. As a result, the Department is investing $51.8 million in grants to 75 community-based and tribal organizations serving youth to expand substance use prevention programs. She also shared that DHCS is seeking stakeholder representation from up to 25 individuals and/or organizations with SUD prevention, treatment, and recovery experience to provide guidance, insight, and review from stakeholders across the state on the content and delivery of the AB 2473 curriculum. Applications are due by April 29, 2024. Lastly, she announced that DHCS is accepting proposals for presentations at the 2024 Substance Use Disorder Integrated Care Conference. The deadline to submit proposals is April 19, 2024.

CA's Behavioral Health System Redesign: County Implementation Update

Michelle Cabrera, Executive Director for the County Behavioral Health Directors Association of California provided an overview of California's Behavioral Health Delivery Systems, highlighted significant behavioral health policy changes and reforms, and gave updates on the implementation progress. Michelle highlighted that 45% (16.1 million) of Californians with insurance have with public coverage through Medi-Cal or Medicare as of 2022. Medicare coverage for behavioral health is more limited than Medicaid coverage. Behavioral health needs are often treated as "elective" services for those with private commercial insurance due to lack of network access & quality. Federal and state funding opportunities are often limited to competitive grants, unfunded optional benefits, or one-time, time limited. As a result, everyone across all systems feel the effects including cost shift to public payers including Medi-Cal and county behavioral health.

Michelle provided an extensive list of California's behavioral health reforms impacting county behavioral health from 2022 to 2024. This list included numerous new Medi-Cal

benefits; program and quality reforms; the Children & Youth Behavioral Health initiative; treatment & housing infrastructure initiatives; Lanterman-Petris-Short (LPS) Act & Crisis Continuum reform; CARE Court; Housing/Homelessness initiatives; Department of State Hospitals reform; and Parity. Michelle highlighted that the initiatives included have created a tremendous amount of work at the county level.

Michelle also highlighted reforms that are still pending which include the 90-day in-reach for individuals in carceral settings. She stated that four counties are anticipated to launch in October 2024 and the subsequent counties will be required to implement quarterly with all counties going live by 2026.

Public Comment

Steve McNally from Orange County shared that he has a son with schizophrenia. He thanked Michelle for her presentation and expressed a desire to receive access to the data referenced in her presentation. He shared that his fear is a lack of adequate funding. In a recent meeting his county shared that they estimate it will cost $90 million to create a system to comply with the reporting requirements. He highlighted that the reporting is an unfunded mandate. Steve asked if this concern has come up from any other counties and if it is being discussed at the state level. Steve also stated that given how close that vote on Proposition 1 was, he hopes that the State will ensure adequate stakeholder feedback from the community and the counties to ensure services are not lost for individuals like his son.

Recess

CBHPC Members Present Day 2:

Susie Baker
Stephanie Blake
Monica Caffey
Erin Franco
Jessica Grove
Steve Leoni*
Lynne Martin Del Campo
Barbara Mitchell
Catherine Moore
Javier Moreno
Don Morrison
Dale Mueller
Jessica Ocean
Noel O'Neill
Elizabeth Oseguera
Deborah Pitts
Sarah Poss
Marina Rangel
Danielle Sena
Daphne Shaw
Walter Shwe
Maria Sierra
Deborah Starkey
Bill Stewart
Arden Tucker
Tony Vartan
Susan Wilson
Uma Zykofsky

*=Remote Appearance

CBHPC Members Absent

Amanda Andrews
Karen Baylor
John Black
Erika Cristo
Ian Kemmer (for Veronica Kelley)
Darlene Prettyman
Ali Vangrow
Vandana Pant
Karrie Sequeira

Staff Present: Jenny Bayardo, Naomi Ramirez, Justin Boese, Ashneek Nanua, Gabriella Sedano, Simon Vue, Peter Saechao

Welcome and Introductions

Chairperson Deborah Starkey called the meeting to order. She welcomed Council Members and led self-introductions. A quorum was achieved with 28 of 37 Council Members present.

Local County Behavioral Health Services Overview

Nicole Ebrahimi-Nuyken, Behavioral Health Director from El Dorado County addressed the attendees. Nicole shared the demographics and characteristics of El Dorado County. She highlighted that in El Dorado County the Behavioral Health Division has 3 branches, which are Mental Health Services, Substance Use Disorder Services, and then the Public Guardians Office. In this county, unlike most others, the Public Guardians Office is closely tied to their work and vision. El Dorado County is currently considered a small county for the Behavioral Health Division Group since their total

population is just under the 200,000 threshold with 194,425 individuals. The three Managed Care Plans in El Dorado County are Mountain Valley Health Plan, Anthem Blue Cross, and Kaiser. The County's mental health outpatient services include an Access Team, Children's Services, Transitional Age Youth Services, Adults and Older Adults Services, Medication Management, Wellness and Recovery, Prevention and Early Intervention, Intensive Case Management (ICM/FSP), Assisted Outpatient Treatment (AOT), Psychiatric Emergency Services / Psychiatric Emergency Response Team (PERT), Mental Health Diversion, and LPS Conservatorships & Investigations.

