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Assembly
California Legislature

Joint Informational Hearing

Assembly Health and Housing and Community Development Committees
Assemblymembers Wood and Wicks, Chairs
Governor's Behavioral Health Modernization Proposal
Tuesday, August 22, 2023 9:00 a.m. – 2:30 p.m.
Lunch Break from 12:00 noon – 1:30 p.m.
1020 O Street, Room 1100

Background

INTRODUCTION.

The Assembly Committee on Health and the Assembly Committee on Housing and Community Development are convening this joint informational hearing to examine Governor Newsom's "Proposal to Modernize the Behavioral Health System in California." Announced by the Administration in March of 2023, and on June 2023 codified into two bills, specifically AB 531 (Irwin) and SB 326 (Eggman). Both of these proposals are currently pending in the legislative process and consist of three key elements (described in more detail below), two of which will require voter approval on the ballot in March of 2024.

The intersection of behavioral health (BH) disorders, (which includes both mental health disorders and substance use disorders (SUDs)) and homelessness has evolved into what has become a humanitarian crisis. Together, these three issues have come to represent the pillars of a very complex challenge for California, the enormity of which is evidenced on our streets, in our schools, in our smallest of rural communities, and in our largest, most metropolitan cities.

California has the highest rate of homelessness in the nation and accounts for 30% of the country's homeless population in 2022. According to the June 2023 University of California-San Francisco, Benioff Homelessness and Housing Initiative's study, people who experience homelessness have higher rates of mental health conditions and substance use than the general population. Specifically, a majority (82%) of the participants of the study reported a period in their life where they experienced a serious mental health condition. More than one quarter (27%) had been hospitalized for a mental health condition; 56% of these hospitalizations occurred prior to the first instance of homelessness. Nearly two thirds (65%) reported having had a period in their life in which they regularly used illicit drugs. Almost two thirds (62%) reported having had a period in their life with heavy drinking (defined as drinking at least three times a week to get drunk, or heavy intermittent drinking). More than half (57%) who ever had regular use of illicit drugs or regular heavy alcohol use had never received treatment.

The toll this crisis is having both on the people living in this state and on the resources available to the state is unparalleled. Coupled with the Covid-19 pandemic and the documented affects the pandemic has had on the mental health of Californians, the demands for BH services and housing are unprecedented.

Since 2019, California has embarked on massive investments and policy reforms to strengthen the BH system and housing availability. The state has undertaken numerous initiatives to address each of these areas – collectively and individually. According to Governor Newsom, his proposal "… is the next step in our transformation of how California addresses mental illness, substance use disorders, and homelessness – creating thousands of new beds, building more housing, expanding services, and more. People who are struggling with these issues, especially those who are on the streets or in other vulnerable conditions, will have more resources to get the help they need."

The three key elements of the Governor's proposal are as follows:

1) Authorization of a $4.68 billion in General Obligation Bonds to fund the creation of supportive housing for veterans experiencing homelessness or at risk of homelessness with BH challenges and unlocked, residential facilities for people with BH challenges that are experiencing homelessness or at risk of homelessness. The bond would allocate $865 million to the Department of Housing and Community Development (HCD) for the construction and rehabilitation of housing for veterans and others who are experiencing homelessness or are at risk of homelessness and living with BH challenges. The remaining amount would go to the Department of Health Care Services (DHCS) for the acquisition of capital assets for, and the construction and rehabilitation of, unlocked, voluntary, and community-based treatment settings and residential care settings. This proposal is codified in AB 531 and if passed by the Legislature would qualify as a voter initiative at the March 2024 election.
2) Revise and update the Mental Health Services Act (MHSA) and instead create the Behavioral Health Services Act (BHSA), renaming the Mental Health Services Oversight and Accountability Commission (MHSOAC) as the Behavioral Health Services Oversight and Accountability Commission (BHSOAC). This proposal is codified in SB 326 and if passed by the Legislature would qualify as a voter initiative at the March 2024 election. SB 326 makes significant changes to the MHSA and further discussed below and in the bill's committee analysis available at https://leginfo.legislature.ca.gov/ and,
3) Improve statewide accountability, transparency, and access to BH services.

HOUSING BACKGROUND.

