Commission for Behavioral Health

Meeting Materials Packet

Commission Meeting

May 22, 2025

9 a.m. – 4:00 p.m.

1812 9th Street
Sacramento, CA 95811

(916) 500-0577
info@bhsoac.ca.gov

bhsoac.ca.gov

Commission for Behavioral Health

COMMISSION MEETING NOTICE AND AGENDA

May 22, 2025

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on May 22, 2025, at 9:00 a.m.

This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123, 11123.5, and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE	May 22, 2025
TIME	9:00 a.m.
LOCATION	1812 9th Street, Sacramento, CA 95811 and Virtual

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link: Click Here to Register

COMMISSION MEMBERS:
Mayra E Alvarez, *Chair*
Alfred Rowlett, *Vice Chair*
Pamela Baer
Michael Bernick
Mark Bontrager
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Robert Callan, Jr.
Steve Carnevale
Rayshell Chambers
Shuo (Shuonan) Chen
Christopher Contreras
Dave Cortese, *Senator*
Makenzie Cross
Amy Fairweather, J.D.
Brandon Fernandez
Dave Gordon
John Harabedian, *Assemblymember*
Karen Larsen
Mara Madrigal-Weiss
Gladys Mitchell
Rosielyn Pulmano, *Assembly Designee*
James L. Robinson III, Psy.D., MBA
Marjorie Swartz, *Senate Designee*
Marvin Southard, Ph.D.
Jay'Riah Thomas-Beckett
Gary Tsai, MD
Jevon Wilkes

EXECUTIVE DIRECTOR:
Brenda Grealish

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the detailed explanation of how to participate in public comment after the meeting agenda.

Our Commitment to Excellence

The Commission's 2024-2027 Strategic Plan articulates four strategic goals:

- Champion vision into action to increase public understanding of services that address unmet behavioral health needs.
- Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities.
- Inspire innovation and learning to close the gap between what can be done and what must be done.
- Relentlessly drive expectations in ways that reduce stigma, build empathy, and empower the public.

Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. Items may be considered in any order at the discretion of the Chair. Public comment is taken on each agenda item. Unlisted items will not be considered.

9:00 a.m. **1. Call to Order and Roll Call**

Information

Chair Mayra E. Alvarez will convene the Commission meeting, and a roll call of Commissioners will be taken.

9:10 a.m. **2. Announcements and Caring Moment**

Information

Chair Mayra E. Alvarez, Commissioners, and staff will make announcements and give updates. We will also ask a Commissioner to share a Caring Moment to help us center ourselves on the purpose of our work and the people we serve.

9:40 a.m. **3. General Public Comment**

Information

General Public Comment is reserved for items not listed on the agenda. No discussion or action will take place.

10:00 a.m. **4. Consent Calendar**

Action

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

1. April 24, 2025 Meeting Minutes
2. Napa County: PIVOT - $290,380 over 3 years
3. Yolo County: Semi-Statewide Enterprise Health Record Multi-County Collaborative Project - $5,267,306 over 3 years

- Public Comment
- Vote

10:10 a.m. **5. Advocacy Spotlight**
Information

The Commission will hear a presentation from the California Association of Veteran Service Agencies (CAVSA) on advocacy work conducted for veterans. Presented by *California Association of Veteran Service Agencies (CAVSA).*

- Public Comment

10:40 a.m. **6. May Revise Budget Update**
Action

The Commission will hear an update on the state budget and Governor's May Revise budget proposal and will consider approving a revised spending plan including associated contracts. Presented by *Norma Pate, Deputy Director of Administrative Services and Performance Management.*

- Public Comment
- Vote

11:10 a.m. **7. Mental Health Wellness Act Full-Service Partnership Grant**
Action

The Commission will hear a presentation on grant opportunities to strengthen full-service partnerships. Presented by *Kallie Clark, PhD, MSW, Research Scientist Supervisor I.*

- Public Comment
- Vote

11:40 a.m. **8. Lunch**

The Commission will pause for 20 minutes to allow Commissioners to pick up lunch.

12:00 p.m. **9. Innovation Partnership Fund & Public, Private, and Nonprofit Partnerships Discussion**
Information

The Commission will participate in a panel discussion to explore a range of public, private, and nonprofit partnership models. This session will also include a preliminary facilitated discussion to help prioritize potential concepts for further exploration as part of the upcoming Innovation Partnership Fund grant. Presented by *invited panelists and a facilitator.*

- Public Comment

3:00 p.m. **10. Impacts of Firearm Violence**
Action

The Commission will receive and consider adoption of the policy report *Stopping the Hurt: Preventing the Harms of Firearm Violence Through Public Behavioral Health*. Presented by *Courtney Ackerman, Research Scientist.*

- Public Comment
- Vote

3:30 p.m. **11. Early Psychosis Intervention Strategic Plan**
Action

The Commission will receive and consider accepting a report for early psychosis intervention developed by McKinsey and hear an update from staff on related items. Presented by *McKinsey Institute.*

- Public Comment
- Vote

4:00 p.m. **12. Adjournment**

Our Commitment to Transparency

In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.bhsoac.ca.gov at least 10 calendar days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing bhsoac@bhsoac.ca.gov.

Our Commitment to Those with Disabilities

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing bhsoac@bhsoac.ca.gov. Requests should be made one (1) week in advance, whenever possible.

Notes for Participation

For Public Comments: Prior to making your comments, please state your name for the record and identify any group or organization you represent.

Register to attend for free here:
https://bhsoac-ca-gov.zoom.us/meeting/register/2IzwjC1TReuG9AZMJAtvNw#/registration

Email Us: You can also submit public comment to the Commission by emailing us at publiccomment@bhsoac.ca.gov. Emailed public comments submitted at least 72 hours prior to the Commission meeting will be shared with Commissioners at the upcoming meeting.

Public comment submitted less than 72 hours prior to the Commission meeting will be shared with Commissioners at a future meeting. Please note that public comments submitted to this email address will not receive a written response from the Commission. **Emailing public comments is not intended to replace the public comment period held during each Commission Meeting and in no way precludes a person from also providing public comments during the meetings.**

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding public participation procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fail, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public have a right to offer comment at the Commission's public meeting. The Chair will indicate when a portion of the meeting is open for public comment. Any member of the public wishing to comment during public comment periods must do the following:

→ If joining in person. Complete a public comment request card and submit to Commission staff. When it is time for public comment, staff will call your name and you will be invited to the podium to speak. Members of the public should be prepared to complete their comments within 3 minutes or less, unless a different time allotment is needed and announced by the Chair.

→ If joining by call-in, press *9 on the phone. Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

→ If joining by computer, press the raise hand icon on the control bar. Pressing the raise hand will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line, announce your name, and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

In accordance with California Government Code § 11125.7(c)(1), members of the public who utilize a translator or other translating technology will be given at least twice the allotted time to speak during a Public Comment period.

AGENDA ITEM 4

Action

May 22, 2025 Commission Meeting

Consent Calendar

Summary:
The Commission will consider approval of the Consent Calendar which contains the following Items and Innovation plans:

1) April 24, 2025 Meeting Minutes
2) Napa County: Program Improvements for Valued Outpatient Treatment (PIVOT) up to $290,380
3) Yolo County: Semi-Statewide Enterprise Health Record Multi County Collaborative up to $5,267,306

Background:
Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held for future consideration at the discretion of the Chair.

April 24, 2025 Meeting Minutes
The Behavioral Health Services Oversight and Accountability Commission will review the minutes from the April 24, 2025 Commission meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Innovation Funding Requests
Two (2) counties are requesting Innovation funding approval. They are summarized below:

1. **Napa County: Program Improvements for Valued Outpatient Treatment (PIVOT)**
   The Napa County Behavioral Health is requesting up to $290,380 of Innovation spending authority to prepare for implementation of Proposition 1, also known as the Behavioral Health Services Act (BHSA), by joining Orange County's Progressive Improvements for Valued Outpatient Treatment (PIVOT) Innovation project that was Commission-approved in November 2024. Specifically, the County requests to join the following three (3) components: Full Service Partnership (FSP) Reboot, Developing Capacity for Specialty Mental Health Plan Services (SMHS) with Diverse Communities, and Innovating

Countywide Workforce Initiatives. PIVOT proposes to create and test service models that align the delivery, care coordination, systemwide collaborations, and payment for care to ensure a seamless and integrated experience for behavioral health clients, resulting in improved client outcomes.

Behavioral Health Services Act Alignment and Sustainability
The PIVOT project was developed to directly and immediately assist counties with implementing mandated changes under the Behavioral Health Services Act (BHSA). This includes focusing on comprehensive FSP programs that align with the BHSA's emphasis on high-quality, intensive outpatient services and housing support for participants. It also includes enhancing workforce retention, education, and training to strengthen Napa County's capacity to deliver effective, person-centered care, as well as supporting systems integration for seamless service coordination and cross-system billing. Finally, the project supports the BHSA's focus on promoting data-driven decision through E Health Record (EHR) implementation to ensure that behavioral health services are data-informed and outcomes-driven.

The three (3) project components that Napa County is requesting to join all include sustainability as an intended outcome that will occur through administrative changes, collaboration between programs, new funding structures and revenue optimization, and strategies that support the overall behavioral health system.

Community Planning Process
Local Level

In February 2025, the Napa County Mental Health Stakeholder Advisory Committee met to identify gaps in behavioral health, as well as opportunities to integrate cross-systems training and support to aid community-based organizations and providers with the BHSA transition. This diverse group of Committee members includes representation from various sectors, such as health care, public health, law enforcement, education, family and consumer advocacy, LGBTQ+ services, and mental health organizations.

Workforce and training needs were a heavy focus of the Stakeholder Advisory Committee meeting, ultimately becoming one of the focal points of this Innovation plan. Implementation of SmartCare EHR was also identified as a potential tool that could help align the County's workforce initiatives with Proposition 1 priorities by ensuring high fidelity delivery of services and a seamless transition to BHSA.

Additionally, Napa County is home to a large proportion of older adults, with 24% of the population age 65 and over. In line with the County's Master Plan for Aging, an emphasis on older adult mental health and prevention programs was integrated into this Innovation proposal as an area of attention, particularly given the impending dissolution of PEI funds.

For more information on Napa County's local community planning process, see pages 6-7 of the project proposal.

The County held their public comment period from March 10, 2025 through April 9, 2025 followed by their Behavioral Health Board hearing on April 9, 2025. Napa will seek Board of Supervisors Approval at a date to be determined following Commission approval.

Commission Level

Commission staff shared this project with its community partners and the Commission's email distribution list on March 17, 2025, and comments were directed to County MHSA staff. No comments were received in response to the Commission's request for feedback.

2. **Yolo County: Semi-Statewide Enterprise Health Record Multi County Collaborative**

Yolo County requests authorization to use up to $5,267,306 of Innovation funding to partner with CalMHSA on the Semi-Statewide Enterprise Health Record Innovation Project (EHR Project). If approved, Yolo County will join 23 other counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting. Together, these 24 counties are collectively responsible for more than four million (27%) of the state's Medi-Cal Beneficiaries.

Counties have prioritized this innovation project at this time in response to the severe behavioral workforce challenge they face with the hope that they can preserve the current workforce and improve the quality of services during a time of rising need for mental health treatment services. The EHR Project hypothesizes that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

Behavioral Health Services Act Alignment and Sustainability

This multi-county innovation project aligns with the Behavioral Health Services Act through a shared focus on (a) meeting behavioral health workforce and technological needs in a rapidly changing and increasingly interoperable environment, and (b) increasing access to meaningful data to evaluate behavioral health service outcomes and equity.

Yolo County will utilize Behavioral Health Services and Supports funding along with Medi-Cal funding to sustain this project.

Community Planning Process

Local Level

The County's community planning process occurred over a five-month period resulting in the development of the 2023-2026 Three Year Plan, holding more than 30 focus groups comprised of 516 participants including LGBTQ+ community members, youth, adults, and diverse and racial communities (see Appendix, page 7 for list of dates for focus group participants).

Yolo County reports their community planning process has brought forward comments centered around the need for increased access to services including integrated and culturally competent services for special needs populations, and they hope this project will address the feedback that was received.

Upon approval of this project, Yolo County will create an EHR Stakeholder group that will provide feedback in the design, implementation, and evaluation of this project.

Following community input, the County proposed this project as part of their MHSA Three-Year Program and Expenditure Plan. The public comment period was March 18, 2025 through April 16, 2025, followed by their local Behavioral Health Board hearing held on April 16, 2025.

Commission Level

A final Innovation plan, incorporating community input and MHSOAC technical advice, was submitted to Commission staff on April 21, 2025. This project was shared with the Commission's listserv on March 21, 2025. **No comments were received in response to the sharing of this project.**

Presenter(s): None

Enclosures (5): (1) April 24, 2025 Minutes; (2) April 24, 2025 Motions Summary; (3) Commission Community Engagement Process; (4) Napa County: Program Improvements for Valued Outpatient Treatment (PIVOT) Analysis; (5) Yolo County: Semi-Statewide Enterprise Health Record Multi County Collaborative Analysis

Handouts: None

Additional Materials (2): Links to the final Innovation projects are available on the Commission's website at the following URLs:

Program Improvements for Valued Outpatient Treatment (PIVOT) - MHSA Innovation Project, Napa County 2025

Semi-Statewide Enterprise Health Record - Multi-County Collaborative Innovative Project Plan

Proposed Motion: That the Commission approve the Consent Calendar that includes:

1) April 24, 2025 Meeting Minutes
2) Napa County: Program Improvements for Valued Outpatient Treatment (PIVOT) up to $290,380
3) Yolo County: Semi-Statewide Enterprise Health Record Multi County Collaborative up to $5,267,306

State of California

BEHAVIORAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date April 24, 2025

Time 9:00 a.m.

Location BHSOAC
1812 9th Street
Sacramento, California 95811

Members Participating:

Mayra Alvarez, M.H.A., Chair
Alfred Rowlett, M.B.A., M.S.W., Vice Chair
Pamela Baer*
Michael Bernick. J.D.*
Mark Bontrager, J.D., M.S.W.
Keyondria Bunch, Ph.D.
Robert Callan, Jr.
Steve Carnevale
Rayshell Chambers, M.P.A.
Christopher Contreras
Senator Dave Cortese, J.D.
by Marjorie Swartz[1]
Makenzie Cross
Amy Fairweather, J.D.
Brandon Fernandez, M.P.H.*
David Gordon, Ed.M.
Mara Madrigal-Weiss, M.Ed., Immediate Past Chair
Gladys Mitchell, M.S.W.[1]
Marvin Southard, Ph.D., M.S.W.*
Gary Tsai, M.D., DFAPA, FASAM
Jevon Wilkes

*Participated remotely
[1] a.m. only

Members Absent:

Sheriff Bill Brown, M.P.A.
Shuo Chen, J.D.
Assembly Member John Harabedian
Karen Larsen
Jay Robinson, Psy.D., M.B.A.
Jay'Riah Thomas-Beckett. M.A.

BHSOAC Meeting Staff Present:

Will Lightbourne, Interim Executive Director
Sandra Gallardo, Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance

Management
Kendra Zoller, Deputy Director, Legislation
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Krsangi Knickerbocker, Deputy Chief Counsel
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

[Note: Agenda Items 6 and 8 were taken out of order. These minutes reflect these Agenda Items as listed on the agenda and not as taken in chronological order.]

1: Call to Order and Roll Call

Chair Mayra Alvarez called the meeting of the Behavioral Health Services Oversight and Accountability Commission (BHSOAC, Commission, or Commission for Behavioral Health (CBH)) to order at 9:06 a.m. and welcomed everyone. The meeting was on Zoom, via teleconference, and held at the BHSOAC headquarters, located at 1812 9th Street, Sacramento, California 95811.

Chair Alvarez stated the Commission's Strategic Plan for 2024-27 was approved at the January 25th Commission meeting last year. She reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Chair Alvarez noted for the record that the Commission is required by the Bagley-Keene Open Meeting Act to have a minimum of 14 Commissioners in person to establish a quorum to conduct business today.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending in Person: Chair Alvarez, Vice Chair Rowlett, and Commissioners Bontrager, Bunch, Callan, Carnevale, Chambers, Contreras, Cortese, Cross, Fairweather, Gordon, Madrigal-Weiss, Mitchell, Tsai, and Wilkes. Attending Remotely: Commissioners Baer, Bernick, Fernandez, and Southard.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements and Caring Moment

Chair Alvarez welcomed new Commissioners Amy Fairweather, Brandon Fernandez, Jay-Riah Thomas-Beckett, and Jevon Wilkes and asked them to introduce themselves.

Chief Counsel Gallardo introduced new attorney Krsangi Knickerbocker.

Chair Alvarez gave the announcements as follows:

Caring Moment

Commission meetings will begin with a "caring moment," as suggested by Commissioner Robinson, to help Commissioners center themselves on the purpose of the work and the people served. This practice is meant to remind everyone why the Commission does what it does, to share stories or moments that may impact others in ways that are not always seen, and to provide an opportunity to reflect on how to better serve the community.

Commissioner Cross shared a caring moment about attending the We Live 2025 Conference, hosted by LGBTQ partner Mental Health America of California. She stated it was a day filled with learning, hope, and connection, but also was a vivid reminder as to why the Commission's work is imperative. She noted that it is moments like this that reaffirm how truly powerful collaboration can be. She encouraged everyone to participate in advocacy events.

Agenda Review

The Commission will be moving into closed session during the lunch break. In the past two weeks, the Executive Director Screening Committee has continued to meet to discuss Executive Director candidates. Today, the full Commission will have the opportunity to consider Committee recommendations. A report out will be done upon returning from the closed session of any actions taken during the closed session.

Agenda items will be taken out of order due to changes in quorum throughout the day.

3: General Public Comment

Jerry Hall (attended remotely via Zoom), Certified Peer Support Specialist, BHABrehab.com, stated concern about the long-standing systemic issue statewide. Although county behavioral health boards are required to review and approve the procedures used to ensure citizen and professional involvement in all stages of the community program planning process, many counties are not developing this process.

Jerry Hall stated the community program planning process done before the County Integrated Plan is created includes community objectives and goals, challenges and opportunities, and strategies and tactics to achieve those goals. The speaker noted that the community planning process is not a brief pre-annual planning exercise but is ongoing engagement with the community throughout the year.

Jerry Hall stated one remedy is for the Department of Health Care Services (DHCS) to require counties to submit their behavioral health board's reviewed and approved community planning process plans and budget. The speaker encouraged everyone to access resources provided on BHABrehab.com. The speaker stated the community planning process unifies everyone.

Mark Karmatz (attended remotely via Zoom), consumer and advocate, stated a national mental health newsletter outlined concerns about the federal administration's plan to consolidate the Substance Abuse and Mental Health Services Administration (SAMHSA) and others into the newly-formed Administration for a Healthy America (AHA). The speaker stated this transition will cause many SAMHSA employees to lose their jobs.

Chair Alvarez asked Mark Karmatz to email their request to staff.

Steve McNally (attended remotely via Zoom), family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, thanked the Commission for allowing the community to participate in the executive job search. The speaker noted that Vice Chair Rowlett attended the California Behavioral Health Planning Council (CBHPC) and stated the hope that the ties between this Commission,

the Council, and the local behavioral health advisory boards improve in order to bring in private investments to the table and to get the community engaged.

Steve McNally asked if the Commission will weigh in on any of the modules being set up by the DHCS for the Behavioral Health Services Act (BHSA) to ensure a robust community planning process. County behavioral health boards are mandated to engage in citizen engagement at all stages of the planning process.

Steve McNally suggested that the Commission create a transparency page for all Commissioners that shows their relationships, similar to what the CBHPC has for its members.

Steve McNally stated involuntary transport in the state is not happening because of a hands-off approach. Transferring from law enforcement to the counties will create a significant risk, when individuals do not get transported who should be put on 5150 holds.

Esroruleh Mohammad, Ph.D. (attended remotely via Zoom), Clinical Psychologist, systems equity advocate, and the author of the “BureauCare-to-Custody-Cemetery Pipeline,” provided an overview of their systems equity framework for public health, institutional safety, and interagency reform. The speaker stated concern about structural conditions that have persisted for nearly two decades under the Mental Health Services Act (MHSA). The speaker stated their prevention framework is diagnostic in its clarity and prescriptive in its solutions.

Will Taetzsch (attended remotely via Zoom), Program Director of Substance Treatment, Didi Hirsch Mental Health Services, stated it is critical that California continues to actualize its commitment to funding efforts to provide substance use prevention and harm reduction services for California’s most vulnerable populations. The speaker stated Didi Hirsch and other organizations have the ability to deliver proven interventions to prevent substance use before it starts. The speaker asked the Commission to allocate funding to substance use service provider organizations and to include more discussion on substance use-related topics in future Commission meetings.