El Dorado County spends their Mental Health Block Grant (MHBG) First Episode of Psychosis Services (FEP) funds to enhance training and services. The county has an array of services including early intervention of coordinated, interdisciplinary, and evidence-based treatment when diagnosed with a FEP. They also have Full-Service Partnership (FSP) services which I include both mental health and non-mental health services that help youth/young adult achieve their identified treatment goals using a "whatever it takes" approach. The FEP team offers outreach, screening, engagement, case management, symptom management, medication support services, substance use treatment, linkages to services, and other needed services and supports.

Nicole shared FEP client data for her county, which shows that in the first 9 months of fiscal year 2023-2024 there were 17 FEP clients and a total of 201 sessions received. Of the 17 clients, 4 were 0-15 years old and 13 were 16-25 years old. She also shared gender and ethnicity data for the clients served. She highlighted that the majority (14) of the clients were served at the Wellness Center. Additionally, 8 families attended a total of 58 Parent Support Groups, which she emphasized is important for the support of the clients.

Public Comment

Stacy Dalgleish congratulated Nicole Ebrahimi-Nuyken on her program. Stacy shared that she wishes her family had a program like El Dorado County's when they were in need. She asked Nicole her thoughts on whether the County's success is related to the fact that they have a predominantly white population and do not have to expend funds on serving other populations.

Steve McNally stated that he is intrigued by the County's Wellness Centers. He asked Nicole to provide more information about the size and scope of their wellness centers, what happens within the center, and the County's relationship with the school district. Steve shared the different types of wellness centers his county has.

Behavioral Health System Transformation Overview

Michelle Cabrera, Executive Director for the County Behavioral Health Directors Association of California provided a brief overview of Proposition 1 from the county perspective. Elements of Senate Bill (SB) 326 and Assembly Bill 531 were placed on the March 2024 ballot as Proposition 1. Michelle highlighted that the initiative has

several components, and some parts of SB 326 were not dependent on voter approval and therefore were not placed on the ballot. These sections include the following:

- Bronzan-Mccorquodale ACT/1991 Realignment Welfare and Institutions Code (WIC) Sections 4090, 4094, 4096.5, 5675 which are related to mental health residential programming. These sections primarily add language related to California Advancing and Innovating Medi-Cal (CalAIM) and documentation reform.
- WIC Section 5813.6 which is related to DHCS reporting on state expenditures of the millionaire's tax by department to the Legislature.
- Section 115 which is related to DHCS authorities in effect due to urgency clause.

Michelle stated that we are on a fast 2-year timeline to implement the remaining provisions of the initiative. The Health and Human Services agency intends on engaging external stakeholders through listening session and a variety of standing forums. The State anticipates having bond funding available in the Summer of 2024 using the Behavioral Health Continuum Infrastructure Program (BHCIP) and Homekey structures. In early 2025, the State will release policy and guidance for county 3-year plans, which will guide the new community planning process. This will result in the core changes to the structure and funding of Mental Health Services Act (MHSA) programs and services starting at the end of 2025 or beginning of 2026.

Michelle provided a high-level summary of the elements of Proposition 1. She shared that eligible housing Interventions include rental subsidies; operating subsidies; shared housing; family housing for eligible children and youth; the nonfederal share for transitional rent; other housing supports, as defined by the Department of Health Care Services (DHCS), including, but not limited to, the community supports policy guide; Capital development projects, including affordable housing; and project-based housing assistance, including master leasing of project-based housing. Michelle also provided insight on the planning, reporting, and accountability process.

Public Comment

Stacy Dalgleish asked if now that there is a fiscal carve out for substance use disorder (SUD) whether a clinician can re-chart and add a diagnosis for SUD to be paid from SUD funds.

Barbara Wilson thanked Michelle for her presentation. She followed up by asking Michelle if she thinks there is a possibility for regional planning through this new initiative.

Steve McNally thanked Michelle for her presentation. He shared that the data that is available needs to be shared more openly. He expressed the importance of stakeholders including local boards to be more connected to the State during the decision-making processes.

Break

Opportunities for BIPOC and LGBTQ+ Communities in the Behavioral Health Services Act (BHSA)

Stacie Hiramoto, Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) provided an overview of Proposition 1 focused on Community Defined Evidence Practices (CDEPs) and Reducing Disparities. CDEPs offer culturally anchored interventions that reflect the values, practices, histories, and lived experience of the communities they serve. Stacie stated that CDEPS are often preferred and more effective in serving black, indigenous, and people of color (BIPOC) and lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) communities. They incorporate their culture, employ people from their respective communities, and ultimately reduce disparities. She highlighted that the California Reducing Disparities project (CRDP) is the largest and best example of many community defined evidence practices that have been funded by government for many years and formally evaluated. She shared the website to view more information of the CRDP.

Stacie shared that the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA) was primarily used to fund CDEPs. Under Proposition 1 the PEI will be split into 2 separate components. The Population-Based Prevention will be administered by the State Department of Public Health (CDPH). The Early Intervention will be administered be each county within the Behavioral Health Services and Supports (BHSS) component. She shared that CDEPs have also been funded through the Innovations component at the county level, however under proposition 1 Innovation funds are now at the State level at the Behavioral Health Services Oversight and Accountability Commission (BHSOAC). Stacie stated that under Proposition 1 the best opportunity for funding CDEPs will likely be under Population Based Prevention and the second-best option will likely be under Innovations. However, she shared that there may be some challenges as the proposition language states that Population-Based prevention cannot be used for individuals.