Over 173,000 individuals in California experience homelessness on any given night, based on the most recent annual point in time (PIT) count conducted in January 2022. This is largely considered an undercount of the actual number of people experiencing homelessness because it does not consider those that are couch-surfing or temporarily housed in non-traditional shelters. Of those individuals, over 115,000 are unsheltered, meaning they live on the streets, sleep in cars, camp in parks, or are otherwise staying in places not meant for human habitation. California accounted for 30% of the country's homeless population in 2022, despite our state making up

less than 12% of the nation's total population. In addition, California is home to 50% of the country's unsheltered people. Significant racial disproportionality exists among those experiencing homelessness. People who identify as Black/African American are overrepresented in California's population of people experiencing homelessness. According to the 2022 PIT count, 30% of the homeless population are Black/African American, while only comprising six percent of the state's overall population.

The causes and duration of homelessness are varied. Some individuals experiencing homelessness are chronically homeless, meaning they have experienced homelessness for at least a year — or repeatedly — while struggling with a disabling condition such as a serious mental illness, SUD, or physical disability. Based on the 2022 PIT count, 60,905 people in the state are chronically homeless and of those 45,132 are unsheltered. An individual is considered chronically homeless if they have a disability as defined under federal law; are living in a place not meant for human habitation, safe haven or an emergency shelter; and have been homeless for at least 12 months or on at least four separate occasions in the last three years. In addition, an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or another similar facility, for fewer than 90 days and met all of the criteria previously stated is also considered chronically homeless.

Although some individuals struggle with substance abuse or mental illness, a growing group of people fall into homelessness due to a mismatch between wages and housing costs. One in three households in the state does not earn enough money to meet their basic needs. From October 1, 2020, to September 20, 2021, the average Fair Market Rent (FMR) for a two-bedroom apartment in the state was $2,030. To afford rent and utilities without being rent-burdened (paying more than 30% of income toward rent), a household must earn $6,766 per month or $81,191 per year. This translates into an hourly wage of $39.03 for a full-time worker. The top five most common occupations in California – home health care workers, fast food workers, cashiers, laborers, and retail salespersons – pay less than the wage needed to afford a home. Over 89% of extremely low-income renter households in California are rent-burdened and over 64% of lower-income households are rent-burdened currently.

According to the Statewide Housing Plan, to meet California's unmet housing needs, the state needs an additional 2.5 million housing units, including 1.2 million for lower-income households. Decades of underbuilding have led to a lack of housing overall, particularly housing that is affordable to lower-income households. The state needs an additional 180,000 new units of housing a year to keep up with demand – including about 80,000 units of housing affordable to lower-income households. By contrast, production in the past decade has been under 100,000 units per year – including less than 20,000 units of affordable housing.

Despite recent investments over the last few years, state and local governments have not significantly invested in affordable housing production in decades, leading to a lack of supply. In addition, local governments have failed to adequately zone or plan for affordable housing for decades. In the last seven years, the state has taken major steps to increase the supply of housing by requiring local governments to plan and zone for 2.5 million new housing units, holding local governments accountable for approving housing, and streamlining both affordable housing and mixed-income housing. Despite increased financial investments from the state and some local

governments, communities face a basic inflow/outflow challenge: as people experiencing homelessness are successfully housed, more individuals fall into homelessness. In San Diego last year, for every 10 homeless people who found housing, 13 more became homeless; in 2018 in Los Angeles County, for every 133 individuals moved into housing, another 150 became homeless each day.

Veterans Homelessness:

A majority of California's veterans are considered cost-burdened and pay more than 30% of their income towards housing-related costs. In addition, based on the 2022 PIT count, California has 10,395 veterans experiencing homelessness, 7,392 are unsheltered. California has 31% of the total homelessness veteran population in the country. Over 50% of homeless veterans suffer from mental health issues and 70% are affected by substance use disorders.

Permanent Supportive Housing (PSH):

PSH offers long-term stable housing and services to support individuals and families who need ongoing assistance to maintain housing stability and prepare to enter the job market, school, and other community activities. Decades of research show that supportive housing with a Housing First requirement ends homelessness among people who experience chronic homelessness. Supportive housing can lower public health costs, improve property values, and decreases recidivism in local jails and state prisons. For these reasons, the state has invested millions of dollars in leveraging federal and local dollars to create more supportive housing. To be successful, supportive housing requires ongoing funding to support services that help tenants maintain housing. Funding for supportive services comes from numerous sources, including county MHSA allocations, federal grants managed by local Continuums of Care, as well as philanthropic sources.