Kevin Bernadt (attended remotely via Zoom) agreed that the social service system is fragmented and all the burden is on law enforcement and civil servants who are not law enforcement. The speaker suggested lifestyle medicine as a solution to that fragmented system since social services, mental health needs, and health care are under the umbrella of lifestyle medicine. The speaker asked to present at a future Commission meeting on lifestyle medicine.

Richard Gallo (attended remotely via Zoom), Certified Peer Support Specialist, stated concern that the peer workforce was not included in Proposition 1 and is not included in California Advancing and Innovating Medi-Cal (CalAIM). The peer workforce needs to be sustained. It needs to be included in the Full-Service Partnership (FSP) Initiative. Peer Support Specialists with lived experience make a difference in the lives of individuals in the behavioral health community.

Richard Gallo agreed with Jerry Hall about the community planning process. The lack of county buy-in to include the community in the planning process is part of the reason that the MHSA failed statewide.

Linda Hart (attended remotely via Zoom), CEO, African American Health Coalition, shared her experience as a parent of a child in San Bernardino County who has gone through crisis. The speaker stated there a disconnect between the Department of Behavioral Health and the hospitals that have behavioral health units. The speaker provided the example of the lack of communication between county and community hospitals and primary care givers about medications, treatments, or action plans, which leads to being overmedicated or undermedicated.

Linda Hart stated the need for providers to collaborate with each other and caregivers for better outcomes. The speaker also stated that they have yet to receive their child's plan of action. The speaker stated their child has been in and out of the crisis unit at least once a month because of the fact that there is no continuum of care plan that the family can use to better understand next steps.

4: Consent Calendar

Chair Alvarez stated all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action. She noted that the documents related to these projects and the staff analyses are included in the meeting materials.

Chair Alvarez stated this month's Consent Calendar includes the approval of the meeting minutes from March 26th and 27th; six innovation plans including Monterey, Mariposa, Orange, Fresno, Marin, and Ventura Counties; and three advocacy notices of intent to award grants to 0-5, immigrant and refugee, and K-12 populations.

Commissioner Chambers recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Innovation Proposals:

Chair Alvarez stated the six innovation proposals align with the BHSA and include plans for sustainability. They include the following:

- Monterey and Mariposa Counties request to join the existing Psychiatric Advance Directives Phase 2 Multi-County Collaborative.
- Orange County requests to extend their participation in the Psychiatric Advance Directives Phase 2 Multi-County Collaborative, which was originally approved by the Commission in August 2024.
- Fresno County requests funding for a new project that will provide outreach and engagement, as well as increase access to care, for individuals who are homeless or at risk for homelessness and have a serious mental illness, chronic mental illness, and/or substance use disorder.

- Marin County requests an extension for their Student Wellness Ambassador Program, which was originally approved by the Commission in September 2021.
- Ventura County requests funding for a new project that will expand access to comprehensive mental health services for children and transition age youth (TAY) by using the Collaborative Care and Behavioral Health Integration models, which leverage existing infrastructure and workforce to treat both mental and physical needs.

Procurement Updates:

Chair Alvarez stated the three new procurements are as follows:

Immigrant and Refugee Advocacy Notice of Intent to Award. On January 24, 2025, the Commission released a Request for Proposals (RFP) to award $502,500 contracts to each of seven local organizations to conduct advocacy, training and education, and outreach and engagement activities on behalf of immigrant and refugee populations. The application closed on March 14, 2025. The Commission intends to award contracts to the following organizations:

- Asian Americans for Community Involvement, Inc.
- Boat People SOS (BPSOS) Center for Community Advancement, Inc.
- Center for Empowering Refugees and Immigrants
- El Sol Neighborhood Educational Center
- Health Education Council
- International Rescue Committee, Inc.
- Refugees Enrichment and Development Association Inc.

K-12 Advocacy Notice of Intent to Award. On February 18, 2025, the Commission released an RFP to award $2,010,000 to one statewide organization that would conduct state- and local-level advocacy, training and education, and outreach activities on behalf of K-12 student populations. The application closed on April 4, 2025. The Commission intends to award a contract to the following organization:

- Youth Leadership Institute

0-5/Maternal Behavioral Health Notice of Intent to Award. On February 27, 2025, the Commission released an RFP to award $18 million in available Mental Health Wellness Act funds to six community-based organizations in order to reduce out-of-home placements, improve educational outcomes, identify developmental delays, and otherwise serve the behavioral health needs of children 0-5 and their families.

Two small county community-based organizations will each receive $2 million; two medium county community-based organizations will each receive $3 million; and two large county community-based organizations will each receive $400 million. The application closed on March 28, 2025. The Commission intends to award contracts to the following organizations:

- Casa de Esperanza (small county)

- Redwood Community Services (small county)
- Child Parent Institute (medium county)
- North Marin Community Services (medium county)
- St. John's Community Health (large county)
- Foothill Family Service (large county)

Commissioner Comments & Questions

Chair Alvarez thanked staff for their work in reviewing these applications and ensuring that the Commission is communicating the availability of these resources to community organizations. She stated the Commission has had a number of discussions about the need to integrate community-based organizations in its partnerships so that it not only works with counties but also works with community-based organizations, which are a vital part of the infrastructure to meet the health needs of communities. These programs are redefining what it means to have behavioral health services in the community, defined by the community, and in partnership with the community.

Immediate Past Chair Madrigal-Weiss stated the team worked diligently to highlight K-12 youth leadership advocacy. Youth have been asking for the opportunity to work with partners across the state.

Commissioner Baer asked if the Commission will receive updates on the successes and challenges of the 0-5/Maternal Health Care Grants.

Interim Executive Director Lightbourne stated, during the reorganization of some of the Commission's functions, it has been focusing on bringing together the Commission contract teams and research and evaluation teams to ensure, as these grant awards become contracts, that there are clear expectations and deliverables that can be evaluated and, as the required reports are submitted from grantees, that the Commission is not just "checking boxes" but is learning about the progress being made, the difficulties being overcome, and how the Commission can help them make connections to other grantees.

Interim Executive Director Lightbourne stated the Commission intends to hold grantees accountable to provide the Commission with outcomes that help the Commission learn what works, while offering support and assistance to grantees who are trying to knit together a set of resources under the Mental Health Wellness Act and in concert with the BHSA to make new approaches work.

Commissioner Baer stated the accountability is great but asked if grantees will provide regular status reports to the Commission so other communities can help support or even elevate the work being done.

Interim Executive Director Lightbourne stated the membership of the Program Advisory Committee will be proposed later in today's agenda. Part of this Committee's role is to review the regular reports from Commission grantees and help make connections. Grantees can also be invited to share successes and challenges with the Committee and the public.

Vice Chair Rowlett stated the Committee process is a great way to instruct and inform Commissioners as they bring recommendations to the Commission, ask critical questions about key performance indicators, and ensure that the fiscal elements of the proposal are being fulfilled.

Public Comment

There was no public comment.

Action: Chair Alvarez asked for a motion to approve the Consent Calendar. Commissioner Bontrager made a motion, seconded by Commissioner Gordon, that:

- *The Commission approves the Consent Calendar that includes:*
  1. *March 26-27, 2025, Meeting Minutes*
  2. *Monterey County: PADs – Multi-County Collaborative – PHASE II up to $3,000,000*
  3. *Mariposa County: PADs – Multi-County Collaborative – PHASE II up to $160,740*
  4. *Orange County Extension: PADs – Multi-County Collaborative – PHASE II up to $2,739,601*
  5. *Fresno County: The Lodge 2 up to $4,200,000*
  6. *Marin County Extension: Student Wellness Ambassador Program up to $870,000*
  7. *Ventura County: Collaborative Care for Youth: Integrating Collaborative and Behavioral Health Models up to $2,874,361*
  8. *Immigrant and Refugee Advocacy Intent to Award*
  9. *K-12 Advocacy Notice of Intent to Award*
  10. *0-5/Maternal Behavioral Health Mental Health Wellness Act Notice of Intent to Award*

Motion passed 17 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Baer, Bernick, Bontrager, Bunch, Callan, Carnevale, Contreras, Cortese by Senate Designee Swartz, Cross, Fairweather, Fernandez, Gordon, Madrigal-Weiss, Mitchell, and Tsai, Vice Chair Rowlett, and Chair Alvarez.

The following Commissioners abstained: Commissioners Chambers and Wilkes.

Commissioner Chambers rejoined the meeting.

5: Advocacy Spotlight

Chair Alvarez stated the Commission has advocacy contracts with organizations that represent the needs of consumers, diverse racial and ethnic communities, families of consumers, immigrants and refugees, K-12 students, LGBTQ communities, parents and caregivers, transition age youth, and veterans. These groups have unique challenges when attempting to access behavioral health resources.

Chair Alvarez stated these contracts are provided to ensure that the interests of these groups are represented in local behavioral health planning and state-level policy making. To accomplish their work, the contracted advocacy organizations conduct advocacy activities, training, and outreach and engagement events around the state.

Chair Alvarez stated the Advocacy Spotlight is a new standing agenda item for the Commission. One contracted advocacy organization will be invited to share the work they are doing to provide advocacy around the state on behalf of and with marginalized and often underserved populations.

Chair Alvarez stated the Commission will hear a presentation from CalVoices on advocacy work conducted for clients and consumers. She asked the representatives from CalVoices to present this agenda item.

Clare Cortright, Advocacy Director, and Nicole Chilton, Program Manager, CalVoices, provided an overview, with a slide presentation, of the background, work, accomplishments, and impacts of CalVoices' advocacy and engagement activities. Ms. Cortright stated the general strategy is to facilitate the communication of bottom-up concerns and demands to top-down decision-makers by utilizing a learn-teach-implement model. The ultimate goal of this grant cycle is to support individuals in the upcoming community planning process for the BHSA.

A video was shown highlighting Angel Mercado, Peer Trainer, ACCESS California, a program of CalVoices, wherein they shared their story and successes and impacts of ACCESS California.

Ms. Cortright provided the following recommendations to aid in the work of the Commission:

- Ongoing support for community advocacy and expansions of community advocacy.
- Technical assistance for consumer-operated services, including transitioning into Medi-Cal-billable services.
- Integration of peers into all parts of the continuum of care.

Commissioner Comments & Questions

Commissioner Chambers thanked CalVoices for empowering consumer-run organizations to understand their power and ability to advocate and inform the utilizers of this system about the policy landscape. At the end of the day, it is about supporting individuals in recovery. She stated she will continue to uplift the importance of projects like this.

Commissioner Fairweather referred to the recommendation for Medi-Cal-billable services and stated peer work is key, especially with underserved populations, but smaller community-based organizations do not have the capacity to do Medi-Cal billing. She stated the need to encourage counties and providers to subcontract with community-based organizations and take care of the billing process.

Ms. Cortright agreed and stated the importance of technical assistance for smaller community-based organizations.

Commissioner Mitchell stated she loved the video that proves that recovery and healing is possible. She thanked CalVoices for finding opportunities to move peer specialists into the mainstream work model.

Commissioner Bontrager asked if CalVoices can provide technical assistance or best practices to counties on how to best engage the community in light of the new requirements for county program planning to include robust community involvement.

Ms. Cortright stated a core component of ACCESS California is training around the community planning process and how to engage in it.

Commissioner Bontrager stated the counties and the system need to know best practices on how to engage the community in the process of creating their county plans.

Commissioner Carnevale stated hiring peer specialists makes sense strategically and financially. He asked staff to write a paper outlining a broader landscape understanding of peer support, what the landscape looks like across the state, best practices, and where the Commission should focus.

Vice Chair Rowlett stated population health management and CalAIM identified the private insurance industry that funds Enhanced Care Management (ECM) and community services and supports (CSS) as another service provider. He stated those services are available to individuals who are experiencing mild to moderate symptoms only if they have that coverage and with their Medi-Cal. He suggested that the Commission look at this not to punish but to discuss the effectiveness of the service delivery and how to better engage with and help the private insurance industry understand the needs of individuals experiencing mild to moderate symptoms.

Ms. Cortright stated CalVoices is in favor of greater services on the managed care side, too; however, the platinum-type care plan has always been on the county side in terms of the variety and intensity of services. She stated the need for greater support across the spectrum of behavioral health services and for commercial plans to embrace some of these expansions, including integrating peers into that side. Some community-based organizations are looking at being ECM providers within the managed care structure and trying to get as many benefits as possible for a person with the expansions in CSS, as well.

Vice Chair Rowlett agreed that the platinum-type care should be available across the spectrum.

Immediate Past Chair Madrigal-Weiss stated the need to be intentional in including youth peer specialists in the peer workforce and to include youth peers in the paper Commissioner Carnevale asked staff to prepare.

Commissioner Gordon stated more work needs to be done with prevention. He provided the example that CalAIM is doing a smart thing in asking First 5 Commissions to do Memorandums of Understanding (MOUs) with managed care organizations about how they are serving the 0-5 space. He noted that, although it is fine to have an MOU, a much more powerful vehicle is needed in the 0-5 space where so many things can be done to make children's futures better before they even begin school.

Commissioner Gordon stated, in addition to studying the importance of peers in the paper Commissioner Carnevale asked staff to prepare, the merging of the education and health systems need to be studied to ensure that a greater emphasis is being put on prevention where dramatic outcomes can be seen. He noted that school districts do not have the capacity to do billing.

Chair Alvarez emphasized the need to highlight the role of peers and the need to build capacity to bring in community leaders and organizations into the system.

Commissioner Tsai asked for additional information on Recommendation 2 and the technical assistance CalVoices provides to simplify billing issues.

Ms. Cortright stated brick-and-mortar locations that are cash-financed through the MHSA have never been inside the insurance model, such as wellness and recovery centers and drop-in centers. One of the challenges is the need to be site-certified in order to be Medi-Cal billable, which has many requirements.

Commissioner Wilkes stated Certified Peer Support Specialists cannot bill, especially if they are under the age of 18.

Ms. Cortright stated the Certified Medi-Cal Peer Support Specialist (CMPSS) is an adult designation. There is not a credential for youth at this time. The other lived-experience paraprofessional recognized in Medi-Cal is the community health worker.

Commissioner Wilkes stated he would love to see advocacy for youth peer credentialling for establishing relationships for prevention. He asked about dual-credentialling between CMPSS and community health workers for Medi-Cal billing.

Ms. Cortright stated that is still in discussion. She agreed that a person with the lived experience of mental illness or substance use disorder (SUD) does have the relevant lived experience to be dual-certified as a peer support specialist and a community health worker.

Commissioner Fernandez asked how CalVoices has changed their training programs to more adequately address the needs of persons who have SUD along with mental health disorders.

Ms. Cortright stated CalVoices is looking into it. She stated Medi-Cal allows for a person with lived experience of only SUD to be a peer support specialist, but California, in opting in at the federal level to allow peer support to be billable in its Medi-Cal program, did not choose to opt in from the state down to the counties. They did this for budgetary reasons. This means that counties pay for the non-federal share cost and not the state General Fund.

Ms. Cortright stated the result is that counties using the MHSA for the non-federal share costs are restricted to the population with serious mental illness until it changes over to the BHSA. The county opt-in model in the bill that provides Medi-Cal-billable peer support specialists does not include SUD. There is interest in creating a curriculum that includes SUD since the new funding stream is a potential source for the non-federal share costs for SUD peers.

Chair Alvarez stated there are youth peer-to-peer programs throughout California invested in by the Children and Youth Behavioral Health Initiative (CYBHI). There is great opportunity to meet the needs of communities by uplifting the expertise and wisdom of the people. She stated she looks forward to the work of the Commission to move that forward and make it a reality.

Public Comment

Richard Gallo thanked CalVoices for their active role in teaching consumers how to become advocates and how to better understand the system. The speaker stated concern about counties that do not include their staff in the training to learn about the community planning process. The speaker asked the Commission to recognize that many counties and behavioral health directors do not want the community to be part of their planning processes.

Steve McNally stated CalVoices listens, educates, collaborates, and builds partnerships. The speaker stated they were glad to see Commissioners engaged with peers. Silo-breaking starts with influence. Mental health and substance use are being looked at but not managed care and other areas that are interconnected with funding. The speaker stated community planning is not a new concept. It was in the original MHSA but was not done and now communities have lost trust and given up.

Steve McNally stated, when influence meets the facts, change will happen. But often people with the facts do not have access to influence and influence does not flow downstream. The speaker stated they will send a note to the Commission on how to organize themselves from top to bottom in communities and how to focus on the four counties of Los Angeles that share one media market and 45 percent of California. The speaker suggested holding town halls at The California Endowment in Los Angeles, Sacramento, and Oakland. Assembly Bill (AB) 96 is critical to the success of peers in California as budgets at the counties will diminish and managed health care will play a much larger role.

Mark Karmatz stated Los Angeles County will have an online community planning meeting tomorrow at 9:30 a.m. The speaker invited everyone to participate in this meeting.

Laurel Benhamida, Ph.D. (attended remotely via Zoom), Muslim American Society – Social Services Foundation and the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked CalVoices for their trainings and webinars. The speaker stated billing became complex as it sought to prevent fraud and corruption, but now the system is so complex that it penalizes community-based non-profit organizations and the people they serve. It needs to be simplified. Risk management has erred too far in one direction.

Dr. Benhamida suggested that the Commission look at grants for community-based non-profit organizations and staffing. They need grants and technical assistance for free. The speaker suggested using some of the funds that the Commission can access more easily than community-based organizations.

Esroruleh Mohammad, Ph.D., provided an overview of their “BureauCare-to-Custody-Cemetery Pipeline” systems equity framework for public health, institutional safety, and interagency reform. The speaker stated, when clinicians and system-impacted professions contribute frameworks that drive policy transformation, inclusion and attribution are not optional. They are accountability mechanisms. The speaker urged the Commission to ensure that public frameworks guiding transformation are implemented for transparency, author engagement, and fidelity and purpose.

Jerry Hall stated working with CalVoices has been helpful in providing advocacy training. The speaker agreed with CalVoices helping to train county systems. Behavioral health board members are not required to get training so they do not understand the importance of all the elements that CalVoices-trained advocates do. The speaker suggested supporting county behavioral health boards more closely.

Kevin Bernadt suggested adding a disability component and lifestyle medicine and including getting more community members involved to get more feedback from the disability community. The speaker suggested dedicated funding for organizations following the Americans with Disabilities Act (ADA) rules and regulations in California to provide accommodations.

Kevin Bernadt stated the state of Minnesota has a policy for all departments in the state called C7C, which requires equality with people with disabilities in hiring and provides the opportunity for CSDI and the welfare system to bring in people for work.

Kevin Bernadt stated the need for trauma-informed lifestyle medicine to be Medi-Cal-billable. The speaker suggested that the Commission work with Medicare to include lifestyle medicine in the health care system to provide preventative care for disabilities, including behavioral health and physical care, for continuous improvement as well as community coordination. The speaker suggested dedicated funding for advocacy for the community planning process.

Commissioner Discussion

Chair Alvarez thanked CalVoices for sharing about the incredible work that CalVoices is doing and for their partnership with the Commission in this work together. She stated there was robust conversation today and so much more to build on in the work to come through the Commission’s Committees and through the Commission’s work as a whole.

Chair Alvarez stated much of this conversation highlighted the importance of the Medi-Cal program. One in three Californians depend on the Medi-Cal program, but the Medi-Cal program does not exist without the Medicaid program at the national level. In the spirit of uplifting these experiences and the importance of Medicaid and the importance of educating elected officials, she encouraged everyone to reach out to members of Congress to educate them about the importance of Medicaid.

[Note: Agenda Item 6 was taken out of order and was heard after Agenda Item 8.]

6: Update on Recent Allocations

Chair Alvarez stated one of the commitments the Commission made to renewed transparency at the beginning of the year was to keep the Commission and public informed about how grants and contracts are being executed. The Commission will hear updates on recent allocations. She asked staff to present this agenda item.

Interim Executive Director Lightbourne reviewed the activities related to the allocation of funds to Mental Health Wellness Act grantees for the Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) and Older Adults and the Behavioral Health Student Services Act (BHSSA) WestEd evaluation. Commission staff have engaged the various grantees from the EmPATH and Older Adult programs and have met with representatives from WestEd regarding the allocation of funds to support those efforts.

Chair Alvarez stated, in the Commission's commitment to establishing trust and being more transparent in its practices, staff is exploring what more the Commission can do to demonstrate that commitment. She stated she has asked staff to produce a quarterly report of every contract and grant that has been signed, which will be publicly available on the website.

Commissioner Comments & Questions

Commissioner Wilkes asked how the insurance industry is impacting the work of the Commission. He asked about impacts and stories from the Southern California fires.

Interim Executive Director Lightbourne stated Commissioners heard a presentation at the last Commission meeting on known impacts of the Southern California fires and possible future impacts downstream that may emerge due to the fires.

Commissioner Bunch asked if the Commission has started a discussion about how to support and help immigrant communities.