Stacie urged all attendees to be engaged in the Proposition 1 implementation process to ensure services are not loss. She shared that stakeholders should engage with CDPH, BHSOAC, the Department of Health Care Services (DHCS), Department of Health Care Access and Information (HCAI) and local counties.

Behavioral Health Services Act (BHSA): Council Member Discussion

Tony Vartan, Chair-Elect facilitated a conversation with all Council Members about the Behavioral Health Services Act. He emphasized the importance of the Council being involved in the implementation process and asked members to identify areas the Council should be involved.

Daphne Shaw stated several committees discussed the importance of the Council being involved in the development of regulations. She emphasized the importance of this being a top priority for the Council. Tony assured her that the Council will be sending a letter requesting inclusion.

There was a discussion among multiple members about the importance of the Council being involved in the data and outcomes component of the BHSA. It was stated that Performance Outcomes Committee (POC) will be involved in these efforts. Susan Wilson and Uma Zykofsky stated that there is data that will be of interest for multiple committees, and it may result in the need for multiple committees to work together.

Erin Franco asked how the Council feels about each committee having a research component. Tony stated that the Council can explore that if it is something the members would like to do. Further he stated that since the Council has a POC, an option is for a member from each committee to participate in the POC.

Noel O'Neill recommended the Council host a forum in San Diego in January and in Sacramento in April with a panel of representatives from the different state departments responsible for the implementation.

Steve Leoni recommended that Council Members send their list of concerns to Council staff as there is not sufficient time to address all recommendations during the meeting.

Tony urged members to consider Steve's comment. Additionally, he recommended that the Council have a discussion at a future meeting to ensure the recommendations are thoroughly discussed to inform members that may be part of conversations about implementation.

Tony also highlighted that the members of the BHSOAC are ExOfficio members of the Council and asked if there is interest from the Council to ask them to engage with us. Daphne shared that in the past members did participate and expressed the importance of resuming that relationship. Other members agreed.

Public Comment
Stacy Dalgleish asked that the local boards are involved in the development of any new requirements. She also asked that any new requirements for the local behavioral health board be shared with Theresa Comstock from the California Local Behavioral Health Boards and Commissions (CALBHB/C) quickly. Theresa can then make sure all the local boards quickly receive the information, so they understand their new responsibilities.

Richard Krzyzanowski expressed his admiration for all the communities represented at the Council meetings. He stated that he feels like that work of the mental health community is slipping away, however he still he hopes to continue working alongside the Council.

Steve McNally shared his appreciation for the conversation. He asked that whoever runs the state's open data portal provide a tool to take the raw data and turns it into county level data. He highlighted that there is a lot of data available, however the data is not broadly advertised.

Benny Benavidez echoed the comments made by Stacy Dalgleish.

Closing Remarks

Deborah Starkey thanked all participants for attending the meetings over the course of the last 3 days. She also thanked the Council staff for all of their work preparing for the meetings.

Adjourn

Chairperson Deborah Starkey adjourned the meeting at 12:00 p.m.

TAB E

California Behavioral Health Planning Council
General Session

Thursday, October 17, 2024

Agenda Item: Behavioral Health Transformation (BHT) Updates and Integrating Substance Use Disorder (SUD) into Behavioral Health Services Act (BHSA)

Enclosures: Behavioral Health Transformation Presentation

Background/Description:

In March of 2024, Californians voted to pass Proposition 1 to modernize the behavioral health delivery system. The two bills that created the language for the proposition are Senate Bill 326 (Behavioral Health Services Act) and Assembly Bill 531. As an advisory body, the Council must be informed of significant changes to the public behavioral health system to fulfill state mandates outlined in Welfare and Institutions Code 5772 requiring the Council to review and evaluate the effectiveness of behavioral health services in California, advocate for adequate funding and advocate for persons with lived experience of serious mental illness and children with Severe Emotional Disturbances.

The Behavioral Health Services act expands to include persons with lived experience of a substance use disorder without the requirement of co-occurring serious mental illness. The Department of Health Care Services is responsible for the implementation of the Behavioral Health Services Act (SB 326).

Biography:

Marlies Perez has been a Division Chief with the California Department of Health Care Services since May 2013 and at the state level in behavioral health since 2001. Currently, Marlies leads the Community Services Division (CSD) which is charged with policy development, oversight, compliance, and monitoring of approximately $10 billion in behavioral health prevention, harm reduction, treatment, recovery services, housing and infrastructure projects and services. Marlies is also the Project Executive at DHCS for the implementation efforts for Behavioral Health Transformation (Proposition 1). Marlies has a bachelor’s degree in international relations and master’s degree in organizational management.

Behavioral Health Transformation
California Behavioral Health Planning Council

Marlies Perez, Division Chief
BHT Project Executive
Department of Health Care Services

MENTAL HEALTH FOR ALL

October 17, 2024

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Housekeeping

- You may type your comments into the chat box throughout the presentation.
- Once we reach the discussion portion of our workgroup meeting, please raise your hand to speak and we will go in the order of raised hands.