A 2023 Terner Center study "Permanent Supportive Housing as a Solution to Homelessness: The Critical Role of Long-Term Operating Subsidies," states that proper funding for operating and services is necessary to ensure that supportive housing tenants do not fall back into homelessness. However, the study found that funding for both of these is insufficient. Properties with lower budgeted resources had higher rates of rent arrears and move-outs, increasing the risk of residents returning to homelessness, after accounting for the properties' locations. Between 2019 and 2022, the average annual per-unit cost for the sample of properties with PSH units was $17,000. The higher costs of supportive housing are a result of a need for more highly trained staff to provide supportive services and increased maintenance costs.

The state currently offers multiple programs that fund the construction of supportive housing, as described below:

Housing Programs for People Experiencing Homelessness or At-Risk of Homelessness:

No Place Like Home (NPLH).
NPLH dedicated up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing

homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds were repaid by funding from the MHSA enacted by Proposition 63. All of the funds from NPLH have been exhausted. HCD's 2020-21 Annual Report of NPLH reported that from March 2019 to October 2021, $1.3 Billion had been awarded, producing 13,951 supportive housing units. NPLH required counties to demonstrate twenty years of funding for supportive services for supportive housing developments.

Veterans Housing and Homelessness Prevention (VHHP) Program.
Proposition 41, adopted in 2014 created the VHHP Program and authorized $600 million in General Obligation bonds to fund multifamily affordable housing, transitional housing, and supportive housing to veterans. To date the VHHP Program has provided six rounds of funding, administered by HCD in collaboration with the California Housing Finance Agency and California Department of Veterans Affairs (CalVet). No funding remains from the bond. The program funded 3,058 VHHP housing units for veterans and their families with 2,026 of those reserved for extremely low-income veterans, 813 for very low-income veterans, and 219 for low-income veterans. Additionally, 80% of the housing units developed with VHHP funds are restricted to veterans experiencing homelessness. The 2022-23 budget included $100 million in one-time general fund dollars for the program ($50 million in 2022-23 and $50 million in 2023-24).

Home Key.
Home Key provides grant funding to cities and counties to quickly acquire, rehabilitate, or master-lease a broad range of housing types for people experiencing homelessness, including hotels, motels, hostels, single-family homes and multifamily apartments, adult residential facilities, and manufactured housing, and to convert commercial properties and other existing buildings to permanent or interim housing. This program has housed 8,264 people, converted 6,050 units, and created 5,911 new housing units. To qualify to receive a Home Key award, cities and county applicants must demonstrate a commitment of at least seven years of funding for supportive services for a supportive housing development.

Multi-family Housing Program (MHP).
MHP provides loans to developers to build affordable housing for lower income households and supportive housing for individuals experiencing homelessness or at risk of homelessness. Developments are deed restricted for 55-years to provide a long-term stock of affordable and supportive housing. All funding for this program will be exhausted by the end of next year.

Residential Beds.
According to a 2021 RAND Corporation report, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California , psychiatric bed capacity is severely constrained in California as it is in other parts of the country. Today, hundreds of Californians in need of psychiatric beds are held in hospital emergency departments or county jails awaiting openings in inpatient care settings. In addition, a sizable percentage of chronically home-less individuals have a severe mental illness. According to the Rand Corporation, California needs 4,767 subacute and acute beds combined, excluding state hospital beds. Separately, the state faces an estimated shortage of 2,963 community residential beds. California has an estimated total of 5,975 beds at the acute level (19.5 per 100,000 adults) and 4,724 at the subacute level (15.4 per 100,000 adults)—

excluding state hospital beds. If state hospital beds are included, these figures increase to 7,679 (25.1 per 100,000 adults) and 9,168 beds (29.9 per 100,000 adults), respectively. There are larger variations in the number of beds regionally. For example, excluding state hospitals, acute bed capacity ranged from 9.1 beds per 100,000 adults in the Northern San Joaquin Valley to 27.9 beds per 100,000 adults in the Superior region. For subacute bed capacity, regional estimates ranged from 7.4 to 31.8 beds per 100,000 adults. At the community residential level, we estimated that California has a total of 3,872 beds (12.7 per 100,000 adults).