Interim Executive Director Lightbourne stated the Commission has not yet had a strategy session on that issue. He stated, now that the Commission will be executing a new set of contracts approved this morning on the immigrant and refugee population, staff will talk with the contractors about strategic opportunities and the role the Commission can play to support immigrant and refugee communities.

Commissioner Bunch asked about creating a Committee for Commissioners who are interested in being involved.

Commissioner Carnevale suggested examining new opportunities in the context of the Commission's strategic plan with the new Executive Director.

Chair Alvarez agreed and stated the importance of discussing Commissioner Bunch's suggestion within the Program Advisory Committee and the Commission's current resources. Also, the new contracts being awarded are a direct line to the community to provide feedback and identify needs. The contractors report to the Commission and provide recommendations through the Advocacy Spotlight standing agenda item.

Immediate Past Chair Madrigal-Weiss stated the need for the Commission to be responsive to the current aggressive movement towards these communities. She stated

the need to hear from communities to help the Commission provide guidance resources.

Chair Alvarez stated there is much happening across the nation in response to these issues. Information sharing is important. She asked Commissioners to share models and programs with staff as they hear of them.

Public Comment

Public comment for Agenda Item 6 was combined with public comment for Agenda Item 12.

7: Committee Appointments

Chair Alvarez stated she will appoint members to the newly-established Budget and Fiscal, Legislative and External Affairs, and Program Advisory Committees, including the chair and vice chair positions for each. The Commission will also hear an update on the feedback received from the public members of the Commission's two Standing Committees – the Client and Family Leadership Committee (CFLC) and the Cultural and Linguistic Competency Committee (CLCC).

Commissioners were appointed to the following Advisory Committees:

- **Budget and Fiscal Advisory Committee**

Chair: Commission Vice Chair Alfred Rowlett

Vice Chair: Commissioner Christopher Conteras

Membership:

Commissioner Keyondria Bunch

Commissioner Steve Carnevale

Commissioner David Gordon

Commissioner Harabedian (Designee Rosielyn Pulmano)

- **Legislative and External Affairs Advisory Committee**

Chair: Commissioner Mark Bontrager

Vice Chair: Commissioner Robert Callan, Jr.

Membership:

Commissioner Marvin Southard

Commissioner Gladys Mitchell

Commissioner Karen Larsen

- **Program Advisory Committee**

Chair: Commissioner Gary Tsai

Vice Chair: Commissioner Madrigal-Weiss

Membership:

Commissioner Pamela Baer

Commissioner Michael Bernick

Commissioner Rayshell Chambers

Commissioner Dave Cortese (Designee Marjorie Swartz)

Commissioner Makenzie Cross

The Commission's two Standing Committees are as follows:

- **Client and Family Leadership Committee (CFLC)**
- **Cultural and Linguistic Competency Committee (CLCC)**

Chair Alvarez stated the public members of the Commission's two public Standing Committees were surveyed about what they would like to focus on and whether members were interested in continuing to participate. Helpful feedback was received on how these Committees' roles could evolve. To discuss these comments and gather more feedback, the Commission will host a public convening in the near future. She stated Commissioners Chambers, Callan, Bernick, and Southard have expressed interest in working with a public committee. She stated she looks forward to their participation.

Commissioner Comments & Questions

Commissioners asked clarifying questions.

Public Comment

Stacie Hiramoto (attended in person), Director, REMHDCO, thanked the Chair and the Commission for the Standing Committees and the new Advisory Committees. The speaker noted that the Commission has had a tradition of having members of the public on its Committees along with Commissioners. The speaker stated the importance of the public being given the opportunity to have a dialogue with Commissioners on the Committees. The speaker stated they are willing to give the Advisory Committees a chance.

Mark Karmatz stated the importance of including the public and empowering them. Project Return Peer Support Network is doing a training on Certified Peer Support Specialists. It is important to include Certified Peer Support Specialists on all Committees.

[Note: Agenda Item 8 was taken out of order and was heard after Agenda Item 11.]

8: <u>Legislative Priorities</u>

Chair Alvarez stated the Commission will consider supporting bills introduced in the 2025 legislative session. She asked staff to present this agenda item.

Kendra Zoller, Deputy Director of Legislative and External Affairs, stated, going forward, the Commission will review all legislation through the newly-established Legislative and External Affairs Advisory Committee. She provided an overview, with a slide

presentation, of legislation that will help create continuous improvement to behavioral health in California, including Senate Bill (SB) 320 (Limón); Assembly Bill (AB) 96 (Jackson); AB 348 (Krell); AB 1037 (Elhawary); SB 531 (Rubio); and SB 862 (Senate Committee on Health). She stated AB 96 has been made a two-year bill to allow for more time for conversations to be had among the community and work through the complexities of this bill. This bill aligns with the Commission's previously-expressed support for integrating peers into more settings as a part of the strategy to address workforce shortages.

Commissioner Comments & Questions

Commissioner Chambers stated the purpose of AB 96 is to integrate the peer support workforce into the managed care plans. She stated concern that the County Behavioral Health Directors Association of California (CBHDA) and other advocacy organizations opposed this bill. She stated she is excited to work with CalVoices, behavioral health directors, and racial/ethnic organizations for the next year to bridge a partnership with the community health worker workforce and those in opposition to peers moving into commercial spaces. Peers are already there doing the work and want to prove that they can provide the continuum of care like any other profession. Managed care plans deserve to know the peer workforce.

Immediate Past Chair Madrigal-Weiss asked who is in opposition to AB 96.

Ms. Zoller stated there is no official opposition but there were issues raised by the CBHDA and the California Pan-Ethnic Health Network (CPEHN).

Chair Alvarez stated she has heard in the community that there is a broader conversation around how the community workforce is being supported. There is a movement by the Medi-Cal team to integrate a workforce of peers, community health workers, promotoras, and doulas, but there is no strategy and no consideration for how that workforce should be paid, etc. There is an interest in ensuring that there is a more strategic conversation around that.

Public Comment

Richard Gallo agreed with Commissioner Chambers's comments on AB 96.

Stacie Hiramoto stated REMHDCO supports that Certified Peer Specialists should be able to work in Medi-Cal Managed Care and receive reimbursement for their services with mild to moderate symptoms. AB 96 equated peer providers and community health workers; they are similar and some of their work is overlapped, but they have different origins and histories and, in some instances, different values and priorities. This is why REMHDCO was unable to support this bill.

Stacie Hiramoto spoke in support of the other bills the Commission supports. The speaker stated AB 1242 (Nguyen) is a priority bill of a new coalition of Asian health providers and health advocates around the state – the California Asian American and Native Hawaiian, Pacific Islander Health Equity Coalition. This bill addresses systemic and widening disparities in access to services in California by ensuring individuals with limited English proficiency and individuals who are deaf and hard of hearing have meaningful access to the California Health and Human Services Agency (CalHHS).

Meron (phonetic) (attended in person), CalVoices, stated CalVoices is the sponsor of AB 96. The speaker stated CalVoices has accepted the amendment to reduce the focus of the scope of practice for peer services.

Ruqayya Ahmad (attended remotely via Zoom), Policy Manager, CPEHN, stated CPEHN is proud to work closely with peer support specialists and community health workers, promotoras, and representatives across the state. Both workforces play a critical role in health care and they bring distinct expertise, training pathways, and histories. The speaker stated CPEHN looks forward to conversations to ensure that the bill uplifts both workforces and centers equity. The speaker stated CPEHN is happy to discuss any concerns.

Jay Calcagno (attended remotely via Zoom), Policy Analyst, California Behavioral Health Association (CBHA), stated CBHA is one of the co-sponsors of AB 348 and urges the Commission's support.

Selena Liu Raphael (attended remotely via Zoom), California Alliance of Child and Family Services (CACFS), stated the California Alliance of Child and Family Services cosponsors AB 531 and urges the Commission's support.

Laurel Benhamida, Ph.D., stated SB 823 is an expansion of the Community Assistance, Recovery, and Empowerment (CARE) Act, which is a part of the Governor's overall strategy. SB 823 suggests that Bipolar 1 is added as a condition that could be handled by CARE Court. The speaker stated SB 823 has positives and negatives. The speaker suggested that it be presented to the Commission for discussion at a future Commission meeting.

Dr. Benhamida asked for an update on the status of the CARE Court rollout.

Commissioner Discussion

Commissioner Bunch asked about the staff recommended motion for AB 96.

Interim Executive Director Lightbourne stated the motion slide was prepared before the Committee took amendments on Tuesday. The listed language is an old recommendation. It is now a two-year bill and can be removed from consideration today.

Action: Vice Chair Rowlett asked for a motion to approve SB 320. Chair Alvarez made a motion, seconded by Commissioner Bunch, that:

- *The Commission supports SB 320 (Limón) and directs staff to communicate its position to the Legislature and the Governor.*

Motion passed 17 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Baer, Bernick, Bontrager, Bunch, Callan, Carnevale, Chambers, Contreras, Cross, Fairweather, Fernandez, Gordon, Madrigal-Weiss, Southard, and Tsai, Vice Chair Rowlett, and Chair Alvarez.

The following Commissioner abstained: Commissioner Wilkes.

Action: Vice Chair Rowlett asked for a motion to approve SB 348. Commissioner Callan made a motion, seconded by Commissioner Contreras, that:

- *The Commission supports AB 348 (Krell) and directs staff to communicate its position to the Legislature and the Governor.*

Motion passed 17 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Baer, Bernick, Bontrager, Bunch, Callan, Carnevale, Chambers, Contreras, Cross, Fairweather, Fernandez, Gordon, Madrigal-Weiss, Southard, and Tsai, Vice Chair Rowlett, and Chair Alvarez.

The following Commissioner abstained: Commissioner Wilkes.

Action: Vice Chair Rowlett asked for a motion to approve AB 1037. Immediate Past Chair Madrigal-Weiss made a motion, seconded by Chair Alvarez, that:

- *The Commission supports AB 1037 (Elhawary) and directs staff to communicate its position to the Legislature and the Governor.*

Motion passed 17 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Baer, Bernick, Bontrager, Bunch, Callan, Carnevale, Chambers, Contreras, Cross, Fairweather, Fernandez, Gordon, Madrigal-Weiss, Southard, and Tsai, Vice Chair Rowlett, and Chair Alvarez.

The following Commissioner abstained: Commissioner Wilkes.

Action: Vice Chair Rowlett asked for a motion to approve SB 531. Immediate Past Chair Madrigal-Weiss made a motion, seconded by Commissioner Gordon, that:

- *The Commission supports SB 531 (Rubio) and directs staff to communicate its position to the Legislature and the Governor.*

Motion passed 17 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Baer, Bernick, Bontrager, Bunch, Callan, Carnevale, Chambers, Contreras, Cross, Fairweather, Fernandez, Gordon, Madrigal-Weiss, Southard, and Tsai, Vice Chair Rowlett, and Chair Alvarez.

The following Commissioner abstained: Commissioner Wilkes.

Action: Vice Chair Rowlett asked for a motion to approve SB 862. Commissioner Madrigal-Weiss made a motion, seconded by Commissioner Callan, that:

- *The Commission supports SB 862 (Senate Committee on Health) and directs staff to communicate its position to the Legislature and the Governor.*

Motion passed 16 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Baer, Bernick, Bontrager, Bunch, Callan, Carnevale, Chambers, Contreras, Cross, Fairweather, Fernandez, Madrigal-Weiss, Southard, and Tsai, Vice Chair Rowlett, and Chair Alvarez.

The following Commissioners abstained: Commissioners Gordon and Wilkes.

9: Lunch and Closed Session

Chair Alvarez invited the public to take a lunch break.

The Commission met in closed session as permitted by law for the consideration of a personnel matter per Government Code section 11126(a).

The Commission convened into closed session at 11:31 a.m.

10: Re-establish Quorum and Report Out from Closed Session

The Commission reconvened into open session at 1:31 p.m. and reestablished a quorum.

Chair Alvarez reported that the Commission voted to offer the Executive Director role to a candidate. She expressed her sincere thanks to the nine Commissioners who devoted many hours to participating in the Executive Director Screening Committee. She especially recognized Commissioner Robinson for his leadership as Chair of the Committee.

11: Peer Respite Concept Paper

Chair Alvarez stated the Commission will receive an introductory presentation on the upcoming $20 million Mental Health Wellness Act grant focused on peer respite. She stated appreciation to Commissioner Chambers for her leadership and partnership with the team on this important work.

Chair Alvarez reminded everyone that California's Mental Health Wellness Act grant program provides $20 million each year to improve community response to individuals facing behavioral health crises. These grants have supported the ability of crisis responders to connect those having a behavioral health episode with wellness, resiliency, and recovery-oriented programs that offer the least restrictive settings appropriate for their needs.

Chair Alvarez stated, in September 2022, the Commission directed staff to focus on five priorities for Mental Health Wellness Act funding, including peer respite. The Commission's Peer Respite Project, led by Commissioner Rayshell Chambers, will explore opportunities for investing these one-time funds in peer respites. This project will also support a broader discussion around peer services. She asked staff to present this agenda item.

Melissa Martin-Mollard, Chief of Research and Evaluation, provided an overview, with a slide presentation, of the background, peer respite project activities and timelines, and considerations for investing Mental Health Wellness Act funding into peer respites. She asked Commissioner Chambers to say a few words.

Commissioner Chambers stated this is one of the most transformative and exciting solutions, provisions of service, and ways to divert individuals from psychiatric hospitals and other settings that are not as conducive to healing and recovery as these home-like environments, where individuals can leave with wellness tools and a hot handoff to linkages and supports to help keep them from returning to the emergency room.

Vice Chair Rowlett spoke in support of peer respite. He stated peer respites require a blending of funding streams. He asked staff to learn about factors that differentiate peer respites and that may affect their effectiveness by asking the following questions:

- Which peer respite programs bill Medicaid, which reduces the dependence on MHSA or county funding?
- What are the unique challenges associated with sustainability about that?
- What are the attributes that have resulted in an organization or program being able to bill Medicaid?
    - Is it the relationship with the county? Is it the relationship that the workforce has with managed care organizations?
- Are individuals transitioning away from peer respite able to engage effectively with managed care services?
- Are recidivism rates tracked in peer respite? If not, that is a red flag.
- How many peer respite programs have private funding?
- Do you own the facility that your services are being provided in? Is it on a lease?
- Who owns and operates the facility?
- What is the composition of your workforce in peer respite?
- Is the person running the program a member of the executive leadership team or do they have access to or influence in the decision-making?
    - Some peer respites are peer respite in name only and the individuals running the program do not have access to executive leadership when, in fact, they should be a part of the executive leadership team.

Vice Chair Rowlett stated peer respite is a cost-effective alternative to care that works. He challenged the Commission to learn why that is.

Commissioner Carnevale stated the way he gets excited about peer respite is to elevate it above the level described by Vice Chair Rowlett. The paper he asked staff to prepare on peer respite in Agenda Item 5 is an excellent way to reach to the next level to address Vice Chair Rowlett's challenge and to inform the Governor and Legislature not just about peer respite and why it is good but why it is strategically important to the state. He stated, in order to get to that level, the Commission must look at it in the context of the strategic plan and understand how it impacts prevention, early intervention, and data.

Commissioner Carnevale asked Dr. Martin-Mollard and her team to find ways to elevate this in the context of the report presented today and also to bring in the Commission work on sustainable financing to create an effective system that does not operate in scarcity but operates in abundance so that, when making this argument to the state, the Commission is asking for the funding to do it the right way, and that that right way is economical.

Commissioner Wilkes asked about what is being done in the youth peer respite arena. He suggested using part of the funding to support best practices. He suggested that youth homelessness prevention centers and faith communities and the properties they have available can support the sustainability of such programs and the facilities needed.

Commissioner Bontrager stated the number one topic discussed at the California Hospital Association monthly meetings is the inappropriate boarding of individuals in emergency rooms. Respite care facilities are a diversion from emergency rooms where individuals can get better help, more appropriately and timely with less cost to the system. He suggested including the California Hospital Association in the conversation as a way to add political muscle.

Commissioner Fernandez stated he is excited to see more peer respite programs, peer-run organizations, and recovery community organizations are beginning to take center stage again, especially when moving into more value-based models of care and recognizing points of population health management. On a national level, it seems that Medicaid funding takes priority when, by and large, the value of peer respite programs is diminished when they must adhere to bureaucratic and administrative processes associated with Medicaid.

Commissioner Fernandez stated, in the state of California, a number of peer respite programs have tried to figure out how to employ Medi-Cal Peer Support Specialists. They then discover that they must become a certified outpatient provider with associated overhead in order to employ peers.

Commissioner Fernandez cautioned that moving forward into Medi-Cal as a primary payer of peer respite services must be done carefully, or else peers will be driven out of the peer respite program and it will lean into a practitioner model of care.

Commissioner Southard stated there is a prison that has a successful peer training program for individuals with co-occurring disorders so that, upon release, they become providers of peer services. Sometimes it can be done in such a way that it is Medi-Cal billable.

Public Comment

Richard Gallo stated the need for two wheelchair accessible units to be a part of the application process for any respite care program. The number of dual diagnoses of individuals with disabilities needs to be increased so that they have equal access to a respite program.

Richard Gallo stated there are funding sources to tap with the Proposition 1 Housing Bucket in more than one category, but the question is whether that will be sustainable for the operator of the respite program to be able to pay their staff overhead costs.

Richard Gallo stated the state should allow respite program operators in counties that have respite programs to bill Medi-Cal directly without permission from the county. Counties will likely say services are not billable because it takes staff time to help manage billing issues.

Richard Gallo stated the need to look at the language issue of the service provider in providing respite and if they will provide adequate languages in that community.

Mark Karmatz stated Project Return Peer Support Network is opening a new respite program by the University of Southern California. The speaker thanked Richard Gallo for their comments on accessibility.

Esroruleh Mohammad, Ph.D., provided an overview of their "BureauCare-to-Custody-Cemetery Pipeline" systems equity framework for public health, institutional safety, and interagency reform that was developed through a decade of lived experience, systems analysis, and direct services across Los Angeles County Behavioral Health. The speaker agreed with the harmful impacts of bureaucratic complexity on care access and the urgent need for workforce equity and structural realignment. The speaker noted that these concepts are embedded in their model.

12: Innovation Partnership Fund Update

Chair Alvarez stated the Commission will hear an update regarding the results from the Call for Concepts Survey as well as a process moving forward for shaping the Innovation Partnership Fund grant program.

Interim Executive Director Lightbourne provided an overview, with a slide presentation, of the main categories of priorities suggested from the responses to the Call for Concepts Survey. He stated Community-Defined Evidence Practices (CDEPs) was the most frequently suggested priority, followed by workforce, community engagement, SUD, youth, technology, and system improvement and strengthening.

Commissioner Comments & Questions

Commissioner Gordon asked about the winnowing process to condense the survey responses for Commission work.

Interim Executive Director Lightbourne stated the process for condensing the survey responses will begin at the May Commission meeting. Commissioners will begin by establishing goals, separating the survey responses into those that look like good innovative projects to be taken up under the Mental Health Wellness Act or other setting versus those that have potential to contribute to systems change. He stated that shortened list will be brought before the Program Advisory Committee to do a pros and cons analysis on the concepts suggested on the survey and concepts that have been submitted or heard elsewhere. The pros and cons analysis will include such questions as the following:

- Does it move the Commission goals in the right direction?
- How feasible is it?
- Are there risks involved in it? If so, what are the risk mitigations to the extent that the Commission is focused on partnerships?
- What are the bankable assurances that different partners are bringing to the table?

Interim Executive Director Lightbourne stated the expectation is that the Program Advisory Committee will also potentially be doing the required consultation with CalHHS, the DHCS, the Department of Health Care Access and Information (HCAI), and the California Department of Public Health (CDPH) and will provide a specific set of

recommendations for review and approval at the July or August Commission meeting. Once the prioritized concepts have been approved by the Commission, it will be moved through the staff process of implementation with the realization that the commitment the Commission made is to have something ready to go by July 1, 2026.

Commissioner Contreras asked if the process is still open for the public to provide feedback and concepts.

Interim Executive Director Lightbourne stated the process is open for Commissioners and members of the public to suggest concepts for the Program Committee to include in their analysis. This process will close after the May Commission meeting so the Program Committee can begin their work.

Chair Alvarez asked that the May meeting include a Venn diagram of the suggested categories and proposals because many of them overlap in the “buckets” they fall in. This is an important message to convey to the public about what the Commission is looking for.

Chair Alvarez stated the importance of including what innovation means and if there are specific criteria or viability of projects the Commission should consider moving forward. There are other entities that have done public-private partnerships that the Commission can learn from. She suggested highlighting best practices for the Commission to consider. These will be a part of the Commission discussion in May that will then inform the Program Advisory Committee’s work moving forward.

Public Comment

Public Comment for Agenda Item 12 includes public comment for Agenda Item 6.