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

Meeting Agenda

- Introduction to Behavioral Health Transformation
- Current Substance Use Disorder (SUD) Services County Funding
- Integrating SUD in BHSA
- Assertive Field-Based Initiation for SUD Treatment Services Update
- Resources

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

Behavioral Health Transformation

DHCS

Behavioral Health Transformation

In March, California voters passed Proposition 1, a two-bill package to modernize the state's behavioral health care system, including substantial investment in housing for people with behavioral health care needs.

Behavioral Health Services Act

- Reforming behavioral health care funding to provide services to those with the most serious mental illness & to treat substance use disorders.
- Expanding the behavioral health workforce to reflect and connect with California's diverse population.
- Focusing on outcomes, accountability, and equity.

Behavioral Health Bond

- Funding behavioral health treatment beds, supportive housing, and community sites.
- Directing funding for housing for veterans with behavioral health needs.

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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 will leverage BHCIP.

Beginning Early 2025

Integrated Plan Guidance and Policy

Policy and guidance will be **released in phases** beginning with policy and guidance for integrated plans.

Summer 2026

Integrated Plan

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

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

Behavioral Health Bond

- **Behavioral Health Bond** provides **$6.38 billion**, with up to **$4.4 billion** for competitive grants for counties, cities, tribal entities, nonprofit entities, and the private sector toward **behavioral health treatment settings**.
- Of the **$4.4 billion** available for treatment sites, $1.5 billion, with $30 million set aside for tribes, will be awarded through competitive grants **exclusively** to counties, cities, and tribal entities.
- Funds will be distributed through the current **Behavioral Health Continuum Infrastructure Program (BHCIP).**

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Current Substance Use Disorder Services County Funding

DHCS

Current County SUD Funding Sources

- County behavioral health departments receive state, federal and other sources of funding to provide Substance Use Disorder (SUD) services at the local level.
- Each funding source has different requirements counties must follow including:
  - Eligibility of individuals served
  - Allowable expenses
  - Timeframes for expenditure
  - Application and reporting requirements
- Counties utilize the different funding sources to 'braid' funding to meet the needs of individuals at the local level.

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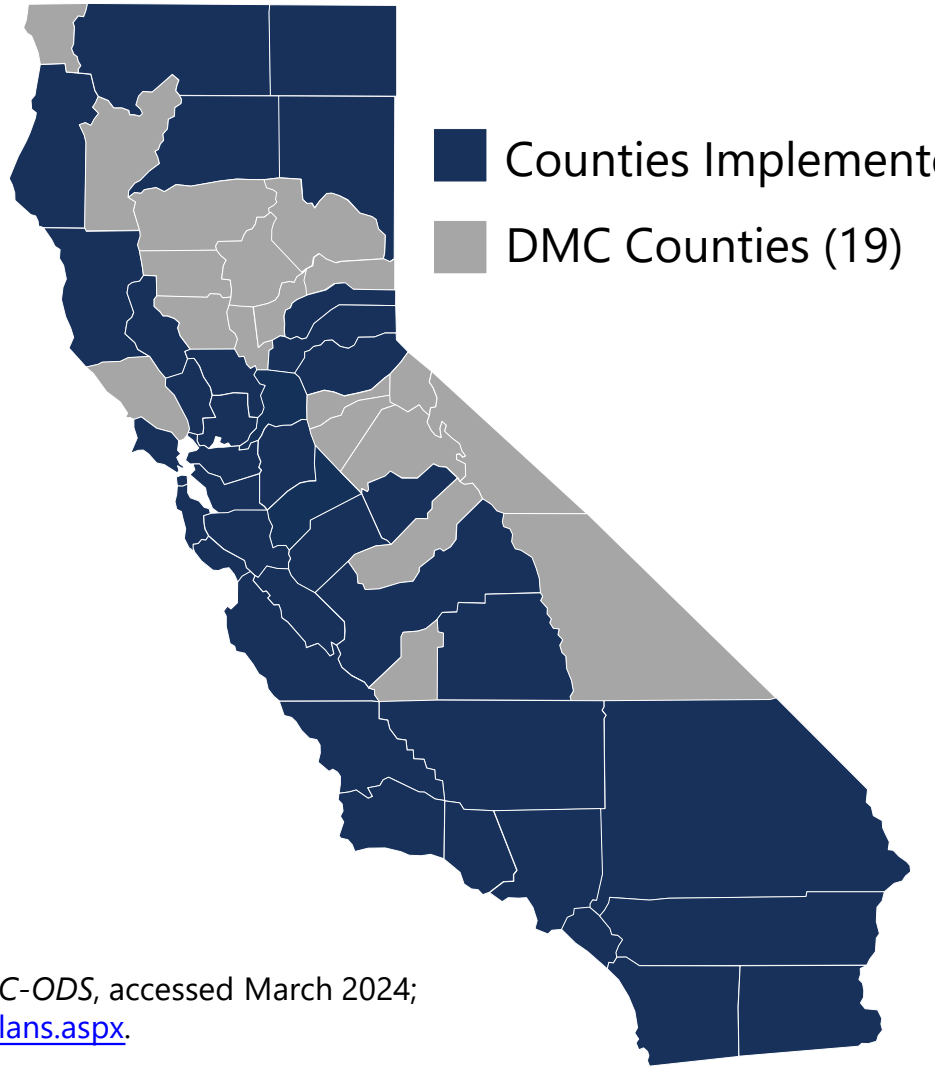
Drug Medi-Cal

- Drug Medi-Cal provides SUD treatment services for Medi-Cal members and is administered by California counties.
- Most Californians live in a county that has chosen to operate an expanded program, known as the Drug Medi-Cal Organized Delivery System (DMC-ODS). They operate as a managed care plan for SUD services.
- DMC-ODS counties support more than **96%** of the State's Medi-Cal population.