DHCS operated homeless and housing related programs.
DHCS operates the following homelessness and housing-related programs:

Behavioral Health Continuum Infrastructure Program. This program finances the construction, acquisition, and rehabilitation of real estate assets or investments needed for mobile crisis infrastructure to expand the community continuum of BH treatment resources.

Community Care Expansion (CCE). This program is part of a statewide investment in infrastructure funding to address homelessness, support healthcare delivery reform, and strengthen the social safety net. CCE focuses on two main areas: (1) the CCE Capital Expansion Program which funds the acquisition, construction, and rehabilitation of residential care settings including funds to establish a capitalized operating subsidy reserves; and, (2) the CCE Preservation Program intended to immediately preserve and prevent the closure of existing licensed residential adult and senior care facilities, including Residential Care Facilities for the Elderly, Adult Residential Facilities, or Residential Facilities for the Chronically Ill.

Housing and Homelessness Incentive Program. Medi-Cal managed care plans can earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. Managed care plans and the local homeless Continuum of Care, in partnership with local public health jurisdictions, county BH, Public Hospitals, county social services, and local housing departments must submit a Homelessness Plan to DHCS and identify how these funds would prioritize aging and disabled homeless Californians.

Housing Policy Questions:
1) Is there sufficient funding for supportive services and the operating costs required for the supportive housing and residential beds created by the bond?
2) Are the housing intervention investments in the BHSA linked to the supportive housing for veterans and residential beds funded by the bond?
3) Are there sufficient staff to support the supportive housing unlocked, residential bed facilities funded by the bond?

BEHAVIORAL HEALTH BACKGROUND.

Prevalence of Mental Illness in California. The California HealthCare Foundation (CHCF) issued a publication in July 2022 entitled, "Mental Health in California: Waiting for Care, (report)" which found that nearly one in seven adults (an estimated 4.4 million individuals) statewide experiences a mental illness of some kind. One in 26 (an estimated 1.2 million individuals) has a serious mental illness (SMI) that makes it difficult to carry out daily activities. Additionally one in 14 (an estimated 621,000) children has a serious emotional disturbance (SED) that limits functioning in family, school, or community.

Other major findings from CHCF's report include: California's statewide suicide rate was slightly below the national average, although rates varied in the state by gender, race/ethnicity, and county; close to two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes did not get treatment; The prevalence of SMI varied by income, with much higher rates of mental illness for both children and adults in families with incomes below 100% of the federal poverty level. The prevalence of SMI among adults ranged by region from highs in Northern and Sierra (4.9%) and San Joaquin Valley (4.8%) to a low in the Greater Bay Area (2.9%). The rate of SED among children in California regions did not vary much by region and hovered between a low of 6.8% (Greater Bay Area) and a high of 7.8% (San Joaquin Valley); Rates of SMI among California adults varied considerably among racial and ethnic groups, American Indian and Alaska Native adults experienced the highest rates (6.8%) followed by Blacks (5.3%) and Multiracial (4.9%); Females were slightly more likely than males to experience SMI and Californians aged 35-44 had the highest rate of SMI and those 65 and over the lowest rate; Adult females were more likely than males to experience serious psychological distress (SPD) (a measure of psychological distress occurring in the past year using a standardized screening tool) with rates for females increasing by 60% from 2015 to 2019; and, rates of SPD for adults who are bisexual gay, lesbian, or homosexual were higher than for adults who are straight or heterosexual.

In perhaps the most recent and damning release of data, the federal Centers for Disease Control and Prevention (CDC) released a "Youth Risk Behavior Survey 2011-2021," in which federal researchers characterized teen girls across the United States as being "engulfed in a growing wave of violence and trauma." The survey reflects that nearly one in three high school girls reported in 2021 that they seriously considered suicide – up nearly 60% from a decade ago. Almost 15% of teen girls said they were forced to have sex, an increase of 27% over two years. Moreover, almost three in five teenage girls reported feeling so persistently sad or hopeless almost every day for at least two weeks in a row that they stopped regular activities – a figure that was double the rate for boys.

The CHCF report demonstrates that people of color, those with low socio-economic status, and the LGTBQ+ community not only have a higher prevalence of mental health disorders but also suffer from the lack of access to and receipt of appropriate mental health treatment.