Stacie Hiramoto referred to Agenda Item 12 and stated the hope that the community is included in the winnowing process to condense the survey responses. The speaker referred to the second bullet point about the May 2025 Commission meeting at the bottom of page 1 of the Next Steps in the Innovation Partnership Funding Planning paper, which was included in the meeting materials, and stated the concern about the planned facilitated Commission discussion to “determine whether the Innovation Partnership Fund focus should be on BHSA priority populations, the wider behavioral health ecosystem, or different initiatives with different targets.”

Stacie Hiramoto stated the language from the statute under Proposition 1 regarding the Innovation Partnership Fund says it should be used to improve BHSA programs and practices funded for the following groups: (1) underserved populations, (2) low-income populations, (3) communities impacted by other behavioral health disparities, and (4) other populations as determined by the BHSOAC. The speaker noted that all four of these groups must be included in the Innovation Partnership Fund.

Wendy Guo, Mental Health Association for Chinese Communities, stated appreciation that the Commissioners mentioned the immigrant underserved population in which their population represents a large percentage. The speaker asked about the awardees of the Immigrant and Refugee Community Advocacy Grant.

Chair Alvarez stated the names of the awardees are posted on the website but will not become final until the protest period is complete.

Kevin Bernadt stated it is exciting to hear about the funding and support for deaf and disabled people. The speaker encouraged more outreach to the community for these innovation grants and asked the Commission to consider adding a Line Item in the budget for interpreters and other accommodations for the disability community to enable them to participate in meetings.

Kevin Bernadt stated they would like to be more involved in advocacy but there are no deaf or disabled representatives at meetings. The speaker noted that the disability community is often excluded.

Richard Gallo referred to Agenda Item 6 and the EmPATH funding and stated they made an inquiry with Dominican Hospital in Santa Cruz and were unsure by their response that the funding is being adequately used and whether the serious mental illness community is being served through their emergency room.

Richard Gallo stated, regarding the workforce, there are enough individuals with lived experience as peer workers who can serve individuals with mental health, substance use, alcohol, being unhoused, experiencing domestic violence, and other issues. It is just a matter of Full-Service Partnerships (FSPs) being creative in how they want to establish their programs. The speaker suggested following the Centers for Independent Living model within the FSP model.

Ms. Martinez asked Richard Gallo to send their full public comment to staff.

Laurel Benhamida, Ph.D., referred to Agenda Item 12 and stated they echoed Stacie Hiramoto's comments about the Innovation Partnership Fund.

Dr. Benhamida referred to Agenda Item 6, specifically about Commissioner Wilkes's question about impacts and stories from the Southern California fires. The speaker suggested that the Commission ask if the Federal Emergency Management Agency (FEMA) is funding behavioral health through the California Mental Health Services Authority (CalMHSA) or if it has been cut off. Some of these services were provided by peers in many languages during the COVID-19 pandemic.

Dr. Benhamida stated, with the executive order from Washington, English is now the official language of the United States. Language access through interpreting and translating services is now voluntary and no longer obligatory, from the federal viewpoint. The speaker asked if California laws ensure that organizations, entities, corporations, and systems will not follow the voluntary model but will consider that they must provide these services.

Dr. Benhamida stated Medicare patients can no longer have telehealth visits. This is a serious change that will impact individuals who are unable to drive to services. The speaker stated it was learned during the COVID-19 pandemic that telehealth mental health services work well for patients.

Chair Alvarez noted that executive orders are not laws. English is not the official language of the United States. This highlights the opportunity for the Commission to educate the public on policies or areas of confusion in communities. It is important band together and share educational opportunities around changes in health care or policies that may have implication for the behavioral health delivery system. There are a number

of resources within the Commission and the broader community that will be helpful in these challenging times.

13: Adjournment

Chair Alvarez thanked everyone for their participation and stated the next Commission meeting will take place in Sacramento on May 22nd. There being no further business, the meeting was adjourned at 3:31 p.m.

Commission for Behavioral Health

April 24, 2025 Commission Meeting
Commissioner Roll Call

	Name	Present In Person	Present Virtual	Absent	On Leave
1.	Commissioner Baer	☐	☒	☐	☐
2.	Commissioner Bernick	☐	☒	☐	☐
3.	Commissioner Bontrager	☒	☐	☐	☐
4.	Commissioner Brown	☐	☐	☒	☐
5.	Commissioner Bunch	☒	☐	☐	☐
6.	Commissioner Callan	☒	☐	☐	☐
7.	Commissioner Carnevale	☒	☐	☐	☐
8.	Commissioner Chambers	☒	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☒
10.	Commissioner Contreras	☒	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☒	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐
14.	Commissioner Fernandez	☐	☒	☐	☐
	Name	Present In Person	Present Virtual	Absent	On Leave
15.	Commissioner Gordon	☒	☐	☐	☐
16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☒	☐
17.	Commissioner Larsen	☐	☐	☒	☐
18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐
19.	Commissioner Mitchell	☒	☐	☐	☐
20.	Commissioner Robinson	☐	☐	☒	☐
21.	Commissioner Southard	☐	☒	☐	☐
22.	Commissioner Tsai	☒	☐	☐	☐
23.	Commissioner Wilkes	☒	☐	☐	☐
24.	Vacant	☐	☐	☐	☐
25.	Vacant	☐	☐	☐	☐
26.	Vice-Chair Rowlett	☒	☐	☐	☐
27.	Chair Alvarez	☒	☐	☐	☐
	Totals:	16	4	4	1

14 commissioners are needed in person to establish a quorum.

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 1 (Agenda Item 4 – Consent Calendar)
Proposed Motion:

That the Commission approve the Consent Calendar that includes:
1) March 26 – 27, 2025 Meeting Minutes
2) Monterey County: PADs - Multi County Collaborative - PHASE II up to $3,000,000
3) Mariposa County: PADs - Multi County Collaborative - PHASE II up to $160,740
4) Orange County Extension: PADs – Multi County Collaborate – PHASE II up to $2,739,601
5) Fresno County: The Lodge 2 for up to $4,200,000
6) Marin County Extension: Student Wellness Ambassador Program for up to $870,000
7) Ventura County: Collaborative Care for Youth: Integrating Collaborative and Behavioral Health Models up to $2,874,361
8) Immigrant and Refugee Advocacy Intent to Award
9) K-12 Advocacy Notice of Intent to Award
10) 0-5/Maternal Behavioral Health Mental Health Wellness Act Notice of Intent to Award

Commissioner making motion: **Bontrager**
Commissioner seconding motion: **Gordon**

(See next page for roll call vote)

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 1 (Agenda Item 4 – Consent Calendar) ***(continued from previous page)***

Motion carried _X_ yes, __ no, and __ abstain, per roll call vote as follows:

	Name	Yes	No	Abstain	Absent	On Leave		Name	Yes	No	Abstain	Absent	On Leave
1.	Commissioner Baer	☒	☐	☐	☐	☐	15.	Commissioner Gordon	☒	☐	☐	☐	☐
2.	Commissioner Bernick	☒	☐	☐	☐	☐	16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☐	☒	☐
3.	Commissioner Bontrager	☒	☐	☐	☐	☐	17.	Commissioner Larsen	☐	☐	☐	☒	☐
4.	Commissioner Brown	☐	☐	☐	☒	☐	18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐	☐
5.	Commissioner Bunch	☒	☐	☐	☐	☐	19.	Commissioner Mitchell	☒	☐	☐	☐	☐
6.	Commissioner Callan	☒	☐	☐	☐	☐	20.	Commissioner Robinson	☐	☐	☐	☒	☐
7.	Commissioner Carnevale	☒	☐	☐	☐	☐	21.	Commissioner Southard	☐	☐	☐	☒	☐
8.	Commissioner Chambers	☐	☐	☒	☐	☐	22.	Commissioner Tsai	☒	☐	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☐	☒	23.	Commissioner Wilkes	☐	☐	☒	☐	☐
10.	Commissioner Contreras	☒	☐	☐	☐	☐	24.	Vacant	☐	☐	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☒	☐	☐	☐	☐	25.	Vacant	☐	☐	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐	☐	26.	Vice-Chair Rowlett	☒	☐	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐	☐	27.	Chair Alvarez	☒	☐	☐	☐	☐
14.	Commissioner Fernandez	☒	☐	☐	☐	☐		**TOTALS**	**17**	**0**	**2**	**5**	**1**

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 2 (Agenda Item 8 – Legislative Priorities)
Proposed Motion:

That the Commission supports SB 320 (Limón) and directs staff to communicate its position to the legislature and the Governor.

Commissioner making motion: **Alvarez**
Commissioner seconding motion: **Bunch**

Motion carried _X_ yes, __ no, and __ abstain, per roll call vote as follows:

	Name	Yes	No	Abstain	Absent	On Leave		Name	Yes	No	Abstain	Absent	On Leave
1.	Commissioner Baer	☒	☐	☐	☐	☐	15.	Commissioner Gordon	☒	☐	☐	☐	☐
2.	Commissioner Bernick	☒	☐	☐	☐	☐	16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☐	☒	☐
3.	Commissioner Bontrager	☒	☐	☐	☐	☐	17.	Commissioner Larsen	☐	☐	☐	☒	☐
4.	Commissioner Brown	☐	☐	☐	☒	☐	18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐	☐
5.	Commissioner Bunch	☒	☐	☐	☐	☐	19.	Commissioner Mitchell	☐	☐	☐	☒	☐
6.	Commissioner Callan	☒	☐	☐	☐	☐	20.	Commissioner Robinson	☐	☐	☐	☒	☐
7.	Commissioner Carnevale	☒	☐	☐	☐	☐	21.	Commissioner Southard	☒	☐	☐	☐	☐
8.	Commissioner Chambers	☒	☐	☐	☐	☐	22.	Commissioner Tsai	☒	☐	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☐	☒	23.	Commissioner Wilkes	☐	☐	☒	☐	☐
10.	Commissioner Contreras	☒	☐	☐	☐	☐	24.	Vacant	☐	☐	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☐	☐	☐	☒	☐	25.	Vacant	☐	☐	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐	☐	26.	Vice-Chair Rowlett	☒	☐	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐	☐	27.	Chair Alvarez	☒	☐	☐	☐	☐
14.	Commissioner Fernandez	☒	☐	☐	☐	☐		**TOTALS**	**17**	**0**	**1**	**6**	**1**

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 3 (Agenda Item 8 – Legislative Priorities)
Proposed Motion:

That the Commission supports AB 348 (Krell) and directs staff to communicate its position to the legislature and the Governor.

Commissioner making motion: **Callan**
Commissioner seconding motion: **Contreras**

Motion carried _X_ yes, __ no, and __ abstain, per roll call vote as follows:

	Name	Yes	No	Abstain	Absent	On Leave		Name	Yes	No	Abstain	Absent	On Leave
1.	Commissioner Baer	☒	☐	☐	☐	☐	15.	Commissioner Gordon	☒	☐	☐	☐	☐
2.	Commissioner Bernick	☒	☐	☐	☐	☐	16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☐	☒	☐
3.	Commissioner Bontrager	☒	☐	☐	☐	☐	17.	Commissioner Larsen	☐	☐	☐	☒	☐
4.	Commissioner Brown	☐	☐	☐	☒	☐	18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐	☐
5.	Commissioner Bunch	☒	☐	☐	☐	☐	19.	Commissioner Mitchell	☐	☐	☐	☒	☐
6.	Commissioner Callan	☒	☐	☐	☐	☐	20.	Commissioner Robinson	☐	☐	☐	☒	☐
7.	Commissioner Carnevale	☒	☐	☐	☐	☐	21.	Commissioner Southard	☒	☐	☐	☐	☐
8.	Commissioner Chambers	☒	☐	☐	☐	☐	22.	Commissioner Tsai	☒	☐	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☐	☒	23.	Commissioner Wilkes	☐	☐	☒	☐	☐
10.	Commissioner Contreras	☒	☐	☐	☐	☐	24.	Vacant	☐	☐	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☐	☐	☐	☒	☐	25.	Vacant	☐	☐	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐	☐	26.	Vice-Chair Rowlett	☒	☐	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐	☐	27.	Chair Alvarez	☒	☐	☐	☐	☐
14.	Commissioner Fernandez	☒	☐	☐	☐	☐		**TOTALS**	**17**	**0**	**1**	**6**	**1**

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 4 (Agenda Item 8 – Legislative Priorities)
Proposed Motion:

That the Commission supports AB 1037 (Elhawary) and directs staff to communicate its position to the legislature and the Governor.

Commissioner making motion: **Madrigal-Weiss**
Commissioner seconding motion: **Alvarez**

Motion carried _X_ yes, __ no, and __ abstain, per roll call vote as follows:

	Name	Yes	No	Abstain	Absent	On Leave		Name	Yes	No	Abstain	Absent	On Leave
1.	Commissioner Baer	☒	☐	☐	☐	☐	15.	Commissioner Gordon	☒	☐	☐	☐	☐
2.	Commissioner Bernick	☒	☐	☐	☐	☐	16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☐	☒	☐
3.	Commissioner Bontrager	☒	☐	☐	☐	☐	17.	Commissioner Larsen	☐	☐	☐	☒	☐
4.	Commissioner Brown	☐	☐	☐	☒	☐	18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐	☐
5.	Commissioner Bunch	☒	☐	☐	☐	☐	19.	Commissioner Mitchell	☐	☐	☐	☒	☐
6.	Commissioner Callan	☒	☐	☐	☐	☐	20.	Commissioner Robinson	☐	☐	☐	☒	☐
7.	Commissioner Carnevale	☒	☐	☐	☐	☐	21.	Commissioner Southard	☒	☐	☐	☐	☐
8.	Commissioner Chambers	☒	☐	☐	☐	☐	22.	Commissioner Tsai	☒	☐	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☐	☒	23.	Commissioner Wilkes	☐	☐	☒	☐	☐
10.	Commissioner Contreras	☒	☐	☐	☐	☐	24.	Vacant	☐	☐	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☐	☐	☐	☒	☐	25.	Vacant	☐	☐	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐	☐	26.	Vice-Chair Rowlett	☒	☐	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐	☐	27.	Chair Alvarez	☒	☐	☐	☐	☐
14.	Commissioner Fernandez	☒	☐	☐	☐	☐		**TOTALS**	**17**	**0**	**1**	**6**	**1**

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 5 (Agenda Item 8 – Legislative Priorities)
Proposed Motion:

That the Commission supports SB 531 (Rubio) and directs staff to communicate its position to the legislature and the Governor.

Commissioner making motion: **Madrigal-Weiss**
Commissioner seconding motion: **Gordon**

Motion carried _X_ yes, __ no, and __ abstain, per roll call vote as follows:

	Name	Yes	No	Abstain	Absent	On Leave		Name	Yes	No	Abstain	Absent	On Leave
1.	Commissioner Baer	☒	☐	☐	☐	☐	15.	Commissioner Gordon	☒	☐	☐	☐	☐
2.	Commissioner Bernick	☒	☐	☐	☐	☐	16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☐	☒	☐
3.	Commissioner Bontrager	☒	☐	☐	☐	☐	17.	Commissioner Larsen	☐	☐	☐	☒	☐
4.	Commissioner Brown	☐	☐	☐	☒	☐	18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐	☐
5.	Commissioner Bunch	☒	☐	☐	☐	☐	19.	Commissioner Mitchell	☐	☐	☐	☒	☐
6.	Commissioner Callan	☒	☐	☐	☐	☐	20.	Commissioner Robinson	☐	☐	☐	☒	☐
7.	Commissioner Carnevale	☒	☐	☐	☐	☐	21.	Commissioner Southard	☒	☐	☐	☐	☐
8.	Commissioner Chambers	☒	☐	☐	☐	☐	22.	Commissioner Tsai	☒	☐	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☐	☒	23.	Commissioner Wilkes	☐	☐	☒	☐	☐
10.	Commissioner Contreras	☒	☐	☐	☐	☐	24.	Vacant	☐	☐	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☐	☐	☐	☒	☐	25.	Vacant	☐	☐	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐	☐	26.	Vice-Chair Rowlett	☒	☐	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐	☐	27.	Chair Alvarez	☒	☐	☐	☐	☐
14.	Commissioner Fernandez	☒	☐	☐	☐	☐		**TOTALS**	**17**	**0**	**1**	**6**	**1**

Commission for Behavioral Health

Motions Summary
April 24, 2025 Commission Meeting

Motion #: 6 (Agenda Item 8 – Legislative Priorities)
Proposed Motion:

That the Commission supports SB 862 (Senate Committee on Health) and directs staff to communicate its position to the legislature and the Governor.

Commissioner making motion: **Madrigal-Weiss**
Commissioner seconding motion: **Callan**

Motion carried _X_ yes, __ no, and __ abstain, per roll call vote as follows:

	Name	Yes	No	Abstain	Absent	On Leave		Name	Yes	No	Abstain	Absent	On Leave
1.	Commissioner Baer	☒	☐	☐	☐	☐	15.	Commissioner Gordon	☐	☐	☒	☐	☐
2.	Commissioner Bernick	☒	☐	☐	☐	☐	16.	Commissioner Harabedian (or Designee Pulmano)	☐	☐	☐	☒	☐
3.	Commissioner Bontrager	☒	☐	☐	☐	☐	17.	Commissioner Larsen	☐	☐	☐	☒	☐
4.	Commissioner Brown	☐	☐	☐	☒	☐	18.	Commissioner Madrigal-Weiss	☒	☐	☐	☐	☐
5.	Commissioner Bunch	☒	☐	☐	☐	☐	19.	Commissioner Mitchell	☐	☐	☐	☒	☐
6.	Commissioner Callan	☒	☐	☐	☐	☐	20.	Commissioner Robinson	☐	☐	☐	☒	☐
7.	Commissioner Carnevale	☒	☐	☐	☐	☐	21.	Commissioner Southard	☒	☐	☐	☐	☐
8.	Commissioner Chambers	☒	☐	☐	☐	☐	22.	Commissioner Tsai	☒	☐	☐	☐	☐
9.	~~Commissioner Chen~~	☐	☐	☐	☐	☒	23.	Commissioner Wilkes	☐	☐	☒	☐	☐
10.	Commissioner Contreras	☒	☐	☐	☐	☐	24.	Vacant	☐	☐	☐	☐	☐
11.	Commissioner Cortese (or Designee Swartz)	☐	☐	☐	☒	☐	25.	Vacant	☐	☐	☐	☐	☐
12.	Commissioner Cross	☒	☐	☐	☐	☐	26.	Vice-Chair Rowlett	☒	☐	☐	☐	☐
13.	Commissioner Fairweather	☒	☐	☐	☐	☐	27.	Chair Alvarez	☒	☐	☐	☐	☐
14.	Commissioner Fernandez	☒	☐	☐	☐	☐		**TOTALS**	**16**	**0**	**2**	**6**	**1**

Commission Process for Community Engagement on Innovation Plans

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  iii. Commission staff will then share the link for innovation projects with the following recipients:
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  i. When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  ii. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

STAFF ANALYSIS—Napa County

Innovation (INN) Project Name:	**Program Improvements for Valued Outpatient Treatment (PIVOT)**
Total INN Funding Requested:	**$290,380**
Duration of INN Project:	**3 years**
BHSOAC consideration of INN Project:	**May 22, 2025**

Review History:

Public Comment Period:	March 10, 2025 to April 9, 2025
Behavioral Health Board Hearing:	April 9, 2025
Approved by the County Board of Supervisors:	To Be Scheduled
County submitted INN Project:	March 11, 2025
Project Shared with Commission Partners:	March 17, 2025

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):
This project seeks to increase the quality of mental health services, including measured outcomes; increase access to underserved groups; and promote interagency collaboration.

This proposed project meets Innovation criteria by introducing a new practice or approach to the overall mental health system and by making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

Project Introduction
The Napa County Behavioral Health (County) is requesting up to $290,380 of Innovation spending authority to prepare for implementation of Proposition 1, also known as the Behavioral Health Services Act (BHSA), by joining Orange County's Progressive Improvements for Valued Outpatient Treatment (PIVOT) Innovation project that was Commission-approved in November 2024. Specifically, the County requests to join the following three (3) components: Full Service Partnership (FSP) Reboot, Developing Capacity for Specialty Mental Health Plan Services (SMHS) with Diverse Communities, and Innovating Countywide Workforce Initiatives. PIVOT proposes to create and test service models that align the delivery, care coordination, systemwide collaborations, and payment for care to ensure a

seamless and integrated experience for behavioral health clients, resulting in improved client outcomes.

Behavioral Health Services Act (BHSA) Alignment and Sustainability

The PIVOT project was developed to directly and immediately assist counties with implementing mandated changes under the BHSA. This includes focusing on comprehensive FSP programs that align with the BHSA's emphasis on high-quality, intensive outpatient services and housing support for participants. It also includes enhancing workforce retention, education, and training to strengthen Napa County's capacity to deliver effective, person-centered care, as well as supporting systems integration for seamless service coordination and cross-system billing. Finally, the project supports the BHSA's focus on promoting data-driven decision through EHR implementation to ensure that behavioral health services are data-informed and outcomes-driven.