Source: California Department of Health Care Services, *Counties Participating in DMC-ODS*, accessed March 2024; available at: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx.

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Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of SUD treatment services by providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services.

DMC Benefits

- Outpatient treatment services
- Intensive outpatient treatment services
- Medications for addiction treatment
- Narcotic treatment programs
- Perinatal and youth residential
- Peer support services*
- Mobile crisis services
- Early intervention (youth under 21 years)

All DMC and DMC-ODS services are covered pursuant to EPSDT.

DMC-ODS Benefits

- Outpatient treatment services
- Intensive outpatient treatment services
- Medications for addiction treatment
- Narcotic treatment programs
- Residential – all populations
- Peer support services*
- Mobile crisis services
- Early intervention (youth under 21 years)
- Withdrawal management
- Recovery support services
- Care coordination
- Clinician consultation
- Partial hospitalization*
- Recovery Incentives*
- Inpatient treatment/withdrawal management

* Optional services

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Opioid Settlement

The table illustrates funding and uses resulting from opioid settlements and bankruptcies.

Fund Type	Allocation	Allowable Uses
Settlement Funds		
California Abatement Accounts Fund (70%)	All Participating Subdivisions	Future Opioid Remediation (in one or more of the areas described in Exhibit E of the Settlement Agreements)
		High Impact Abatement Activities (No less than 50% of funds)
California Subdivision Fund (15%)	Cities and counties from Initial Plaintiff Subdivisions	Future Opioid Remediation Reimburse past opioid-related expenses (i.e., litigation fees)
California State Fund (15%)	State of California	Future Opioid Remediation
Bankruptcy Funds		
Local Government Share (60%)	All participating cities and counties	Future Opioid Remediation (in one or more of the uses listed in Exhibit 4 of the Mallinckrodt Bankruptcy Plan)
State Share (40%)	State of California	Future Opioid Remediation

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Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

- California's annual SUBG allocation from the Substance Abuse and Mental Health Administration to counties is ~$230M, which is allocated based on population size to provide SUD related activities and services.
- To prevent and treat SUDs, the SUBG Program funds prevention, treatment, recovery support, and other services independently or with Medi-Cal funded services.
- The SUBG program includes the following "set-asides" defined by federal statute and state priorities:
  - Discretionary – for programs specific to local needs, funded at the county's discretion (i.e., residential treatment, recovery support services)
  - Perinatal – services for pregnant women and women with dependent children
  - Prevention – for primary prevention services
  - Adolescent/Youth – youth treatment programs

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Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

The SUBG program prioritizes programs that provide SUD prevention, treatment, and recovery services, specifically for the following populations and service areas:

- Pregnant women and women with dependent children
- Intravenous drug users
- Tuberculosis services
- Early intervention services for HIV/AIDS
- Primary prevention services

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2011 Realignment

SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount, which funds:

- Specialty Mental Health
- **Drug Medi-Cal**
- **Residential perinatal drug services and treatment**
- **Drug court operations**
- Other non-Drug Medi-Cal programs (Government Code Section 30025 (f)(16)(B))
- Allocations of Realignment funds run on a fiscal year of October 1 – September 30. They are monthly allocations to counties from the State Controller's Office.

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Integrating SUD in BHSA

DHCS

BHSA Intent Language and SUD

SECTION 1.

» The people of the State of California hereby find and declare all of the following

(b) One in 10 Californians meet the criteria for a **substance use disorder**.

(c) The number of amphetamine-related emergency department (ED) visits increased nearly 50 percent between 2018 and 2020, while the number of non-heroin-related opioid ED visits, including fentanyl ED visits, more than doubled in the same period. Data shows a 121% increase in opioid deaths between 2019 and 2021.

SECTION 2

(b) The time has come to modernize the MHSA to focus funds where they are most needed: expanding services to include treatment for those with **substance use disorders** and ……

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BHSA Definition of Substance Use Disorder

» "Substance use disorder means an adult, child, or youth who has at least one diagnosis of a moderate or severe substance use disorder" from the most current version of the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders with the exception of tobacco-related disorders and non-substance-related disorders.

» "Substance use disorder treatment services" include **harm reduction, treatment**, and **recovery services**, including federal Food and Drug Administration approved **medications**.

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

Harm Reduction

DHCS is exploring the utilization of the SAMHSA harm reduction definition which includes:

- Connect individuals to overdose education, counseling, and referral to treatment for infectious diseases and SUDs.
- Distribute opioid overdose reversal medications (e.g., naloxone) to individuals at risk of overdose, or to those who are likely to respond to an overdose.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections.
- Reduce infectious disease transmission among people who use drugs (including those who inject drugs) by equipping them with sterile supplies, accurate information and facilitating referrals to resources.
- Reduce overdose deaths, promote linkages to care, facilitate co-location of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders

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Recovery Services

DHCS is exploring aligning the BHSA definition of Recovery Services with the Drug Medi-Cal Organized Delivery System (DMC-ODS) definition.

