Public Comment from T. Mohammad

From: Tamim Mohammad <tamimmohammad@gmail.com>
Sent: Tuesday, March 24, 2026 11:28 AM
To: BHSOAC Public Comment <publiccomment@bhsoac.ca.gov>; BHSOAC <mhsoac@mhsoac.ca.gov>
Cc: Mayra Alvarez <mayra.alvarez@bhsoac.ca.gov>; Brenda Grealish <brenda.grealish@bhsoac.ca.gov>; Amariani Martinez <amariani.martinez@bhsoac.ca.gov>
Subject: Public Comment Submission – March 27, 2026 BHSOAC Meeting (Submitted March 24, 2026)

Re: Public Comment Submission – March 27, 2026 BHSOAC Meeting (Submitted March 24, 2026)

Good morning, Behavioral Health Services Oversight and Accountability Commission,

I am submitting this public comment on March 24, 2026 for the March 27, 2026 Commission meeting to document system conditions and responses following prior notice regarding ADA Title II communication requirements and program access within Medi-Cal behavioral health systems.

This submission is also provided pursuant to a documented ADA Title II written-only communication accommodation, previously confirmed in October 2025 in state and departmental proceedings. I respectfully request that this comment be accepted and included in the meeting record given the standard 72-hour submission guideline, or alternatively, that this submission be preserved as part of the Commission's ADA accommodation and access record.

The Commission's current agenda includes discussion of the crisis continuum and lived experience and family inclusion structures. These issues are directly relevant to the implementation of crisis-continuum planning and lived experience inclusion discussed in today's agenda. These gaps have persisted despite the availability of public-safety, family navigation, suicide prevention and postvention, oversight, and ethics-informed approaches grounded in lived experience, research, and system-level data, including those previously submitted through public processes and direct engagement.

In practice, despite prior notice, access to care and participation did not occur through county-administered systems in a timely or accessible manner. Barriers to effective

communication and participation persisted, including lack of consistent written communication pathways.

As a result, necessary psychiatric care was obtained outside the local system after a prolonged period without consistent access.

This comment is submitted to document the gap between system-level planning related to crisis response and inclusion, and actual access to care and participation experienced in practice.

A related complaint has been submitted to federal oversight for review of these access and communication issues.

I respectfully request that this record be maintained as part of the Commission's oversight of crisis systems, inclusion structures, and access to care.

Respectfully,
Dr. Esroruleh T. Mohammad
Licensed Psychologist
CARE Court Petitioner