The three (3) project components that Napa County is requesting to join all include sustainability as an intended outcome that will occur through administrative changes, collaboration between programs, new funding structures and revenue optimization, and strategies that support the overall behavioral health system.

What is the Problem?

With the passing of Proposition 1, Counties face significant impacts to their current behavioral health system of care. The new legislation enacts additional guidelines for FSP programs to ensure fidelity to evidence-based practices (EBPs) and quality services. Thirty-five percent (35%) of the BHSA total budget must be directed toward these programs, and thus, requires Counties to reevaluate current FSP administrative and workflow processes to align with the added requirements.

Previous funding categories under the Mental Health Services Act (MHSA) are also shifting or disappearing altogether, such as the removal of Prevention and Early Intervention and Innovation funding components. These programs provide vital services that prevent serious mental illnesses from occurring and/or worsening. Due to the restructuring of this funding, programs currently funded by these categories are at risk of discontinuation.

Additionally, strategies to foster a robust and skilled workforce that can support the BHSA changes are necessary to ensure effective implementation across BHSA and other complex Behavioral Health Transformation initiatives (i.e., Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment [BH-CONNECT], Peer Certification, and SmartCare Electronic Health Record [EHR] systems).

How this Innovation project addresses this problem

Each component of the original PIVOT project was presented with their own schedule of activities and learning objectives. Napa County plans on addressing FSP processes, Medi-Cal opportunities, and workforce capacity through the solutions below:

FSP Reboot

The FSP Reboot component of the PIVOT project aims to implement evidence-based practices, such as Intensive Case Management, Assertive Community Treatment, Forensic Assertive Community Treatment, Individual Placement and Support, Supported Employment, High-Fidelity Wraparound, and Assertive Field-Based Substance Use Disorder (SUD) Treatment services. This component will establish care standards with acuity-based levels and clear step-down criteria, while also providing outpatient behavioral health services for ongoing evaluation and stabilization, and maintain engagement with clinical and non-clinical services, including housing support. In adherence to the new BHSA requirements, the County will also integrate SUD services into its existing behavioral health system.

Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities

Napa County is home to people from diverse backgrounds who face unique needs and challenges. County demographics show that 35% of the population is from Hispanic/Latino origin, with Spanish currently recognized as a threshold language. Older adults ages 65 and over make up 24% of the County's community members, with statistics also showing a growing Filipino and Asian community. Prevention and Early Intervention funds have historically been a vital means to reaching and serving these diverse groups. In order to help Prevention and Early Intervention (PEI) providers explore new funding opportunities, Napa County seeks to draw down Medi-Cal revenue from specialty and non-specialty services.

Innovating Countywide Workforce Initiatives

The Workforce component of this project will focus on building training capacity, implementing EBPs, and enhancing integration efforts across behavioral health services and initiatives, including BH-CONNECT, Peer Certification, and the SmartCare EHR system. It will involve both county and contracted partners delivering high-quality services and reinforce administrative and clinical training processes that also integrate SUD activities. Activities will focus on enhancing workforce capabilities to ensure seamless and culturally responsive integration of new systems and BHSA standards.

Community Planning Process

Local Level

In February 2025, the Napa County Mental Health Stakeholder Advisory Committee met to identify gaps in behavioral health, as well as opportunities to integrate cross-systems training and support to aid community-based organizations and providers with the BHSA transition. This diverse group of Committee members includes representation from various sectors, such as health care, public health, law enforcement, education, family and consumer advocacy, LGBTQ+ services, and mental health organizations.

Workforce and training needs were a heavy focus of the Stakeholder Advisory Committee meeting, ultimately becoming one of the focal points of this Innovation plan. Implementation of SmartCare EHR was also identified as a potential tool that could help align the County's workforce initiatives with Proposition 1 priorities by ensuring high fidelity delivery of services and a seamless transition to BHSA.

Additionally, Napa County is home to a large proportion of older adults, with 24% of the population age 65 and over. In line with the County's Master Plan for Aging, an emphasis on older adult mental health and prevention programs was integrated into this Innovation proposal as an area of attention, particularly given the impending dissolution of PEI funds.

For more information on Napa County's local community planning process, see pages 6-7 of the project proposal.

Commission Level

Commission staff shared this project with its community partners and the Commission's email distribution list on March 17, 2025, and comments were directed to County MHSA staff. No comments were received in response to the Commission's request for feedback.

Learning Objectives and Evaluation

The PIVOT objectives and evaluation plan adhere to the new guidelines required in the BHSA, and learning goals are outlined below.

***FSP Reboot**:* FSP programs remain a priority of the BHSA, now with added requirements for evaluation and service criteria. The FSP Reboot component serves to strengthen Napa County's administrative infrastructure through adjustments and updates to workflows, operational processes, and staff training that meet the following objectives:

- Map FSP service models, including Navigation and High-Fidelity Wraparound programs, through staff and clinician interviews.
- Review policies, procedures, and forms to assess eligibility, intake, staffing, and service use while identifying gaps in current processes in relation to new requirements.
- Collaborate with staff and stakeholders to adjust service models for new care levels and other EBPs.
- Standardize practices to enhance consistency, efficiency, and revenue generation across FSP programs.
- Define step-down criteria, streamline transitions between care levels, and establish tracking systems to monitor progress.
- Develop Key Performance Indicators (KPIs) to monitor outcomes and service efficiency.
- Create a training plan to support the transition and ensure compliance with new standards.
- Utilize findings to inform Napa County's Three-Year Integrated Plan, ensuring it reflects lessons learned as well as new standards and requirements.

***Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities**:*
By joining this component, Napa County seeks to accomplish the following objectives:

- Conduct strategic planning to identify funding opportunities and assess providers' readiness for peer certification and Medi-Cal participation.
- Guide providers through SMHS and Drug Medi-Cal Organized Delivery System (DMC-ODS) certification, while strengthening capacity with technical assistance (TA) and training in administration, billing, documentation, and compliance to support sustained Medi-Cal billing.
- Support the integration of Culturally Defined Evidence Practices (CDEPs) aligned with Medi-Cal billing requirements.
- Assist in peer certification, including training and integration of peer roles.
- Develop tailored action plans to guide providers through certification and funding access.
- Utilize findings to inform and enhance Napa County's BHSA Three Year Integrated Plan, ensuring it reflects lessons learned as well as new standards and requirements.

Innovating Countywide Workforce Initiatives: The PIVOT project will strengthen Napa County's workforce capacity by reinforcing administrative and clinical training processes. Objectives to accomplish this goal may include, but are not limited to:

- Building training capacity across the system by developing training programs that enhance staff competencies and ensure consistent and quality services.
- Implementing EBPs as part of BHSA and BH-CONNECT.
- Training and support in the SmartCare EHR system, with a focus on onboarding and quality assurance efforts.
- Supporting and training staff in mental health and SUD integration activities to support the integration of DMC-ODS and Mental Health Plan (MHP) services with 24/7 access line operations, screening procedures, and clinical service protocols.

For additional information on the PIVOT project components, see pages 2-6 of the proposed plan.

The Budget

The County is requesting authorization to spend up to $290,380 of MHSA Innovation funding for this project over a period of three (3) years. One-hundred percent (100%) of the project will be supported by Innovation funding.

EXPENDITURES	Year 1 (FY 25-26)	Year 2 (FY 26-27)	Year 3 (FY 27-28)	TOTAL
Consultants	$ 50,000	$ 50,000	$ 50,000	$ 150,000
Training and TA Providers	$ 42,184	$ 42,184	$ 42,184	$ 126,552
Administrative (indirect)	$ 4,609	$ 4,609	$ 4,609	$ 13,827
TOTAL	**$ 96,793**	**$ 96,793**	**$ 96,793**	**$ 290,380**

Fifty-two percent (52%) of projected expenditures are allocated for consultant services responsible for implementation and evaluation of Napa County's PIVOT project. These consultants will provide subject matter expertise in program design, data analysis, and

evaluation strategies that will later inform development of the County's Three-Year Integrated Plan.

Forty-four percent (44%) of the requested Innovation funds are reserved for training and TA providers who will be instrumental in building capacity of both county staff and contracted community partners. This includes development of culturally responsive practices, integration of EBPs, and administrative enhancements. These individuals will also be responsible for identifying funding opportunities, assessing providers' readiness for SMHS and DMC-ODS certification, and providing ongoing training and TA for staff and contractors on EBPs, culturally-defined evidence practices (CDEPs), SmartCare EHR, Peer Certification, and Medi-Cal.

At roughly four percent (4%), the remaining funds will go toward indirect administrative costs, which includes project oversight, fiscal management, and regulatory compliance. For additional information on the project budget, see pages 9-10 of the proposed plan.

Conclusion

The proposed project, Program Improvements for Valued Outpatient Treatment (PIVOT), appears to meet the minimum requirements listed under MHSA Innovation regulations and aligns with the goals of the BHSA; however, should the Commission approve this project, the County may only expend funds following Napa County Board of Supervisors approval.

Commission *for* Behavioral Health

STAFF ANALYSIS – YOLO COUNTY

Innovation (INN) Project Name:	**Semi-Statewide Enterprise Health Record Project**
Total INN Funding Requested:	**$5,267,306**
Duration of INN Project:	**3 Years**
BHSOAC consideration of INN Project:	**May 22, 2025**

Review History:

Approved by the County Board of Supervisors:	April 29, 2025
Mental Health Board Hearing:	April 16, 2025
Public Comment Period:	March 18, 2025 – April 16, 2025
County submitted INN Project:	April 21, 2025
Date Project Shared with Stakeholders:	March 21, 2025

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to *increase the quality of mental health services, including measured outcomes and promote interagency; and community collaboration related to Mental Health Servies or supports or outcomes.*

This Proposed Project meets INN criteria *by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

Project Introduction:

Yolo County requests authorization to use up to $5,267,306 of Innovation funding to partner with CalMHSA on the Semi-Statewide Enterprise Health Record Innovation Project (EHR Project). If approved, Yolo County will join 23 other counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting. Together, these 24 counties are collectively responsible for more than four million (27%) of the state's Medi-Cal Beneficiaries.

Counties have prioritized this innovation project at this time in response to the severe behavioral workforce challenge they face with the hope that they can preserve the current

workforce and improve the quality of services during a time of rising need for mental health treatment services. The EHR Project hypothesizes that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

Behavioral Health Services Act Alignment and Sustainability (see project, pages 3-4):
This multi-county innovation project aligns with the Behavioral Health Services Act through a shared focus on (a) meeting behavioral health workforce and technological needs in a rapidly changing and increasingly interoperable environment, and (b) increasing access to meaningful data to evaluate behavioral health service outcomes and equity.

Yolo County will utilize Behavioral Health Services and Supports funding along with Medi-Cal funding to sustain this project.

What is the Problem:

The excessive documentation of health records has been identified as a source of burnout and dissatisfaction among healthcare direct service staff and have not evolved to prioritize the user experience of either the providers or recipients of care, resulting in an estimated 40% of a healthcare staff's workday currently spent on documenting encounters, instead of providing direct client care.

Yolo County is challenged with current reporting requirements and anticipates that these challenges will grow. The County utilizes another platform for documentation and Medi-Cal billing; however, the County states there is limited data to allow for conclusions over a longitudinal period of time. Additionally, community-based organizations who provide over 70% of the County's behavioral health services have not had success in utilizing the platform, resulting in County staff needing to complete the administrative lift. With the limited number of providers who serve in this small County, it is important to have a data-collecting platform that is efficient and effective.

By joining the EHR Project, Yolo County will receive additional support through a partnership with CalMHSA and through the learnings of other participating counties. Joining the EHR Project will assist the county in their transition to Medi-Cal/CalAIM implementation and in addressing issues related to providers having uniform and easy access to records, medication management and data.

Consistent with challenges reported by participating counties, CalMHSA has found that the majority of EHR products are developed to meet the needs of the larger physical health care market, and the few national vendors who cater to the behavioral health market have been disincentivized from operating in California due to several unique aspects of the California behavioral health landscape.

CalMHSA highlights three ongoing difficulties that result in county behavioral health plans being dissatisfied with their current EHRs and few choices to implement new solutions. These include:

- Configuring the existing EHRs to meet the ever-changing California requirements,
- Collecting and reporting on meaningful outcomes for all the county behavioral health services (including MHSA-funded activities), and
- Providing direct service staff and the clients they serve with tools that enhance rather than hinder care, which has been difficult and costly to tackle on an individual county basis.

The California Advancing and Innovating Medi-Cal (CalAIM) initiative targets documentation redesign, payment reform and data exchange requirements that will bring California Behavioral Health requirements into greater alignment with national physical healthcare standards, resulting in a lower-barrier entry for EHR vendors seeking to serve California. CalMHSA proposes to maximize the opportunity presented by the CalAIM changes to support County Behavioral Health Plans (BHPs) in revamping their primary service tool to meet the current challenges by partnering with counties and launching the Semi-Statewide EHR initiative.

Initial MHSA Capital Facilities and Technological Needs (CFTN) funding allowed counties to acquire their first EHRs, catalyzing the transformation from paper charts to electronic documentation. While these electronic tools may have offered the best available solutions at the time, newer software solutions have evolved to meet current health industry standards such as privacy, security, and interoperability. These electronic records are used to document and claim Medi-Cal services that County BHPs provide and, if properly enhanced, can capture vital data and performance metrics across the entire suite of activities and responsibilities currently shouldered by BHPs.

How this Innovation project addresses this problem:

California counties have joined together to envision an enterprise solution where the EHR goes far beyond its origins to provide a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system, hypothesizing that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

Through the identification of challenges/shortcomings within existing (legacy) EHRs that contribute to key indicators of provider burnout, this information will be utilized to implement solutions within the new EHR that are compatible with the needs of the County BHP's workforce as well as the clients they serve.

In addition, the EHR Project is making a considerable investment in ensuring that industry standards for privacy and security are central to the product. CalMHSA is working with

healthcare privacy legal experts to create master consenting documents that enhance the opportunity for consenting clients to receive coordinated care.

The project identifies three key aims:

1. Reduce documentation burden by 30% to increase the time our scarce workforce must provide treatment services to our client population.
2. Facilitate cross-county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties can test and adopt innovative practices with reduced administrative burden.

The key principles of the EHR project include (see pages 4-5 for specifics):

- **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County BHPs.

- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems.

- **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi-Cal claiming).

- **Lean and Human Centered:** CalMHSA will engage with experts in human centered design to reimagine the clinical workflow in a way that both reduces "clicks" (the documentation burden), increases client safety, and natively collects outcomes.

- **Interoperable:** Reimagining the clinical workflow so critical information about the people being served is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like Health Information Exchanges (HIEs).

Through a competitive Request for Proposal process, CalMHSA has selected Streamline Healthcare Solutions, LLC as the vendor for the development, implementation, and maintenance of the Semi-Statewide EHR. CalMHSA's agreement with Streamline Healthcare Solutions includes non-compete terms and provisions for CalMHSA to maintain appropriate intellectual property rights of the EHR, which will be customized to meet the unique needs of California's behavioral health system.

RAND is the selected evaluation vendor and will assist in ensuring the Innovation project is congruent with quantitative and qualitative data reporting on key indicators.

To support a more successful multi-county collaboration, CalMHSA has done a deep dive into the Help@Hand Innovation investment to incorporate lessons learned and to work toward implementing a shared decision-making model.

The Community Program Planning Process (see Appendix, pages 6-10):

Local Level

The County's community planning process occurred over a five-month period resulting in the development of the 2023-2026 Three Year Plan, holding more than 30 focus groups comprised of 516 participants including LGBTQ+ community members, youth, adults, and diverse and racial communities (see Appendix, page 7 for list of dates for focus group participants).

Yolo County reports their community planning process has brought forward comments centered around the need for increased access to services including integrated and culturally competent services for special needs populations, and they hope this project will address the feedback that was received.

Upon approval of this project, Yolo County will create an EHR Stakeholder group that will provide feedback in the design, implementation, and evaluation of this project.

Following community input, the County proposed this project as part of their MHSA Three-Year Program and Expenditure Plan. The public comment period was March 18, 2025 through April 16, 2025, followed by their local Behavioral Health Board hearing on April 16, 2025.

Commission Level

A final Innovation plan, incorporating community input and MHSOAC technical advice, was submitted to Commission staff on April 21, 2025. This project was shared with the Commission's listserv on March 21, 2025. **No comments were received in response to the sharing of this project.**

Learning Objectives and Evaluation:

CalMHSA estimates that the project could impact up to 14,000 EHR users throughout the state.

The EHR Innovation project will have three (3) phases:

1) **Formative Evaluation**: Prior to implementation of the new EHR, the project will measure key indicators of time, effort, cognitive burden, and satisfaction while providers utilize their current or "legacy" EHR systems.
2) **Design Phase**: Based on data gathered from the initial phase, human-centered design experts will assist with identifying solutions to problems discovered during the evaluation of the legacy products. This process will help ensure the needs of service providers inclusive of licensed professionals, paraprofessionals, and peers. In turn, their clients will be at the forefront of the design and implementation of the new EHR.

3) **Summative Evaluation**: After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

CalMHSA selected RAND, an expert in California's behavioral health space, to complete the EHR Project evaluation. RAND will assist in ensuring the project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the project planning phase. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention.

To ensure that the project is developed in a manner that is most in line with the needs of the behavioral health workforce and the diverse communities they serve, RAND will subcontract with a subject matter expert in human-centered design.

CalMHSA identified three project objectives with RAND:

Objective I: *Shared decision making and collective impact*. Over the course of the EHR project, RAND will evaluate stakeholder perceptions of and satisfaction with the decision-making process as well as suggestions for improvement.

Objective II: *Formative assessment*. RAND will conduct formative assessments to iteratively improve the new EHR's user experience and usability during design, development, and pilot implementation phases.

Objective III: *Summative assessment*. Conduct a summative evaluation of user experience and satisfaction with the new EHR compared to legacy EHRs, as well as a post-implementation assessment of key indicators.

The Budget (see Appendix, pages 12-15):

On January 25, 2023, Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura Counties were approved to collectively spend up to $30,003,104.67 in MHSA Innovation funding for this project over a period of five (5) years. On November 17, 2022, Humboldt, Sonoma and Tulare Counties were approved to spend up to $12,310,146.54 over five (5) years to launch the project. Sierra County was approved to join the EHR Collaborative on July 25, 2024, and now Yolo County comes forward to join as well.

Yolo County is requesting authorization to spend up to $5,267,306 in MHSA Innovation funding, over a period of three (3) years, to join the EHR Project ***and will be utilizing funds that are subject to revert at the end of this fiscal year for this project.***

Consultant costs total $3,452,171 (65.5% of total budget) will be paid to CalMHSA and is allocated for Project Management and participation in the collaborative. Of this amount, $150,000 has been allotted for the evaluation of this project.

CalMHSA will serve as the Administrative Entity and Project Manager. CalMHSA will execute Participation Agreements with each respective county, as well as contracts with the following EHR Vendor and Evaluator:

- Streamline Healthcare Solutions: This vendor will be responsible for the development, implementation, and maintenance of the Semi-Statewide EHR.
- RAND: As the evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project.

Local Personnel costs total $1,703,645 (32.3% of total budget) and will cover various positions needed to monitor this project (see Appendix, pages 12-13).

The County anticipates administrative/overhead costs to be $111,490 (2.1% of total budget).

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	CalMHSA	Evaluation	Sustainability Plan (Y/N)
Yolo	**$5,267,306**	**$1,815,135**	**$3,302,171**	**$150,000 (3%)**	**Y**
Previously Approved:					
Imperial	$2,974,849	$718,744	$2,256,105	$150,000 (5%)	Y
Kings	$3,203,101.78	$1,802,706.08	$1,250,395.7	$150,000 (4.7%)	Y
Mono	$986,402.89	$317,350	$669,052.89	$150,000 (15%)	Y
Placer	$4,562,393	$1,199,845	$3,362,548	$250,000 (5%)	Y
San Benito	$4,940,202	$3,785,392	$1,154,810	$150,000 (3%)	Y
San Joaquin	$8,748,140	$744,978	$8,003,162	$500,000 (5.7%)	Y
Siskiyou	$1,073,106	$92,311	$980,795	$150,000 (13.9%)	Y
Ventura	$3,514,910	$917,284	$2,597,626	$500,000 (14%)	Y
Sonoma	$4,420,447.54	In Kind	$4,170,447.54	$250,000 (5.6%)	Y
Humboldt	$608,678	$17,482	$441,196	$150,000 (24%)	Y
Tulare	$7,281,021	$2,508,218	$4,522,803	$250,000 (3.4%)	Y
Sierra	$910,906	$195,691	$665,215	$50,000 (5.4%)	Y
Innovation Total	**$48,491,463**				

*The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; **however**, if Innovation Project is approved, the County must receive and inform the BHSOAC of this certification of approval from the Yolo County Board of Supervisors before any Innovation Funds can be spent. Additionally, this project has included language specific to BHSA alignment and sustainability.*

AGENDA ITEM 5

Information

May 22, 2025 Commission Meeting

Advocacy Spotlight: California Association of Veteran Service Agencies

Summary:
Commission advocacy partner California Association of Veteran Service Agencies (CAVSA) will highlight the work and accomplishments of their advocacy program for Veteran Populations.