Mental health equity can be defined as the state in which everyone has a fair and just opportunity to reach their highest level of mental health and emotional well-being. According to the CDC's Office of Minority Health and Health Equity's July 12, 2022 report entitled "Prioritizing

Minority Mental Health," "Mental health care is important for mental wellbeing, yet many people from racial and ethnic minority groups face obstacles in accessing needed care. These obstacles may include lack or insufficient health insurance, lack of racial and ethnic diversity among mental healthcare providers, lack of culturally competent providers, financial strain, and stigma." These or similar obstacles are also present for the LGTBQ+ communities and result in higher incidences of mental health issues than for the general population.

Prevalence of SUD in California.

SUDs are recognized within the Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as DSM, is the American Psychiatric Association's gold-standard text on the names, symptoms, and diagnostic features of every recognized mental illness – including addictions. The DSM recognizes substance-related disorders resulting from the use of 10 separate classes of drugs including alcohol, cannabis, hallucinogens, opioids, and sedatives stimulants (amphetamine type substances, cocaine). There are two groups of substance-related disorders: SUDs and substance-induced disorders. SUDs are patterns of symptoms resulting from the use of a substance that one continues to take, despite experiencing problems as a result. SUDs span a wide variety of problems arising from substance use, and cover 11 different criteria: The 11 criteria in the DSM can be grouped into four primary categories: physical dependence, risky use, social problems, and impaired control. The DSM allows clinicians to specify how severe or how much of a problem the SUD is depending on how many symptoms are identified. Mild SUD is two to three symptoms, moderate SUD is four to five, and six or more indicate a severe SUD. Understanding the severity of SUDs facilitates doctors and therapists determining which treatments to recommend and choosing the appropriate level of care. Substance-induced disorders involve problems that are caused by the effects of substances, including substance-induced mental disorders. Substance-induced disorders, include psychosis, bipolar and related disorders; depressive disorders; delirium; and, neurocognitive disorders. Substance/medication-induced mental disorders are mental problems that develop in people who did not have mental health problems before using substances.

A 2022 publication from the CHCF, entitled "Substance Use in California: Prevalence and Treatment" reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a SUD within the last year. While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with an SUD within the last year received treatment. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a 10-fold increase in fentanyl related deaths between 2015 and 2019. The California Department of Public Health's Opioid Overdose Dashboard reported there were 7,175 deaths related to "any" opioid overdose in 2021, with 5,961 (83%) of those deaths fentanyl related.

SUDs and opioid use disorders disproportionately affect low-income individuals. Thus, Medi-Cal plays an essential role in reducing the burden associated with this condition throughout the state. Nationally, the Medicaid program represents the single largest source of coverage for SUD services and accounts for 27% of all SUD treatment spending in the US. In California, a total of

1.2 million beneficiaries had an SUD in 2015, which means that almost half of all Californians with SUD are covered by the program.

Recent Investments and Initiatives in California's BH System.
The focus of the Legislature over the past two to three years has increasingly been on addressing the mental health crisis in California. Numerous new initiatives have been adopted aimed at addressing specific aspects of the crisis including:

1) School based mental health services;
2) Educational campaigns;
3) Provision of housing for individuals suffering from mental illness;
4) Requiring mental health services for specific populations;
5) Building out the facilities infrastructure to ensure there are sufficient treatment beds; and,
6) Increasing the BH workforce; and many more.

Billions of dollars have been committed to improving and transforming the mental health system in California. The following represents just a sample of some major (and lessor) efforts across health, housing and education. This is not by any means a comprehensive list but demonstrates the breadth and scope of efforts all envisioned as pieces of the solution. While some of the funds allocated for these programs are ongoing, some programs provide one-time funding with specific goals and timelines for completion in order to create the appropriate support necessary to ultimately provide greater access for those individuals in our state requiring services and supports to live safe and meaningful lives.