- Effective January 1, 2022, as described in State Plan Amendment 21-0058 and Behavioral Health Information Notices 21-075 and 22-025, Recovery Services include the following service components:
  - Assessment
  - Care Coordination
  - Counseling (individual and group)
  - Family Therapy
  - Recovery Monitoring
  - Relapse Prevention

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SUD in BHSA

- Counties will utilize data to allocate BHSA funding between mental health and **substance use disorder** treatment services.
- If counties are not utilizing a proportionate amount of BHSA funding to support **substance use disorders** based on the needs identified by the data in the Integrated Plan, the county will demonstrate what other BH funding sources are being utilized to cover SUD services.
- Counties will identify strategies to address **SUD disparities** in their Integrated Plan.
- In counties with **separate** mental health and **SUD departments**, both departments will work together to utilize BHSA funding in line with local data needs and reflected in their single Integrated Plan.

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SUD in BHSA

- Counties can utilize BHSA funding as the match for Drug Medi-Cal and Drug Medi-Cal Organized Delivery System prior to expending BHSA-only funds for **SUD services**. Counties spend ~12% of their total Medi-Cal behavioral health treatment dollars on SUD (i.e., through DMC/DMC-ODS), suggesting a significant opportunity exists to increase access to lifesaving treatment.
- For **SUD services** not covered by Medi-Cal, BHSA funding can be utilized for individuals with moderate to severe conditions.
- BHSA funds can be utilized as the match for federal dollars of DMC and DMC-ODS services.
- DHCS may utilize the SAMHSA Harm Reduction definition as a framework for BHSA.
- DHCS may utilize the DMC-ODS definition for BHSA Recovery Services.

BHSA and SUD Integration

DHCS

SUD and the BHSA Planning Process

Input from various SUD stakeholders is a new requirement in BHSA. The Welfare and Institutions Code (WIC) requires the following:

- Addition of SUD stakeholders into the community planning process as outlined in WIC 5963.03.
- Change of local mental health boards into the behavioral health board by adding the required SUD representatives in WIC 5604.2.
- Additional SUD membership to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC).

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County Integrated Plan for Behavioral Health Services and Outcomes

	Three-Year County Integrated Plans (IP)
Purpose	Prospective data-driven plan and budget for all county BH services.
Goal	Standardize strategic planning to increase transparency, foster cross-system alignment, reduce disparities, eliminate fragmentation, and promote stakeholder engagement.
Frequency	Developed every three years.
Timing	First due June 30, 2026.

See Welfare and Institutions Code 5963.02 (SB 326 Sec. 109)

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Expanded Focus of Integrated Plan

The expanded scope for the Integrated Plan will support the state in achieving the following goals:

- Collect local and aggregate information on all behavioral health services delivered statewide.
- Increase transparency and accountability in county reporting and ensure counties are efficiently using behavioral health funding.
- Conduct robust data analysis across counties, services, and funding streams and identify gaps in service delivery.

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Capturing Behavioral Health Funding

- BHSA requires counties to submit three-year County Integrated Plans for Behavioral Health Services and Outcomes (IP) that outline planned county activities and projected expenditures for all county mental health and **substance use disorder services** funded under the following behavioral health funding streams[1]
  - Bronzan-McCorquodale Act (1991 and 2011 realignment);
  - Medi-Cal behavioral health, including Specialty Mental Health Services, Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS);
  - Federal block grants;
  - Opioid settlement funding; and
  - BHSA.

[1] 5963.02 (c)(1)

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BHSA Specifications for SUD

Per WIC 5891.5, the programs, services, and support funded with BHSA may include SUD treatment services for children, youth, adults, and older adults.

- Counties providing substance use disorder treatment services **must provide** all forms of federal Food and Drug Administration approved medications **for addiction treatment.**
- Counties may use BHSA funding to assess whether a person has a substance use disorder and **treat** the individual **prior to a diagnosis** of a substance use disorder.
- Counties must include substance use disorder treatment services in the Integrated Plan and/or Annual Update.

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BHSA Funding of SUD Services

- Allows funding of SUD services **across all three funding categories**; Housing, Full-Service Partnership and Behavioral Health Services and Supports.
- BHSA enables counties to fund these services alone or in combination with other state and federal funds to support expansion of **SUD services**.
- **SUD** may be included in state-directed responsibilities (e.g. Population-based Prevention overseen by California Depart. of Public Health, Workforce overseen by Dept. of Health Care Access and Information, Innovation Partnership Fund overseen by Behavioral Health Services Oversight and Accountability Commission).

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Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

The BHSA requires counties to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to DHCS on an annual basis.

The BHOATR provides information on county implementation of their Integrated Plans, including reporting on actual mental health and **substance use disorder** expenditures and activities undertaken during the reporting period.

DHCS will use county BHOATRs to develop a statewide BHOATR outlining activities and gaps in mental health and **substance use disorder** delivery across California.