Background:
The Behavioral Health Services Oversight and Accountability Commission as authorized by the State Legislature, oversees funding to community-based organizations (CBOs) to support the behavioral health needs of underserved populations through advocacy, training and education, and outreach and engagement activities. These nine populations are:

- Clients and Consumers
- Diverse Racial and Ethnic Communities
- Families
- Immigrant and Refugee Populations
- K-12 Students
- LGBTQ Populations
- Parents and Caregivers
- Veteran Populations
- Transition Age Youth (TAY)

Veterans include military service members of any age and branch who have been discharged (either honorably or dishonorably) and are experiencing, sought treatment for, or are at risk of developing behavioral health issues or diagnoses. The overwhelmingly diverse ethno-cultural backgrounds among veteran communities create a substantial impact on the systems and services targeted towards those transitioning to civilian life. The lack of data on veterans, the prevalent homelessness, and increasing rate of death by suicide are all behavioral health-related issues that have been identified among California's veterans.

The National Veteran Suicide Prevention Report states that the rate of suicide deaths for veterans was considerably higher than that of the general population, ranging from 12-66% higher in different geographical regions. The National Survey on Drug Use and Health reports that 26% of veterans have experienced mental illness and/or substance use disorder. The alarming prevalence rates of suicide and substance use, as well as increased risk for other negative outcomes including homelessness in this population requires attention and deliberate intervention.

CAVSA was awarded the Veteran Populations Advocacy contract in March 2024 to conduct advocacy, education, and outreach activities to address the behavioral health needs of Veterans at the state level. CAVSA and its member agencies are experienced with assessing the impact of behavioral health programs and state policy outcomes, gathering data on the impact of veteran populations, and aggregating and disseminating findings with communities and decision makers. Through these member agencies--U.S. VETS, Nation's Finest, Veterans Village of San Diego, Swords to Plowshares, California Veterans Assistance Foundation, New Directions for Veterans and Veterans Housing Development Corporation--CAVSA has devised and conducted statewide surveys of direct service providers and Veteran Service Organizations to determine the adequacy of local behavioral health funding and the impact of stigma, the presence or absence of local Veteran Treatment Courts, and other aspects of behavioral healthcare. CAVSA partners with both veterans and experts to assist in program analysis and state policy outcomes to determine need and improve access to services.

CAVSA's approach to state level advocacy includes the following:

- Reliance on organizations working in partnership to elevate and resolve the issue most important to veterants behavioral halth and wellness.
- Gathering the most recent data on homelessness, overdoses, completed suicides, self-injury, traumatic brain injury, post-traumatic stress disorder, and justice involvevement to determine potential avenues for policy intervention
- Continuous arguing for inclusion of veteran's voice in local oversight bodies
- Focus on rural communities to target funding, increase housing resources, developing opiod addiction programs, and enhancing transportation services for this population
- *Swords to Plowshares* is a leader in developing permanent supportive housing communities for veterans. Swords' developed Maceo May Apartments, which opened in 2023 on Treasure Island, and is home to 104 vets and include resident support with behavioral health care, an active peer program, and VA case management.
- *U.S.VETS* hosted their Annual Suicide Prevention and Awareness Virtual Summit in November 2024. Guest speakers gave testimonials and discussed clinical implications of lived experiences, behavioral health outreach and suicide prevention

Presenter(s): California Association of Veteran Service Agencies (CAVSA)

Enclosures: None

Handouts: CAVSA Presentation

Proposed Motion: None

AGENDA ITEM 6

Action

May 22, 2025, Commission Meeting

Governor's Proposed Budget May Revision and Commission's Spending Plan Update

Summary

The Behavioral Health Services Oversight and Accountability Commission receives budget updates in July, January, and May. These updates align with key fiscal milestones: the start of the fiscal year, the Governor's proposed budget, and the May Revision. The goal is to promote fiscal transparency and ensure expenditure aligns with the Commission's priorities.

Governor's Proposed Budget May Revision

The May Revision of the 2025-2026 state budget, released on May 14, 2025, proposes $321.9 billion in expenditures ($226.4 billion general fund) and reflects a projected $11.9 billion deficit. The actual deficit is nearly $40 billion, considering $27.3 billion in previously agreed financial remedies, including $16.1 billion in cuts and a $7.1 billion withdrawal from the state's rainy-day fund. The Governor attributes the revenue shortfall to federal tariff policy.

Key points:

- **Budget Deficit**: California faces a $12 billion deficit due to rising social service costs and national economic challenges.
- **Revised Spending Plan**: Governor Gavin Newsom's $322 billion revised budget includes cuts to Medi-Cal, adjustments to state-funded insurance, and reductions in home health services. Funds are being reallocated from specialized accounts to support core services.
- **Medi-Cal Cuts**: Proposed measures include freezing new enrollments, raising premiums, and reducing benefits to manage higher-than-expected enrollment and costs. They also propose significant cuts to Medi-Cal, reversing the recent expansion to undocumented Californians and increasing the uninsured population.
- **External Influences**: Federal tariff policies, stock market declines, and a delayed tax deadline for Los Angeles County contribute to the state's financial challenges.
- **Negotiations and Deadlines**: Intensified negotiations with lawmakers are expected ahead of the June 15 budget deadline.
- **Federal and State Fiscal Interconnection**: Legislative leaders highlight the limits of state control over federal policy changes, emphasizing the interconnectedness of state and federal fiscal policies.

The May Revision proposes no general salary increases for state employees for the 2025–26 fiscal year. Funding for planned July 1, 2025, salary increases will be removed, saving $766.7 million. Health care premium and enrollment increases for 2026 remain funded.

Behavioral Health Initiatives in the May Revise

Proposition 1/Behavioral Health Services Act - Proposition 1, approved in March 2024, amended the Mental Health Services Act and created a $6.38 billion bond for behavioral health treatment, residential facilities, and supportive housing. In 2024, $85 million ($50 million General Fund) was allocated to counties, with an additional $93.5 million ($55 million General Fund) planned for 2025-26 to implement Proposition 1.

- **Behavioral Health Infrastructure Bond Act** – Increase of approximately $17 million for the Department of Health Care Services to support the implementation and administration of the Behavioral Health Services Act Infrastructure Bond Act.

- **Behavioral Health Transformation** – Behavioral Health Services Act Implementation – Allocates the California Health and Human Services $280,000 ongoing Behavioral Health Services Act funds to support coordination and implementation of behavioral health initiatives, including Senate Bill 326 (Eggman), Chapter 790, Statutes of 2024.

- **Behavioral Health Services Act Planning and Resources** – Allocates $7.4 million one-time from the Behavioral Health Services Fund to the Department of Public Health, Office of Policy and Planning to support planning and implementation of the Behavioral Health Services Act.

- **Mental Health and Impacts of Social Media Adjustment (AB 1282)** – Enacts a net-zero shift of resources for the Department of Health Care Services. May Revision proposal moves Behavioral Services Act funds from local assistance to state operations.

- **Behavioral Health Transformation** – Allocates $382,000 Managed Care Funds for the Department of Managed Health Care to investigate county complaints about managed care health plans' compliance with Senate Bill 326 (Eggman), Chapter 790, Statutes of 2024, and Proposition 1.

Behavioral Health Federal Adjustments

Congressional leaders are seeking budget cuts that could jeopardize behavioral health services in California. Medicaid, the largest payer of behavioral health services nationwide and a significant portion of counties' mental health budgets, would face reductions. Such cuts would undermine state and local governments' capacity to deliver behavioral health support. Programs like CalAIM and BH-CONNECT, which rely on federal waivers to use Medicaid funding for initiatives such as housing navigation, could lose critical support. If these waivers expire or are rescinded, hospitals, community centers, and other providers essential to Californians in need would face severe challenges. The May Revise includes the following adjustments:

- **California Advancing Innovative Medi-Cal** – Continues to fund this multiyear initiative to transform the Medi-Cal program with the goal of improving health outcomes, particularly for individuals experiencing homelessness, foster youth, and justice-involved individuals. It integrates physical health, mental health, and social services to make care simpler and more patient-focused, while improving support through innovative payment and delivery methods.

- **BH-CONNECT** – Maintains $8 billion in funding over four years for BH-CONNECT, a multiyear initiative to improve Medi-Cal behavioral health services.

- **Behavioral Health Workforce Initiative** – Starting in January 2026, invests $1.9 billion to address workforce shortages in behavioral health. It will support clinical training, stipends, supervision, and professional development to create sustainable pipelines for licensed and paraprofessional providers under California's BH-CONNECT waiver.

- **In-Home Supportive Services for Undocumented Adults** – Eliminates $159 million ongoing for In-Home Supportive Services for undocumented adults aged 19 and older.

- **Medi-Cal Assets for Older and Disabled Adults** – Eliminates $55.9 million ongoing to align In-Home Supportive Services with the reinstatement of the Medi-Cal asset limit for older and disabled adults.

- **Halts Access to Health Programs for Undocumented Immigrants** – Halts access to health programs for undocumented immigrants by implementing an enrollment freeze for Medi-Cal expansion, eliminating long-term care benefits and In-Home Supportive Services, removing dental benefits, and introducing a $100 monthly premium for those already enrolled.

- **Behavioral Health Federal Funds Adjustment** – Proposes a one-time funding increase of $72.9 million over multiple years for the Department of Health Care Services' community mental health services, substance use disorder treatment, and prevention services.

Reducing Disparities

- **Reducing Disparities Program** – Eliminates funding for the California Reducing Disparities program and cuts the Department of Public Health budget by $15.8 million.

Children and Youth

- **Children and Youth Behavioral Health Initiative** – Continues to fund this multiyear, multi-department package of investments that enhances mental health and wellness support for children, youth, and families. It emphasizes prevention and early intervention, making services more accessible in schools and community settings.

- **Transforming Maternal Mental Health Model** – Proposed $2.9 million increase in ongoing funding to the Department of Health Care Services for the implementation of a maternal health initiative.

Behavioral Health and Criminal Justice

- **Community Assistance, Recovery, and Empowerment (CARE) Court** – Continues to fund this plan that establishes court-ordered treatment for individuals experiencing both homelessness and serious behavioral health challenges.

- **Incompetent to Stand Trial** – Reduces funding for state hospital programs, including the Incompetent to Stand Trial (IST) Program, Community-Based Restoration and Felony Diversion programs, and isolation unit needs. The May Revision maintains funding based on actual program expenses.

- **Eliminate Incompetent to Stand Trial Infrastructure Grant Program** – Eliminates $232.5 million in unused county grants and $195.5 million in infrastructure funds for community placements. Delays and a shift to cost containment are cited as reasons.

- **Incompetent to Stand Trial Evaluations** – Reverts $9.1 million General Fund in 2023-24 and 2024-25 due to unspent funds for improvements to Incompetent to Stand Trial evaluations in the Judicial Branch.

Substance Use Prevention

- **Youth Substance Use Prevention and Treatment** – Allocates $272.5 million Proposition 64 Funds from cannabis tax revenues to support school and community-based prevention, early intervention, and youth SUD treatment services in California.

Suicide Prevention

- **988 Suicide and Crisis Lifeline Centers** – Allocates $17.5 million one-time funding from the 988 State Suicide and Behavioral Health Crisis Services Fund to support crisis centers in managing the rising call, chat, and text volumes for the 988 line. This funding will sustain current capacity.

Housing and Homelessness

- **Housing and Homelessness** – Proposes $16.8 million over three years to reorganize housing agencies and $200 million for Flexible Housing Pools to support behavioral health reforms.

New Behavioral Health Investments

- **CalHOPE Warm Line:** $5 million from the Behavioral Health Services Fund (BHSF) will support the continuation of the CalHOPE Warm Line — a 24/7 phone line offering free, confidential support to Californians — through 2025-26 and beyond.

- **Trainings for ACEs Providers:** $2.9 million in total funds (with $1.46 million from the BHSF and $1.46 million from federal funds) will support trainings for Adverse Childhood Experiences (ACEs) providers.

May Revision Impact to the Commission

The May revision eliminates the Mental Health Wellness Act (MHWA) funds starting in FY 2025-26, resulting in the loss of $60 million from the $120 million allocation previously directed by the Commission toward six major initiatives. This change directly impacts three initiatives: 0-5/maternal behavioral health, Full-Service Partnerships, and Peer Respite.

Over the past several years, the Commission allocated $120 million in MHWA funds to these initiatives, focusing on improving access to behavioral health services, reducing stigma, and fostering well-being in underserved communities. These efforts prioritized addressing behavioral health challenges in areas historically facing barriers to care, striving to create a more equitable behavioral health system.

The timeline of events and decisions regarding proposals and allocations is as follows:

- **November 2022**: The Commission directed staff to present proposals for EmPATH, older adults, children aged 0-5/maternal behavioral health, Peer Respite, and substance use disorder services.

- **September 22, 2022**: $17 million was approved for EmPATH emergency psychiatry ICU programs, with an additional $3 million for technical assistance and evaluation.

- **November 17, 2022**: $20 million was approved to scale the PEARLS and AgeWise programs in collaboration with the California Department of Aging.

- **January 25, 2024**: $20 million was approved for SUD initiatives, including $16 million for three counties and $4 million for technical assistance, evaluation, and research.

- **February 22, 2024**: $20 million from the Mental Health Wellness Act funding was devoted to strengthening Full-Service Partnerships, and the Commission requested staff to present a funding proposal at a future meeting.

- **August 22, 2024**: $10 million of the devoted $20 million was approved for capacity building and technical assistance in FSPs, emphasizing value-based contracting and performance management.

- **November 21, 2024**: $20 million was approved to enhance care for birthing people, children aged 0-5, and their parents, aiming to reduce out-of-home placements, improve

educational outcomes, and identify developmental delays and behavioral health risks through partnerships with Community-Based Organizations (CBOs).

- **May 22, 2025**: At the May 22, 2025 meeting, the Commission will hear presentation and consider the release of an Request for Proposal to award $10 million of the devoted $20 million for Full-Service Partnerships to build internal capacity in performance management.

- **October 2025**: $20 million is devoted to Peer Respite programs, which are voluntary, short-term, community-based, non-clinical support programs for people experiencing or at risk of experiencing a psychiatric crisis. The Commission is currently developing an outline for Peer Respite grants with the goal of bringing an outline for Request for Proposals to the Commission this Fall.

If future MHWA funding is eliminated, the community may face significant challenges. Programs addressing behavioral health disparities and access inequities could end, leaving underserved populations unsupported. The loss of funding could exacerbate behavioral health challenges for vulnerable groups and hinder progress toward equitable outcomes. Additionally, initiatives driven by the Commission would cease, reducing opportunities for marginalized voices to influence behavioral health policies.

The proposed funding elimination in the May Revise will cut $60 million from initiatives like Full Services Partnerships, 0-5/maternal behavioral health, and peer respite services.

MHWA Initiatives and Funding Distribution from Fiscal Years 2021/22 through 2026/27.

Grants	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	Total
EmPATH	$10,000,000	$9,250,000	$750,000				$20,000,000
Older Adults	$10,000,000	$9,250,000	$750,000				$20,000,000
SUD		$1,500,000	$10,000,000	$8,500,000			$20,000,000
Maternal BH			$8,500,000	$6,500,000	$5,000,000		$20,000,000
FSP 1				$5,000,000	$5,000,000		$10,000,000
Peer Respite					$10,000,000	$10,000,000	$20,000,000
FSP 2						$10,000,000	$10,000,000
Total	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$120,000,000

For more information on the Governor's May Revise:

- Governor's Budget Summary

  https://ebudget.ca.gov/FullBudgetSummary.pdf

- California Budget & Policy Center

  https://calbudgetcenter.org/resources/first-look-understanding-the-governors-2025-26-may-revision/

- Department of Health Care Services Highlights

  https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2025-26-May-Revision-Budget-Highlights.pdf

Commission Budget Update as of May 2025

The Commission's budget is organized into three main categories: Operations, Budget Directed, and Local Assistance.

- **Operations:** Includes Personnel and Core Operations. These funds are provided for staff, rent, and other related expenses needed to support the work of the Commission. Funding is usually ongoing with some exceptions such as one-time funding to support Commission directed initiatives.
- **Budget Directed:** Funding provided in the Governor's Budget Act for technical assistance, implementation, and evaluation of grant and contract programs with one-time and ongoing funding that is allocated over multiple fiscal years.
- **Local Assistance:** Includes the majority of Commission's funding that is provided to counties and other local partners. Funding is provided via grants and contacts to counties or organizations on an ongoing and/or one-time basis, spread over multiple fiscal years.

Annual funding in the Commission's budget can be authorized for a single fiscal year or multiple fiscal years. Fluctuations in annual funding reflect the availability of one-time funding, funding authorizations that are available over multiple years, and periodic on-going budget decisions that result in either growth or reductions in expenditure authority.

Past, Current and Proposed Budget for the Commission for Behavioral Health

Item	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26
Operations				
Personnel	$8,100,000	$8,968,000	$9,656,000	$9,892,000
Operations	$3,168,000	$4,295,000	$4,295,000	$4,079,000
Total Operations	**$11,268,000**	**$13,263,000**	**$13,951,000**	**$13,971,000**
Budget Directed				
BHSSA Evaluation*	$16,646,000			
Fellowship/Transformational Change*	$5,000,000			
Universal Mental Health Screening Study*		$200,000		
EPI Reappropriation*		$1,675,000		
Evaluation of FSP Outcomes	$400,000	$400,000	$400,000	$400,000
Prop 1			$100,000	$100,000
Total Budget Directed	**$22,046,000**	**$2,275,000**	**$500,000**	**$500,000**
Local Assistance				
Children & Youth Behavioral Health Initiative*		$15,000,000		
Community Advocacy	$6,700,000	$6,700,000	$6,700,000	$6,700,000
Behavioral Health Student Services Act (BHSSA)	$8,830,000	$7,606,000	$7,606,000	$7,606,000
Mental Health Wellness Act	$20,000,000	$20,000,000	$20,000,000	($20,000,000)
Total Local Assistance Funds	**$78,430,000**	**$49,306,000**	**$34,306,000**	**$14,306,000**
Vacancies Adjustment			($385,000)	($385,000)
7.95% State Budget Adjustment			($1,152,000)	($1,152,000)
Grand Total	**$111,744,000**	**$64,844,000**	**$47,220,000**	**$27,240,000**

* One-time funds

Update on Initiatives: Allocation of Reappropriated Funds for EmPATH and Older Adults

At the March 2025 Commission Meeting, the Commission approved expanding two grant programs: EmPATH ($3 million) and Older Adults ($995,300):

- **EmPATH Grant Program:** The Commission authorized $1 million for Sutter Coast, which initially received $1 million less than other grantees, and $2 million to be divided among the other grantees to expand their programs.
- **Older Adults Grant Program**: The Commission authorized $995,300 to expand current PEARLS and Age Wise grantees.

The Commission requested an update on these allocations to better understand the expansion of the EmPATH and Older Adults grant programs.

Over the last few months, staff engaged with grantees to best determine the additional needs for the EmPATH and Older Adult grantees and determined the following:

EmPATH Grant Program

The Commission redistributed $3 million in unused EmPATH funds to existing grantees. These funds, originally allocated to a grantee who could not participate, were redistributed after a multistep screening process to ensure fairness and meet genuine needs. Sutter Coast received $1 million to address a $1 million shortfall, while the remaining $2 million was split among other grantees.

- Sutter Coast: $1,000,000
- Fresno Community Regional Medical Center: $214,578
- Henry Mayo Newall Memorial Hospital: $200,000
- College Medical Center-Long Beach: $ 253,764
- Mercy Medical Center—Redding: $200,097
- Twin Cities Adventist Health: $200,000
- Sharp Chula Vista: $235,565
- Loma Linda UCH: $347,998
- Loma Linda UMC: $347,998

The redistributed amount totaled $3,000,000. These additional funds were requested to account for higher than anticipated construction costs due to inflation, to support IT infrastructure, and hire staff to support key positions associated with successful implementation.

Older Adults PEARLS and AgeWise Grant Program

The Commission also redistributed unused PEARLS and AgeWise funds to existing grantees. These funds, originally allocated to two grantees who could not participate, were redistributed after a multistep process to ensure fairness and meet genuine needs. Seven grantees submitted requests for additional funds:

- Family Service Agency of Santa Barbara County: $138,411
- Agency on Aging: $140,000
- Stanislaus County Department Area Agency on Aging: $140,000
- Peers Envisioning and Engaging in Recovery Services: $135,486
- Pacific Center: $140,000
- Council on Aging: $71,600
- Korean Services: $99,966

The total request was $865,463, less than the $995,300 available for reappropriation. These requests were for increased staffing, IT support, vehicles, and equipment and were all reasonable and not duplicative of their original proposed activities.