1) MHSA;
2) Children and Youth Behavioral Health Initiative;
3) School Behavioral Health Infrastructure Grants;
4) Behavioral Health Continuum Infrastructure Program;
5) Expansion of the Incompetent to Stand Trial Diversion Program;
6) Development of Mental Health and Wellness Instructional Resources and Training;
7) Behavioral Health Workforce Development;
8) Community Assistance, Recovery, and Empowerment (CARE) Court;
9) Behavioral Health Bridge Housing;
10) CalAIM (Medi-Cal) BH Initiatives;
11) 988 Behavioral Health Emergency Crisis Phone Line;
12) Creation of an Office of Suicide Prevention;
13) Enhanced Funding for Behavioral Health Oriented Teacher Training;
14) School Health Demonstration Project;
15) Community Schools;
16) Project Cal-Well;
17) Project Cal-Stop;
18) Medi-Cal Justice-Involved Initiative;
19) Medi-Cal MAT Expansion Program;
20) Medi-Cal Community-Based Mobile Crisis Intervention Services; and,
21) CalHOPE Crisis Counseling Assistance and Training Program.

MHSA.
Approved by voters in 2004, the MHSA places a 1% tax on personal income over $1 million and dedicates the associated revenues to mental health services. According to the MHSOAC, the MHSA was informed and inspired by the emergence of effective practices for dealing with serious mental health conditions and legislatively sponsored pilot projects in comprehensive services that improved outcomes, including reductions in homelessness, criminal justice involvement, and hospitalizations for individuals with serious mental health conditions.

The vast majority of MHSA revenues—at least 95%—goes directly to counties to support a variety of services for individuals with or at risk of mental illness. Currently, the MHSA establishes broad categories for how counties can spend the funding: Community Services and Supports (CSS) which funds direct service. Seventy-eight percent of CSS must fund full service partnerships (FSPs); Prevention and Early Intervention (PEI), which funds services that prevent mental illness before it becomes severe (19% of PEI is allocated to programs and services for children and youth); and Innovation, (funded at 5%) which encourages counties to experiment with new approaches to addressing mental illness. The MHSA requires each county mental health program (CMHP) to prepare and submit a three-year plan to DHCS, after review from a local mental health board and approval from the board of supervisors. The plan must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to counties related to each component of the MHSA. In the three-year plans, CMHPs are required to include a list of all programs for which MHSA funding is being requested, with local stakeholder input, and that identifies how the funds will be spent and which populations will be served. The MHSA makes explicit reference to those with co-occurring conditions and permits use of funds to treat those with a co-occurring SUD, as long as an individual has a primary mental health condition. CMHPs also must submit their plans for approval to the MHSOAC before they can spend innovation program funds. Counties generally have three years to spend funds (smaller counties have five years) before DHCS can revert funds back to the Mental Health Services Fund for redistribution to other counties.

Major changes under the BHSA Proposal.
Focus on the most vulnerable: The Governor's BH proposal focuses on ensuring that the most seriously ill adults and children are receiving the services needed to provide whole person, wrap-around care. The proposal focuses on adults who are also at risk of experiencing homelessness or who are at risk of being justice involved, at risk of institutionalization, and/or meet the criteria for BH linkages under the California Advancing and Innovating Medi-Cal Justice Involved Initiative, as well as adults with SMI at-risk of conservatorship. Children and youth with SED or SUD, who are experiencing homelessness, are involved or at risk of being justice involved, at risk of institutionalization, and/or meet the criteria for BH linkages under the CalAIM Justice Involved Initiative or are in or transitioning out of the child welfare system are also a major focus.

Addition of Stand-Alone SUD. Generally, the MHSA allows money to be used for SUDs, which is a mental health condition, but is most often required to be a co-occurring disorder with a specific mental health disorder. The Governor's initial proposal would instead explicitly require counties to fund services for those with stand-alone SUDs and not have to document that the person has a primary mental health condition. However, the August 15 amendments to SB

326 contain language that permits, rather than requires, counties to provide stand-along SUD treatment services.

Housing Interventions. The most significant and controversial modification to the MHSA under the BHSA is the creation of a Housing Intervention allocation that requires each county to establish and administer a housing intervention program to provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness. Counties are required, except as specified) to spend 30% of their entire HSA allocation for these new housing interventions. Housing services provided in FSPs will be attributed to this 30% allocation.

Modifications to the MHSA Community Planning Process (CPP) and Reporting Requirements.