State Auditor Report

- The State Auditor shall issue a comprehensive report on the progress and effectiveness of implementation of BHSA by December 31, 2029, and every 3 years thereafter until 2035. All entities with BHSA funding, including DHCS and the counties, will be audited.
- **Shall include:**
  - BHSA policy impact
  - Timeliness of guidance and technical assistance
  - Progress toward goals and outcomes
  - Gaps in service and trends in unmet needs
  - **Inclusion and impact of SUD services and personnel**
  - Effectiveness of reporting
  - Requirements
  - DHCS oversight of plans and reports
  - Coordination and collaboration areas of improvement
  - Recommendations of changes or improvements

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Housing Intervention Component

Per WIC 5830, counties are required to establish and administer a program for housing interventions.

1. Housing interventions to individuals with a **substance use disorder** are allowable for counties. (WIC 5891.5)
2. Housing interventions must not deny access to housing for individuals that are utilizing **medications for addiction treatment** or other authorized medications.
3. Housing interventions must comply with the core components of Housing First principles and may include **recovery housing**.

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Behavioral Health Services and Supports Component

Per WIC 5892, thirty-five percent of the funds distributed to counties must be used for Behavioral Health Services and Supports (BHSS).

- Counties may fund under BHSS may include the addition of **substance use disorder services**.
- Early Intervention Programs are designed to prevent mental illnesses **and substance use disorders** from becoming severe and disabling and to reduce disparities in behavioral health.
- Outreach and Engagement activities may be targeted to individuals and communities in **the behavioral health system**
- Workforce Education and Training activities may target the **behavioral health workforce.**

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

Full Service Partnership Component

Per WIC 5887, each county must establish and administer a full service partnership program.

- The program must include mental health services, supportive services, and **substance use disorder treatment services**, as needed by the individual.
- The program must include **assertive field-based initiation for substance use disorder treatment services,** including the provision of medications for addiction treatment.

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

Assertive Field-Based Initiation for SUD Treatment Services Update

DHCS

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

Policy Design Principles

Assertive SUD engagement proposes a "no-wrong door" approach to connect more Californians to MAT and follow-up integrated treatment and support.

- **Voluntary participation**, focusing on field-based MAT initiation for individuals who want to be connected to treatment
- **Outreach and engagement to individuals wherever they are**, (e.g., on the street, EDs, in syringe exchange programs, in homeless encampments)
- **Expand low-barrier, rapid access to all forms of MAT** (buprenorphine, methadone, naltrexone) for individuals with opioid use disorder and alcohol use disorder when they ready for treatment using harm reduction principles
- **Link to ongoing comprehensive treatment and supports with FSP, Medi-Cal and other county programs** (e.g., care coordination, primary care, housing and employment supports)
- Provide **flexibility for counties** to respond to local conditions and populations
- **Build upon and expand** existing SUD treatment models and programs within California
- **Maximize available resources**, including Medi-Cal, to most efficiently use BHSA funding

Full Service Partnership Component "Whatever It Takes"

Per WIC 5887, each county must establish and administer a full service partnership program.

- The program must include mental health services, supportive services, and **substance use disorder treatment services**, as needed by the individual.
- The program must include **assertive field-based initiation for substance use disorder treatment services,** including the provision of medications for addiction treatment.

Proposed Definition of Assertive field-based initiation for substance use disorder treatment services

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

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

FSP Integration With SUD

Expectations for BHSA

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.*

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Deep Dive: Co-Occurring Capabilities

Individuals living with serious behavioral health disorders and co-occurring SUD could be eligible for any FSP Level of Care. FSP teams must be capable of treating individuals with co-occurring needs.

- **Strategies to build on co-occurring capabilities under BHSA:** Enable BHSA eligible individuals living with co-occurring SMI/SED and SUD to receive FSP levels of care, allow (but do not require) SUD only FSP, and require FSP programs to provide access to MAT/SUD treatment, by*:
  - **Connecting individuals to FSP teams, as appropriate**, after they receive assertive field-based initiation for SUD treatment services
  - **Conducting ASAM screening** as part of integrated assessment upon intake
  - **Offering MAT services directly to clients or having an effective referral process in place** (i.e., established relationship with a MAT provider and transportation to appointments for MAT)
  - **Equipping FSP program staff** at all levels of care to provide comprehensive care to individuals living with co-occurring SMI/SED and SUD (e.g., training for existing prescribers who are not familiar or comfortable with prescribing MAT)
  - Developing strategies for **infrastructure for billing and claiming**

*Strategies to build co-occurring capabilities are an allowable use of FSP funding

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Assertive Field Based Program Goal

Embrace a **"low barrier" harm-reduction and person-centered model** to prevent overdose and infectious disease transmission, improve the quality of life for and engage individuals with substance use disorder (SUD) in treatment.

Key components of this model include promoting **availability and accessibility** of care, **flexibility** in approach and a **collaborative** and **comprehensive** approach across substance use, mental health, primary care and social supports to address the **complex needs** of individuals with SUD.

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Available Resources

Visit the DHCS BHT website for additional information, updates, and resources related to BHT. Below highlights resources which have recently been added to the webpage.