The Commission seeks expenditure authorization for the following items:

$400,000 for Full-Service Partnership Evaluation	Amend interagency agreement with University of California San Francisco to add funding to evaluate child-serving Full-Service Partnerships
$143,010 for Salesforce Tableau renewal	Yearly software renewal for the research dashboard
$55,000 amendment to the Centris contract	Additional funds for more security
$18,000 for office plant installation and maintenance	Office plants for cleaner air and workplace mental wellness. Onetime costs of approximately $6k for containers and delivery/installation and monthly maintenance (approx. $1k per month).
$45,000 for Sellers Dorsey	Meeting facilitations for the Innovation Partnership fund discussion
$9,000 for Asana	Project management software used by the Research team.

Presenter: Norma Pate, Deputy Director of Administration and Performance Management

Enclosures: Proposal for Commission Approval: Advancing Accountability and Evaluation of Child-serving Full-Service Partnerships (FSPs)

Handouts: PowerPoint Presentation

Proposed Motion: That the Commission approves the six contracts as presented:

1. $400,000 Amend interagency Agreement with University of California San Francisco
2. $143,010 - Salesforce to renew access to Tableau.
3. $55,000 - Amendment to the Centris contract
4. $45,000 - Contract with Sellers Dorsey for meeting facilitation
5. $18,000 - Office plants
6. $9,000 - Asana project management software

May 22, 2025

Proposal for Commission Approval: Advancing Accountability and Evaluation of Child-serving Full-Service Partnerships (FSPs)

Summary:

The Commission requests to amend its interagency agreement with the University of California, San Francisco (UCSF) to conduct evaluations of child-serving FSPs. This amendment to the existing UCSF interagency agreement is consistent with the biennial Legislative reporting requirements in Section 5845.8 of the Welfare and Institutions Code (enacted by Senate Bill 465, Chapter 544, Statutes of 2021) for data analytics and evaluations of FSPs in California. Prior years' funding supported research that sought to better understand barriers to data reporting. This proposal would build upon that work by integrating existing statewide datasets to examine utilization needs and outcomes in child-serving FSPs. This would enable increased accountability and performance across the state's public behavioral health infrastructure as it relates to programs for children with behavioral health needs, consistent with the goals of the Behavioral Health Services Act (BHSA, Proposition 1, 2024).

Purpose:

The proposed project would focus on better understanding utilization, accountability, and outcomes for child-serving Full-Service Partnerships (FSPs)-comprehensive care programs for children and youth with the most intensive behavioral health needs.

Requested Commission Action:

Approve submission of the amended interagency agreement with UCSF to evaluate the utilization and outcomes for child-serving FSPs statewide.

AGENDA ITEM 7

Action

May 22, 2025 Commission Meeting

Grant Opportunities: Mental Health Wellness Act Full Service Partnership Grant

Summary:
The Commission will consider the approval of the Request for Proposal for Mental Health Wellness Act (MHWA) funds of $10 million for a contractor or contractors to coordinate the recruitment, technical assistance, and training for a minimum of eight (8) California County Behavioral Health Departments and twenty (20) Full Service Partnership (FSP) service providers within those counties to build internal capacity in performance management.

Background:
Full Service Partnerships represent California's comprehensive and intensive efforts to serve individuals with serious mental illness in their communities and connect them to the resources they need to gain stability and maintain independence. On the continuum of care, FSPs are the last effort to divert individuals away from the most devastating impacts of serious mental illness, including homelessness, incarceration, and hospitalization.

California's Full Service Partnership programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused or are at risk of becoming unhoused, and who have a severe mental illness, often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. FSPs provide services across the lifespan including children, transition aged youth, adults, and older adults.

This RFP aligns with findings and recommendations from the Commission's second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services, in compliance with Senate Bill(SB) 465. The Behavioral Health Services Oversight and Accountability Commission (Commission) oversees the evaluation and biennial reporting on Full Service Partnerships (FSP) to the California State Legislature (SB 465). Part of this legislative mandate is to identify ways to improve FSPs and drive improvements in service delivery and client outcomes.

Adoption
At its regular meeting on March 27, 2025, the Commission approved the adoption of the 2024 FSP Legislative Report. In that report, the Commission found that most counties are not currently engaged in substantive performance management practices and recommended statewide investments in performance management, specifically:

The launch of a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management.

The scope of this Request for Proposals (RFP) aligns with the findings and recommendations of the adopted 2024 FSP Legislative Report.

A maximum of one (1) award will be made.

RFP Target Release Date- June 2025

Presenter: Kallie Clark, Chief of Research, Evaluation and Programs, BHSOAC

Enclosures: None

Handouts: PowerPoint presentation

Proposed Motion: That the Commission authorizes staff to release an RFP to award $10 million in Mental Health Wellness Act funding through a competitive bid process designed to coordinate the recruitment, technical assistance, and training for county behavioral health departments and FSP service providers to build internal capacity in performance management.

AGENDA ITEM 9

Information

May 22, 2025 Commission Meeting

Innovation Partnership Fund & Public, Private, and Nonprofit Partnerships Discussion

Summary:
The Commission will participate in a panel discussion to explore a range of public, private, and nonprofit partnership models. This session will also include a preliminary facilitated discussion by Marko Mijic, Managing Director, Sellers Dorsey, to help prioritize potential concepts for further exploration as part of the upcoming Innovation Partnership Fund grant.

Background: Under the Behavioral Health Services Act (BHSA), the Commission will begin administering the Innovation Partnership Fund on July 1, 2026, awarding grants to private, public, and nonprofit partners. With $20 million per year over five years (totaling $100 million), the fund will support innovative, evidence-based approaches to mental health and substance use disorder services, with a focus on underserved, low-income populations, and communities impacted by behavioral health disparities. The BHSA also requires the commission to consult with state partners on the priorities for the fund.

On March 14, 2025, the Commission released a Call for Concepts survey to gather public feedback to identify a range of potential innovation projects that may inform the Commission on IPF funding priorities. A summary of initial feedback was shared at the April meeting and additional analysis will be presented for input and discussion.

Presenter(s):
Panelists: Maricela Rodriguez, Senior Advisor for Civic Engagement and Strategic Partnerships, Office of Governor Newsom; Kate Anderson, Director, Center for Strategic Partnerships

Facilitator: Marko Mijic, Managing Partner, Sellers Dorsey

Enclosures (2): (1) Analysis of Innovation Partnership Fund Priorities; (2) Stakeholder Innovation Partnership Fund Letter

Handouts: PowerPoint Presentation

Proposed Motion: None

Innovation Partnership Fund: Concept Analysis

The Commission invited stakeholders to offer suggestions to be considered in the planning for the implementation of the Innovation Partnership Fund (IPF). The invitation emphasized that suggestions should be focused on system change in the delivery of behavioral health services to the priority populations in Proposition 1 and the BHSA. As of April 20, 2025, more than 40 organizations responded, including the California Health and Human Services Agency (Cal HHS), the Department of Health Care Access and Information (HCAI), community and advocacy groups, agency associations, counties, and profit and non-profit organizations. This document provides brief analysis of each of the concepts identified.

Access to Services

Concept: Digital Behavioral Health Ecosystem with Advocate Support
Proposed by: AdvocateMH

This concept addresses the fragmentation in behavioral health services by creating an ecosystem that aggregates best-in-class digital behavioral health services while providing licensed clinician "advocates" to help individuals and families navigate care. The problem it tackles is the difficulty people face in finding appropriate care in a complex system, often leading to delayed treatment or no treatment at all. By providing free advocates who ensure people can receive high-quality services (both online and in person), this approach would increase access to care, improve care coordination, and provide measurement of outcomes. This would transform the system by creating trusted pathways to care, reducing the burden on individuals to navigate complex systems alone, and ensuring quality through outcome measurement. The urgency lies in addressing the immediate gap between people seeking help and their ability to connect with appropriate services, particularly for those exiting crisis services, primary care, health systems, or nonprofits who need continued support.

Concept: Same-Day Access in Community Health Centers
Proposed by: California Primary Care Association (California Behavioral Health Association and the California Alliance of Child and Family Services are co-signers)

This concept addresses a significant regulatory barrier in California's healthcare system that prevents community health centers from billing Medi-Cal for both a primary care and mental health visit on the same day. This forces patients who need different services to return on separate days, creating an unnecessary barrier to integrated care. The proposal would allow same-day billing for both services, similar to what is already permitted for oral health. This system change would dramatically improve access for the 7.8 million Californians served by nearly 2,300 community health centers, particularly benefiting those with transportation challenges or work constraints. This would transform care by enabling true integration of

primary and behavioral health services, supporting crisis intervention, early intervention, and prevention. The urgency is clear as California faces a growing mental health crisis with 1 in 7 adults experiencing mental illness, and this regulatory change would fill a critical gap between existing programs (Proposition 1, CYBHI, and CalAIM) by increasing access to mild-to-moderate mental health services.

Concept: Foster Youth Behavioral Health Access Hub
Proposed by: California Alliance of Child and Family Services

California's Behavioral Health Transformation is focused on improving equity, access, and outcomes — particularly for youth with complex needs. This concept directly advances that transformation by addressing long-standing structural inequities in how foster youth access behavioral health care. It ensures care is not delayed by county or plan transitions, and it improves care coordination across systems. Foster youth are frequently placed with caregivers who live in a different county, resulting in complex administrative processes within systems like Medi-Cal; significant administrative burden on providers, caregivers, and case managers to coordinate authorizations and transfers across fragmented systems; and altogether time-consuming processes that divert from patient care. This foster youth cross-county hub model would improve access to behavioral health for the 40,000 youth in foster care and also significantly increase efficiency by coordinating benefits and services across county lines; facilitating timely authorization and connection to providers across managed care and specialty mental health systems; providing care navigation and case consultation for youth with complex needs; and ensuring that foster youth receive the right services, at the right time, and in the right amount—regardless of geography. Each day thousands of foster youth experience delayed or disrupted care during critical developmental periods, potentially leading to worsening mental health conditions, placement instability, and poorer long-term outcomes. The hub would serve as a linchpin for a more integrated, person-centered behavioral health system that is trauma-responsive and capable of serving high-need populations efficiently and equitably, directly advancing the state's commitment to behavioral health system transformation.

Concept: School-Based Health Centers
Proposed by: California School-Based Health Alliance

This concept addresses limited access to mental health services for students by expanding School-Based Health Centers (SBHCs) that integrate mental health services with primary care on or near school campuses. The problem it tackles is that many students, particularly those from underserved communities, lack access to mental health support or are hesitant to seek dedicated mental health services. SBHCs reach students who might not otherwise be identified or opt into mental health care by providing integrated services and cross-referrals with medical services. The benefits of this model are both clinical and financial. By using community-based partnerships, this model would transform the system by leveraging multiple "braided and blended" funding sources to ensure sustainable services, reaching 400,000+ students annually with two-thirds of centers already offering mental health services. The urgency is evident in the growing youth mental health crisis and the need to address social determinants of health,

trauma, adverse childhood experiences, substance misuse, and other risk behaviors in school-aged populations.

CDEPs

Concept: LGBTQ+ Community-Based Evidence-Based Practices
Proposed by: The San Joaquin Pride Center

This concept addresses the lack of culturally competent mental health services for LGBTQ+ individuals, particularly in rural communities like San Joaquin County. The problem it highlights is that LGBTQ+ people are not guaranteed understanding by mental health counselors and may face stigma and discrimination in large behavioral health systems. Having participated in the California Reducing Disparities Program, the San Joaquin Pride Center has observed that vulnerable populations respond more positively when care is rooted in communities they trust. The proposal would continue to develop and implement community-defined evidence-based practices specifically for LGBTQ+ communities. This would transform the system by creating safe and affirming locations where LGBTQ+ individuals are more likely to take advantage of services and by building connections across various marginalized communities (African American, Native American, AAPI, and Latino). The urgency is clear as LGBTQ+ individuals continue to face barriers to appropriate care, with rural areas presenting particular challenges.

Concept: CDEP Development and Integration Framework
Proposed by: Third Sector

This concept addresses the need for clear guidance on how to identify, develop, and integrate Community Defined Evidence Practices (CDEPs) into county behavioral health systems. The problem is that while the BHSA specifically calls out CDEPs as an effective strategy for advancing early intervention and reducing racial disparities, it doesn't offer significant guidance on implementation. Counties need support to answer key questions: How can they identify existing community practices that could qualify as CDEPs? What are the barriers to working with CBOs that haven't historically been part of the behavioral health system? The proposal suggests allocating funds for technical assistance to help counties and CBOs fund and scale CDEPs, including evaluation of local environments and training curricula for the 2026-2029 Integrated Plan. This would transform the system by providing concrete steps for implementing CDEPs rather than leaving them as catch phrases in legislation. The urgency stems from the approaching planning cycle and the need to build capacity before the next Integrated Plan is due.

Concept: Expansion of Interdisciplinary Collaboration and Cultural Transformation Model
Proposed by: Solano County Behavioral Health

This concept addresses disparities in access to behavioral health services by proposing to expand Solano County's Interdisciplinary Collaboration and Cultural Transformation Model

(ICCTM) innovation project, previously developed with UC Davis. The problem it tackles is the need for better community planning and engagement to ensure behavioral health services reach underserved populations. The proposal would expand the small learning collaborative from the project's second phase to all counties, allowing them to tailor the model to their communities. This would transform the system by creating an innovation pathway for addressing disparities and developing community-defined evidence-based practices tailored to each community's needs. The urgency is connected to the implementation of Behavioral Health Transformation, which will focus on early intervention and direct services to those with the highest need—this approach ensures that underserved populations have improved access to services across Medi-Cal managed care plans and specialty mental health services.

Concept: CDEP System Integration

Proposed by: Special Service for Groups, Inc.; Hmong Cultural Center of Butte County; Racial & Ethnic Mental Health Disparities Coalition (REMHDCO); Center for Applied Research Solutions (CARS); Whole Systems Learning

This concept addresses the need to incorporate Community Defined Evidence Practices (CDEPs) as integral components of California's behavioral health system. The problem it highlights is that CDEPs, which reflect the values, practices, histories, and lived experiences of the communities they serve, are often marginalized despite their effectiveness in delivering prevention strategies at individual, family, and community levels. Many of these proposals suggest that the Commission's vision for the innovation ecosystem should include a public commitment to ensure that R&D funded by public innovation funds becomes the intellectual property of California's people. This would transform the system by reducing behavioral health disparities for underserved communities, including BIPOC and LGBTQ+ individuals and families. The urgency is that CDEPs fulfill the Innovation Partnership Fund’s mandate to support practices and programs for underserved, low-income, and communities impacted by other health disparities. Proposing organizations compare CDEPs to other healthcare providers and services that were once excluded from mainstream medical models but are now accepted (chiropractors, homeopaths, acupuncturists, etc.), suggesting that similar integration is overdue for community-defined practices.

Concept: CDEP Development Process

Proposed by: Ventura County

This concept addresses the lack of standardized guidelines for establishing and qualifying Community-Defined Evidence Practices (CDEPs). The problem it tackles is that while CDEPs are recognized as valuable, there's no clear pathway for how programs can qualify or create a CDEP, leaving many innovative community-based approaches marginalized despite their effectiveness. The proposal seeks to develop standardized guidelines for CDEP program development and qualification, creating a clear "runway" with defined milestones for emerging programs. Additionally, it aims to integrate existing cultural practices (like traditional healing centers) more formally alongside conventional behavioral health services, similar to how IPS or Clubhouse models operate under BHSA. This would transform the system by bringing culturally

responsive care into the mainstream behavioral health system and providing tangible implementation steps beyond just a "catch phrase" in legislation. The urgency stems from the continued disparities in behavioral health outcomes among diverse communities while effective cultural practices remain sidelined due to lack of formal recognition pathways.

Crisis Prevention, Early Intervention, and Crisis Response

Concept: Post-Emergency Department/Hospitalization Support Program
Proposed by: TownHome Crisis Care

This concept addresses the gap in support for individuals discharged from emergency departments and inpatient psychiatric facilities. The problem it tackles is that these individuals often lack appropriate follow-up care, increasing the risk of readmission or deterioration. The proposal offers a "soft landing" approach that focuses on building resilience and addressing social determinants of health over a 3-10 day period post-discharge. This would transform the system by providing trauma-informed care without locked doors or compulsory treatment, while still offering daily therapy, outpatient facilitation, and medication management. The urgency lies in reducing readmissions and providing better transitions from acute care to community-based support, ultimately reducing the burden on emergency services and improving patient outcomes.

Concept: Virtual MAT Bridge Clinic for Substance Use Disorders (Concept also listed as Access to Services; Early Intervention; Peer-Provided Services; Technology; and Treatment)
Proposed by: UC Davis

This concept addresses the significant gap in immediate access to medication-assisted treatment (MAT) for individuals with substance use disorders who are exiting emergency departments, jails, or seeking help independently. The problem it tackles is that many individuals face barriers like lack of a medical home, transportation issues, and difficulty navigating county program intakes, leading to missed opportunities for engagement in treatment. The proposal outlines a low-barrier, 24/7 virtual MAT Bridge Clinic providing seven-day-a-week access to virtual walk-in appointments, bridge prescriptions to stabilize individuals during transition to structured care, addiction-trained providers who can initiate or continue buprenorphine treatment, real-time advice for fentanyl users, and peer support navigators. Telehealth provides immediate access, overcoming geographic and social barriers. This approach would transform the system by reaching high-risk individuals currently disconnected from care, creating a bridge between crisis encounters and long-term treatment, reducing bottlenecks and wait times, aligning with County ODS systems, and using real-time data to inform systemic improvements. The urgency is clear as the opioid crisis continues and

individuals leaving EDs or jails often face a critical window for intervention that is missed in the current system. By improving patient outcomes and reducing crisis care costs, this model could serve as a scalable, statewide blueprint for accessible, sustainable addiction treatment.

Early Intervention

Concept: Allied Network for Neurodevelopmental Advancement (ANNA) (Concept also listed as Access to Services and Community Defined Evidence-Based Practices)
Proposed by: ANNA

This concept addresses gaps in autism care delivery by proposing a next-generation provider focused on evidence-based early intervention. The problem it tackles is that are outdated intervention models (traditional adult-directed ABA models often do not align with developmental science), current autism services are typically siloed, and there is a lack of culturally competent access. ANNA proposes using Naturalistic Developmental Behavioral Interventions (NDBI), a child-led, play-based approach that embeds learning into everyday moments. The model integrates diagnostic evaluation, intensive intervention, caregiver coaching, and progress monitoring under one provider. By scaling a unified, evidence-based model, this would transform the system by shifting from behavioral compliance to developmental growth, building family trust, increasing child engagement, and improving long-term outcomes. ANNA technology enables fidelity monitoring, clinical documentation, and real-time decision support. The urgency stems from the growing prevalence of autism spectrum disorders and the critical importance of early intervention during key developmental windows, particularly for children aged 1-6.

Concept: Mind Numbers: Data-Driven Platform for SMI Monitoring (Concept also listed as Crisis Prevention, Early Intervention, and Crisis Response; Prevention; Technology; and Workforce Development)
Proposed by: Mind Numbers

This concept addresses the reactive nature of serious mental illness (SMI) care where traditional systems often intervene only after crisis points. The proposal outlines a technology-based solution that uses passive symptom monitoring through a mobile app to track mood, sleep, activity, and daily routines. The platform analyzes these data points to provide early warning signs of symptom escalation and offers actionable insights to both users and clinicians. This would transform the current reactive care model into a preventive approach by enabling earlier interventions before crises occur. The system change connection is significant—it would reduce hospitalizations by enabling pre-crisis interventions, increase care accessibility for underserved populations through technology, and provide clinicians with objective data to support more effective treatment decisions. The urgency is clear as the current system continues to struggle with repeat hospitalizations and crisis interventions that could be prevented through earlier detection and intervention. By leveraging AI-driven behavioral analytics and clinical rating scales, Mind Numbers offer a scalable, cost-effective solution that provides timely support, especially for underserved communities facing financial and systemic

barriers. This aligns with BHSA goals by targeting individuals with the greatest need through continuous symptom tracking for timely interventions; reducing disparities with accessible, tech-driven solutions; supporting workforce strategies with objective data; and measuring impact on trends, treatment adherence, and interventions.