The Governor's proposal also adopts a new process (similar in some ways to the existing CPP but much more robust) that still requires each county to develop, every three years an Integrated Plan for Behavioral Health Service and Outcomes (IPBHSO), in consultation with stakeholders. The relevant list of stakeholders is significantly expanded and the IPBHSO requires a county to continually demonstrate a partnership with constituents and stakeholders in multiple areas, including mental health and SUD policy development, program planning and implementation, monitoring, workforce, quality improvements, health equity, evaluation and budget allocations. Development of the plan requires a county to consider the community health improvement plan of the local health jurisdiction. For a county with a population greater than 200,000, it requires collaboration with the five most populous cities in the county, managed care plans, and continuums of care to outline respective responsibilities and coordination of services relating to housing interventions. The IPBHSO also requires counties and Medi-Cal BH delivery systems, to submit annually the County Behavioral Health Outcomes, Accountability and Transparency report. Moreover, the IPBHSO requires DHCS to establish metrics to measure and evaluate the quality and efficacy of the BH services and programs. This new planning process also permits DHCS to impose corrective action plans, monetary sanctions or temporarily withhold payments to the county or Medi-Cal BH delivery system if they fail to meet the requirements of the IPBHSO.

Other major provisions of the Governor's BH proposal include.

1) Increasing the state-directed allocation (taken off the top of the BHSA dollars before county allocations are made) from 5% to 10% in order to do the following:
   a) Establish a dedicated funding stream of at least 4% to bolster the public mental health system workforce. This effort would be overseen by the Department of Health Care Access and Information (HCAI); and,
   b) Establishing a dedicated funding stream of at least 3% to fund population-based prevention programs through the Department of Public Health.
2) Placing a strong focus on maximizing other funding streams, particularly drawing down federal dollars as a match for BHSA funds and ensuring that private insurance companies reimburse counties for the services they are responsible to provide.

Stakeholder Response.
Several organizations including the Mayors of the Major Cities, NAMI California, The Steinberg Institute and the United States Veterans Initiative, California have all expressed support for the Governor's proposal. However, the proposal has also raised significant concerns across a broad spectrum of stakeholders. The primary areas of concern are the elimination of PEI as a separate funding buckets, the impact of this reduction on schoolbased mental health services, and, the lack of focus on reducing racial and ethnic disparities and improving access to services for historically marginalized communities. County BH directors have expressed concern that this proposal will have the unintentional result of dramatically reducing the level of funding currently being spent on core mental health services, particularly funding for outpatient, crisis, and recovery services. Other concerns include the potential that the addition of SUDs will further limit the availability of funding that is used to support county mental health services program and that while supportive of housing initiatives, the proposal to earmark a third of the BHSA funding to pay for housing requires further reduces available resources for critical BH services. (See the SB 326 analysis link above to review more stakeholder responses.)

BH Policy Questions:
1) Will elimination of the PEI bucket drastically reduce services for some of the most vulnerable communities, or will the BHSA proposal provide greater opportunity for counties to provide an array of services by ensuring they maximize funds by actively seeking federal financial participation, and holding private insurers accountable for the services they are responsible for providing?
2) Will the introduction of a Housing Intervention component and the reallocation of 30% of BHSA funds to this component, place critical services such as out-patient treatment, outreach and engagement and crisis treatment/stabilization services at risk?
3) Does this proposal sufficiently address the needs of historically marginalized populations and the reduction and elimination of health disparities and access to BH services?

SUMMARY

The Governor's proposal represents the most comprehensive and far reaching changes to the BH system in California in decades and the $4.68 billion General Obligation bonds is an unprecedented investment in supportive housing and unlocked, residential beds for many Californians experiencing homelessness or at risk of homelessness. These proposals attempt to shift the decision making and spending considerations for both housing and BH that would have enormous impact not only on 58 individual counties but also hundreds of cities and all communities throughout California. Counties are perhaps the most essential partners in the successful implementation of the Governor's proposal but a number of state entities also share responsibility for implementation. Although DHCS is responsible for implementing the majority of the changes contained in the BHSA, there are also key roles for BHSOAC, HCAI, HCD, and The Department of Public Health.

As California voters are asked to approve complex and impactful initiatives at the March 2024 ballot, continued oversight and thorough vetting would be crucial. As such, it is critical for the Legislature to ensure that the reforms are implemented not only effectively and timely and most importantly truly serving the needs of vulnerable Californians.