BHTInfo Mailbox

Send questions to and share feedback to ***BHTinfo@dhcs.ca.gov***

Infographic

Behavioral Health Services Act: Maximizing Funding Opportunities (July 2024)

FAQs

1. Proposition 1: An Overview (July 2024)
2. Behavioral Health Services Act (July 2024)
3. Behavioral Health Bond (July 2024)
4. Housing Support Primer (July 2024)

Discussion

Thank You

For Questions

BHTinfo@dhcs.ca.gov

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TAB F

California Behavioral Health Planning Council
General Session

Friday, October 18, 2024

Agenda Item: Substance Abuse and Mental Health Services Administration (SAMHSA) Update

Enclosures: None

Background/Description:

The California Behavioral Health Planning Council (CBHPC) exists as required by Public Law 102-321 for the state of California to receive block grant funds. Federal law requires the CBHPC to perform multiple functions including monitoring, reviewing, and evaluating annually the allocation and adequacy of mental health services within the State.

The Council regularly receives updates from the Regional Director for the Substance Abuse and Mental Health Services Administration in U.S. Department of Health and Human Services Region IX. Region IX has recently expanded, and the Council has onboarded many new members, for this reason the new Behavioral Health Advisor, *Carly Blemmel,* will provide an overview of SAMHSA, the services provided out of Region IX and general updates.

Biography:

Carly Blemmel currently serves as the Behavioral Health Advisor for Region 9 (Arizona, California, Hawaii, Guam, Nevada, American Samoa, CNMI, FSM, Marshall Islands, Palau and their Indigenous Peoples and Nations) at the Substance Abuse and Mental Health Services Administration (SAMHSA). She brings with her an extensive portfolio of experience, boasting over 15 years in behavioral health, substance use, and integrated healthcare. As a Licensed Professional Counselor, Carly has been a driving force behind the creation and implementation of numerous impactful programs in prevention and treatment. Her expertise extends to the development and implementation of integrated programs in women's health and primary care clinics. Carly is also an enrolled member of the Choctaw Nation of Oklahoma and deeply values her culture. Her commitment to community goes beyond her professional role, as she also dedicates personal time to organizing and participating in cultural programs and practices. She holds a master’s degree from East Central University in Ada, Oklahoma, and is currently enrolled in the Doctor of Behavioral Health program (DBH) at Arizona State University to better fulfill her commitment to service leadership.

TAB G

California Behavioral Health Planning Council
General Session

Friday, October 18, 2024

Agenda Item: San Francisco County Behavioral Health Services

Enclosures: None

Background/Description:

Hillary Kunins, MD, MPH, MS, Director, Behavioral Health Services and Mental Health SF, San Francisco Department of Public Health will provide a brief overview of the behavioral health services provided in San Francisco County.

Director Hillary Kunins will then update the Council on Senate Bill 43 (SB 43) Implementation as one of the early adopters of the recently passed legislation. Senate Bill 43, passed in October of 2023, expands the definition of “gravely disabled” in state welfare and institution code.

The California Behavioral Health Planning Council (CBHPC) has the authority and is mandated in Welfare and Institutions Code 5772 to advocate for an effective, quality mental health system, to review assess, and make recommendations regarding all components of the public behavioral health system, and is to advise the legislature, DHCS, and county mental health boards. As such, the CBHPC is tracking the implementation of Senate Bill 43.

Biography:

Dr. Hillary Kunins is the Director of Behavioral Health Services and Mental Health San Francisco at the San Francisco Department of Public Health (SFDPH). In 2021, she joined SFDPH from the New York City Department of Health and Mental Hygiene (DOHMH) where she served as the Executive Deputy Commissioner of Mental Hygiene from 2019 to 2021 and as the Assistant Commissioner for the Bureau of Alcohol and Drug Use from 2012 to 2019.

At DOHMH, Dr. Kunins led the reimagining of New York City's public health approach to substance use and served as the DOHMH lead for Mayor Bill de Blasio's $60 million HealingNYC initiative to address the overdose epidemic. She has dedicated her career to creating health equity through science-based public health and healthcare programs and policy for people with behavioral health concerns, including substance use disorders and serious mental illness.

Dr. Kunins received her MD and MPH from Columbia University and her MS in Clinical Research from Einstein College of Medicine. She completed her primary care-internal medicine residency and chief residency at Montefiore/Einstein. Dr. Kunins is a Fellow of the American College of Physicians and of the American Society of Addiction Medicine.

TAB H

California Behavioral Health Planning Council
General Session

Friday, October 18, 2024

Agenda Item: Conservatorship in California

Enclosures: Conservatorship Presentation (for a copy of this document please contact Naomi Ramirez at Naomi.Ramirez@cbhpc.dhcs.ca.gov)

Background/Description:

The Patients' Rights Committee (PRC) monitors, evaluates, and recommends improvements in the protection and upholding of patients' rights to ensure consumers receive effective, timely, and humane treatment in a public mental health system in California. The composition and duties of the Patients' Rights Committee are mandated in CA Welfare and Institutions Code 5514,shown below.

> *There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of* mental health services.

Due to the volume of recent legislation related to conservatorship and Council Member interest in understanding conservatorship laws, the Patients' Rights Committee has identified a leading expert to present to the full Council.

Biography:

Alex Barnard is an assistant professor of sociology at New York University and received his PhD from UC Berkeley in 2019. His book, Conservatorship: Inside California's System of Coercion and Care for Mental Illness, examines the failings of involuntary treatment in California. He is currently working on a book on the public mental health system in France. He has published in outlets such as the San Francisco Chronicle, LA Times, and Sacramento Bee, and his research has been featured in The Economist and New York Times.