Integration of SUD and Mental Health

Concept: Whole Person Care Navigator (AI-Powered Copilot) (*Concept also listed as Technology and Treatment*)
Proposed by: Zuckerberg San Francisco General Hospital

This concept addresses the challenge of identifying and addressing social and behavioral health needs that impact overall patient outcomes. The problem it tackles is that simple screening often misses high-risk patients, and care teams struggle with documentation burden and coordination across different domains of care. The proposal is for an AI-powered copilot that extracts and summarizes social and behavioral health needs from varied data sources to support real-time, equity-informed care planning. It identifies high-risk patients, provides personalized social resource recommendations, and suggests treatment plan adjustments based on identified needs (housing insecurity, substance use, financial instability, etc.). This would transform the system by enabling integrated, person-centered care that addresses the full spectrum of patient needs—medical, social, and behavioral. It would enhance provider capacity, support workforce sustainability, and drive equity by targeting structural drivers of poor mental health and substance use outcomes. The urgency is clear as behavioral health providers continue to struggle with documentation burdens and care coordination while trying to address the complex needs of their patients. This concept aligns directly with BHSA goals to reduce disparities, integrate care, support workforce efficiency, and improve outcomes.

Concept: Barrier Removal for Integrated Care
Proposed by: Tehama County Health Services Agency Behavioral Health

This concept addresses barriers contributing to the lack of access to quality behavioral health treatment in Tehama County and the fragmentation of care systems. The problem it highlights is that historically marginalized racial and ethnic groups, low-income populations, and individuals living in rural communities face difficulties in obtaining needed care. The proposal aims to remove these barriers and reduce fragmentation, though specific strategies are not detailed in the submission. This would transform the system by developing a modern behavioral health system with equitable access to high-quality services and supports. The urgency stems from the ongoing difficulties rural communities like Tehama County face in accessing integrated behavioral health services.

Concept: Support for Integration of Mental Health and SUD Services
Proposed by: County Behavioral Health Directors Association (CBHDA)

This concept addresses the challenges in integrating mental health and substance use disorder (SUD) services across the specialty behavioral health continuum. The problem it tackles is that despite funding integration through BHSA, there remain barriers in workforce, educational curricula, licensing and certification, and facilities that prevent true clinical integration. The proposal suggests working with consultants to develop recommendations and strategies for better integration, including analyzing barriers in workforce education and licensing, building upon SB 1238 (Eggman) of 2024 to address facility licensure issues, and conducting a national review of best practices. This would transform the system by supporting the evolution of integrated care at the clinical service delivery level while analyzing necessary legal changes beyond the funding and policy shifts in BHSA. The urgency is connected to the implementation of BHSA, which accelerates the integration of mental health and SUD funding but requires additional support to achieve true clinical integration.

Concept: Integrating SUD Across BHSA
Proposed by: California Health and Human Services Agency (CalHHS)

This concept addresses the lack of full integration of Substance Use Disorder (SUD) into BHSA initiatives, despite SUD—particularly alcohol use—being a leading factor in suicide and self-harm. The proposal uses the Innovation Partnership Fund to embed SUD into all major BHSA components, including stakeholder engagement, CDEPs, EBPs, workforce training, housing, and prevention. It emphasizes integrated treatment for co-occurring disorders and tailored strategies for justice-involved populations. This would transform the system by breaking down silos between mental health and SUD services, creating a more responsive, coordinated, and equitable system. The urgency stems from rising suicide and overdose rates, particularly among high-need populations currently underserved.

Peer Provided Services

Concept: Youth Peer-to-Peer Mental Health Support
Proposed by: California School-Based Health Alliance

This concept addresses the need for complementary approaches to traditional school behavioral health programs. The problem it recognizes is that as youth move through adolescence, they increasingly turn to peers for support, advice, and discussions about difficult experiences. The proposal suggests implementing peer-to-peer mental health programs that equip youth with accurate behavioral health information, communication skills to support one another, and connections to mental health resources and trusted adults. This would transform the system by promoting prevention and early intervention, building best practices in school-based mental health, and strengthening the future behavioral health workforce by introducing

students to this career path early. The urgency is clear given the youth mental health crisis and the opportunity to leverage peer influence as a positive force for mental health promotion and suicide prevention.

Concept: Pacific Islander Mental Health Workforce Development (Concept also listed as Access to Services, Community Defined Evidence-Based Practices, Early Intervention, and Workforce Development and Retention)
Proposed by: City and County of San Francisco BHSA

This concept addresses the lack of culturally responsive mental health services for Pacific Islander communities. The problem it tackles is that these communities are often marginalized and unserved when placed under the broader umbrella of API (Asian and Pacific Islander) services. The proposal outlines a $600,000 annual investment over five years to develop both clinical and peer staff within the Pacific Islander community. Strategies include outreach to college students facing financial pressures and creating community-based teams of clinicians and peers specializing in culturally relevant, innovative clinical interventions. This would transform the system by strengthening early intervention services specifically tailored to Pacific Islander communities and addressing gaps such as translation and support accessing community resources. The urgency stems from the persistent disparities in mental health outcomes and access for Pacific Islander communities who have distinct needs from other Asian American groups.

Concept: Expansion of Peer Roles in the System of Care
Proposed by: Ventura County

This concept, though limited in detail, addresses the constraints of the current peer support system, which has only two billing codes, limiting how peers can be utilized. The problem it identifies is that peers could be providing additional key roles across the system of care but are restricted by current structures. The proposal suggests exploring how peers could be used more broadly to improve clients' connection to care. This would transform the system by moving beyond just "catch phrases" in legislation to offer specific and clear steps for implementation of peer support services. The urgency stems from the underutilization of a valuable workforce component that could help address workforce shortages while improving client engagement and outcomes.

Concept: Peer Support in Housing Programs
Proposed by: San Bernardino County Department of Behavioral Health, Peer Supports program

This concept addresses the challenge of engaging unhoused consumers who are not currently accessing available shelter beds. The problem it tackles is the need for better engagement strategies and sustained support for individuals entering and remaining housed after living unsheltered. The proposal involves staffing shelter-bed housing providers with house managers who have lived experience, providing technical assistance and training such as peer

certification, crisis intervention training, LEAP training, motivational interviewing, and SafeTalk. This would transform the system by modernizing supportive housing opportunities through the incorporation of peer support and recovery-focused training, allowing for more effective and accountable delivery of existing capacity with improved outcomes. The urgency stems from the ongoing homelessness crisis and the underutilization of existing shelter beds due to engagement challenges.

Prevention

Concept: Universal Access to Evidence-Based Parenting Support
Proposed by: Triple P America

This concept addresses the limited accessibility of parenting support programs, particularly for families facing barriers like transportation and scheduling conflicts. The proposal outlines a statewide initiative offering Selected Triple P Seminars, the full suite of Triple P Online (TPOL) programs, and a strategic communications campaign. The seminars would serve as a universal gateway to parenting information and referral path to more intensive online programs, which offer 24/7 access. Fear-Less TPOL, specifically for parents of children with anxiety, would help parents and children get support sooner, reduce waitlists, and reserve more intensive services for those with greatest need. This would transform the system and aligns with BHSA goals by by reaching more families, including underserved communities; equipping parents to promote healthy development from early childhood through adolescence; providing population-level prevention; and including robust evaluation methods to support accountability goals. The urgency is clear as parenting challenges affect families across demographics, and early intervention through parenting support can prevent the development of more serious behavioral health issues.

Concept: Southeast Asian American Community Support
Proposed by: Southeast Asia Resource Action Center (SEARAC)

This concept addresses the need for culturally responsive approaches to mental health for Southeast Asian American communities. The problem it tackles is that Western healthcare systems often lack integration of cultural values and trauma-informed approaches relevant to these communities. The proposal suggests offering grants to maintain traditions (e.g., Cambodian dance schools) while blending with American influences, supporting ethnic entrepreneurship, expanding RFPs to grassroots organizations innovating advocacy methods, and increasing community youth-led initiatives to bridge generational gaps. This would transform the system by acknowledging that innovation in behavioral health isn't just clinical—it's cultural, communal, and systemic. The urgency stems from the persistent trauma and mental health challenges in refugee and immigrant communities that aren't adequately addressed by conventional approaches.

Concept: Early Intervention Program in SUD Prevention
Proposed by: Stanislaus County BHRS

This concept addresses the gap between substance use disorder (SUD) prevention and mental health/SUD treatment by proposing an integrated team that can provide both SUD prevention and mental health/SUD early intervention services. The problem it tackles is that prevention services are often disconnected from early intervention, missing opportunities to identify and support individuals before they require more intensive treatment. The proposal would create a team to ensure they reach all individuals to either prevent the need for SUD or mental health treatment or reduce the chances of escalation into treatment or harm. This would transform the system by integrating mental health and SUD services and increasing early intervention services to both adults and children in the underserved SUD population. The urgency stems from the need to address behavioral health issues before they escalate to require more intensive and costly interventions.

Concept: Health Literacy Public Service Message Campaigns
Proposed by: Civilian

Civilian has created and launched two successful campaigns utilizing CYBHI funds—"Live Beyond," in partnership with the Office of the Surgeon General, and "Never a Bother," with the Department of Public Health. The Never a Bother campaign used traditional advertising, social media content, and community outreach strategies to reach young people across California up to age 25. Live Beyond is a campaign focused on raising awareness and understanding Adverse Childhood Experiences (ACEs), toxic stress, and their potential negative impacts. The system transformation potential lies in the scalability and adaptability to meet local needs. These campaigns reflect an emerging model that meets people where they are—through stories, trusted voices, and cultural spaces—and guides them toward healing without requiring formal system entry.

Technology

Concept: SmartCare EHR Dashboards Development
Proposed by: Lake County Behavioral Health Services

This concept addresses the need for better data visualization, analysis capabilities, and tracking for behavioral health agencies using the SmartCare Electronic Health Record system. The problem it tackles is the difficulty in extracting actionable insights from EHR data to inform treatment services, quality/compliance, and fiscal operations. The proposal involves working with CalMHSA on developing a suite of county-facing Power BI dashboards, with an initial focus on client demographic and service data, followed by dashboards for optimizing EHR data capture and tracking selected initiatives (e.g., CARE Act). This would transform the system by providing local insights into treatment populations and service mix, with quarterly reviews with county leadership. The urgency is connected to the implementation of newer components of Behavioral Health Transformation, which require robust data tracking and analysis capabilities.

Treatment

Concept: Consumer Councils for Service Design and Improvement
Proposed by: Third Sector Capital Partners

This concept addresses the limited influence behavioral health consumers have in service design and improvement despite having the most at stake. The problem it highlights is that while consumers are asked to complete outcome surveys, they're rarely consulted on the questions, data collection methods, or how results are used—undermining accuracy, relevance, and engagement. The proposal suggests creating Consumer Councils made up of current service users who would advise on service delivery, outcomes, data collection, and continuous improvement. They would define recovery and wellness in their own words, identify overlooked areas, ensure data tools use consumer-centered language, participate in Quality Improvement meetings, guide culturally competent evaluation, and receive support to advocate at regional and state levels. This would transform the system by placing consumers at the center of outcomes definition, evaluation, and continuous improvement—areas essential to meaningful, authentic, and equitable change by ensuring transformation is grounded in the lived realities of those being served. The urgency is clear as outcomes valued by consumers (like "being of service to others") are often untracked and unsupported in current service design, leading to misaligned priorities and missed opportunities for more effective services.

Concept: Models for Transitions Through Acute Substance Use Treatment
Proposed by: Kern County Behavioral Health

This concept addresses treatment gaps in coordinating care for individuals transitioning through acute substance use treatment. The problem it tackles is that individuals treated for substance use often have acute care needs that aren't adequately addressed in current treatment models. The proposal suggests developing coordination mechanisms with Managed Care for respite and aftercare/medical services, inpatient detox providers, and acute substance use aftercare provision. This would transform the system by focusing on the integration of substance use disorder treatment with other healthcare needs, recognizing the importance of the whole person and continuity of care. It would leverage covered Medi-Cal services from both managed care plans and county behavioral health to improve the client experience. The urgency stems from the current treatment gap and the need to integrate evidence-based practices to support individuals with substance use and co-occurring disorders through acute care to community reintegration.

Workforce Development and Retention

Concept: Community-Based Behavioral Health Education Training Program
Proposed by: Department of Healthcare Access and Information (HCAI)

This concept addresses the gap between behavioral health professional training and the actual needs of individuals living with serious mental illness. The problem is that most training programs focus narrowly on diagnosis and mild to moderate symptom management, leaving professionals underprepared to address the full scope of consumer needs for recovery. The proposal outlines an innovative training initiative to equip behavioral health professionals with education, skills, and tools needed to provide comprehensive, person-centered care to those with serious mental illness. The program would be rooted in trauma-informed care with specific attention to incarceration impacts and dual-diagnosis treatment competency. This would transform the system by shifting focus from clinical to community-based care, expanding and diversifying the workforce, promoting equity in access and outcomes for marginalized populations, and aligning with transformation goals that treat behavioral health as part of holistic, integrated care. The urgency stems from the growing crisis that frontline behavioral health professionals face while supporting individuals with serious mental illness in complex, under-resourced systems.

Concept: SB 923 Implementation: Trans-Inclusive Care Training (*Also listed as Training/ Affirming Care*)
Proposed by: Fresno County Department of Behavioral Health

This concept addresses the unfunded mandate in SB 923 requiring all direct services personnel in the public system to receive evidence-based trans-inclusive care training. The problem it highlights is the logistical and financial challenge of providing on-demand training for thousands of staff within 45 days of hiring and every other year thereafter, covering specific topics and delivered by population-serving organizations. The proposal suggests that the Office of Behavioral Health (OBH) contract with organizations experienced in serving transgender, gender-diverse, and intersex populations to develop trainings that can be delivered virtually, interactively, and on-demand, with fidelity development. This would transform the system by improving compliance with new state requirements, enhancing access and engagement for underserved populations, and creating a more responsive and equitable system of care. The urgency is clear as this is a legal requirement that must be implemented, despite lacking dedicated funding, to address disparities and improve quality of care.

Concept: Aging and HIV Institute Workforce Training
Proposed by: Aging and HIV Institute (A&H)

This concept addresses severe gaps in workforce readiness to serve older adults living with HIV, as identified by A&H, the 2024 HealthHIV national survey, and California's LGBTQIA+ Older Adults Survey. The problem it tackles is that behavioral health providers often lack the

specialized knowledge needed to provide appropriate care to this population, who face unique challenges at the intersection of aging, HIV, and mental health. The proposal supports Proposition 1 implementation and the 2026-2030 Workforce Education and Training (WET) Five-Year Plan by outlining a statewide, peer-informed workforce training and technical assistance initiative that would cross-train behavioral health, aging, and HIV service providers in trauma-informed and HIV-literate care; scale peer-led navigation models tailored to long-term survivors; embed aging and HIV equity content into public training systems; and support trauma-informed housing models. This would transform the system by improving equity, expanding access, and integrating behavioral health services for a population with significant social needs. The urgency is highlighted by the recognition of older adults with HIV under the HIV & Aging Act, who remain excluded from most workforce, housing, and crisis planning efforts despite their growing numbers and complex needs.

Concept: Street Medicine Training for Behavioral Health Integration
Proposed by: University of Southern California (USC) Street Medicine

This concept addresses the need for more accessible, integrated, and patient-led behavioral health services for people experiencing unsheltered homelessness. The problem it highlights is that street medicine teams, which operate within a trauma-informed framework by meeting patients in their environment, often have limited capacity to manage mental health and substance use disorders due to prescribers' lack of comfort with management strategies. The proposal suggests implementing training programs that would enable street medicine teams to play a larger role in treating existing conditions and shift from crisis response to prevention and early intervention. This would transform the system by creating an expectation of care for street medicine teams and their patients that includes behavioral health components, ultimately providing more comprehensive services to a highly vulnerable population. The urgency stems from the ongoing homelessness crisis and the critical need for behavioral health services among unsheltered individuals, who often face significant barriers to traditional care settings.

Concept: Peer Career Advancement Pathway
Proposed by: Third Sector Capital Partners

This concept addresses the limited career advancement opportunities for peer support specialists in behavioral health departments and providers. The problem it highlights is that while many peers desire advancement and have potential for supervisory roles, few organizations have peer-specific supervisor or manager positions, and some peers don't have interest in or ability to obtain the academic credentials typically required for organizational leadership roles. The proposal suggests creating a statewide classification system for peer positions, ranging from Peer Support Specialist I to Peer Support Senior Manager and even Peer Support Director. This would transform the system by finally putting the idea of valuing lived experience on par with institutional education, placing peers in leadership positions, and centering peer-based culture that uplifts client voice and choice. The urgency is supported by research from Colorado Behavioral Health initiatives showing that peers thrive when paired

with other peers and nested within a larger peer system, rather than working in isolation.

Concept: AI for Workforce Innovation
Proposed by: California Health and Human Services Agency (CalHHS)

This concept addresses inefficiencies and burnout in the behavioral health workforce that threaten BHSA implementation. The proposal calls for using AI to streamline administrative tasks, support training, and enhance quality improvement across the system. By increasing efficiency and job satisfaction, AI would help attract and retain a strong workforce while accelerating the adoption of new practices. This would transform the system by modernizing service delivery and aligning workforce capacity with BHSA goals. The urgency lies in the current workforce crisis, which could stall transformation efforts without immediate intervention.

Concept: Workforce
Proposed by: Commissioner Bernick

Other/Cross-Cutting Concepts

Concept: AAPI Grassroots and Media Outreach
Proposed by: ChimeTV powered by GoldenTV, AMerge Media; OCA Sacramento Chapter; Filipino Community Sacramento Vicinity

This concept aims to amplify Asian American and Pacific Islander (AAPI) voices through media campaigns, storytelling, and community partnerships. The problem it addresses is the lack of visibility and culturally relevant resources for AAPI communities in the behavioral health system. The proposal focuses on fostering inclusivity, raising awareness, and driving impactful change through storytelling, digital media, advocacy, and partnerships. This would transform the system by using both linear and digital media to increase access to culturally relevant resources, reduce stigma, and promote inclusivity. It would bridge generational and technological gaps, empowering the AAPI community with accessible mental health solutions. The urgency is related to mental health challenges in AAPI communities that require culturally appropriate outreach and intervention.

Concept: BHSA Implementation Training & Technical Assistance
Proposed by: County Behavioral Health Directors Association (CBHDA)

This concept addresses the significant technical and operational challenges counties face in transitioning from Mental Health Services Act (MHSA) to Behavioral Health Services Act (BHSA) funding priorities. The problem it tackles is that counties need support to adapt their budgeting, fiscal, and programmatic practices to new requirements. The proposal involves working with CBHDA, CalMHSA, and consultants to provide technical assistance and training, including standardizing materials and messaging, developing "BHSA Bootcamps" that where county staff

will learn about how to retool existing fiscal practices to adapt to the new Integrated Plan and Behavioral Health Outcomes and Accountability Transparency and Reporting requirements, supporting commercial insurance billing capacity development, and helping small MHSA-funded contractors build Medi-Cal billing capability. This would transform the system by enabling counties to successfully implement the new funding and reporting structures required by BHSA. The urgency is immediate as counties must begin adapting their systems now to meet new requirements.

Concept: Cross-cutting Outcomes for Encampments
Proposed by: Healthy Brains Global Initiative

This concept addresses the challenge of effectively engaging with homeless encampments to achieve meaningful outcomes. The problem it tackles is that current approaches often lack accountability and clear connections between funding and results. The proposal suggests a two-phase approach: first, service providers would engage with encampment communities on a budget-reimbursement basis to establish trust and agree on desired outcomes; second, contracts would shift to outcomes-based payments, with providers paid for achieving previously defined outcomes for each individual. This would transform the system by maximizing accountability and making the connection between funds and results more direct and visible. The urgency is clear as this approach would significantly reduce negative hospitalization and incarceration outcomes and require the integration of SUD and mental health services—key goals of behavioral health transformation.

Concept: 'Through the Gate' Support for Jail Leavers
Proposed by: Healthy Brains Global Initiative

This concept addresses the lack of coordinated support for individuals transitioning from jail back to the community. The problem it tackles is that without proper support upon release, many individuals cycle back into incarceration, often due to unaddressed behavioral health needs. The proposal suggests contracting with service providers to engage with people up to three months before release, meet them on release day, and support them in securing both temporary and long-term accommodation as well as employment. Providers would be paid based on achieving these outcomes. This would transform the system by creating a transparent, accountable approach with outcomes-based payments that would make behavioral health dollars go further, reduce waste, and significantly reduce reoffending rates. The urgency stems from the high rates of recidivism among individuals with behavioral health needs and the opportunity to break this cycle through targeted support during the critical transition period.

Concept: Outcomes Funding for Behavioral Health Innovation
Proposed by: Social Finance

This concept addresses the need for greater accountability and transparency in behavioral health funding. The problem it tackles is that current funding models don't always create clear links between resources and outcomes. The proposal suggests creating a Commission-led

Behavioral Health Outcomes Fund that would directly link a portion of payment to priority social and health outcomes. Counties would apply to deliver innovative solutions with specific outcome goals (e.g., reducing opioid overdoses by 10% over 2 years), with careful evaluation plans and embedded measurement to assess progress. This approach builds on the Commission's existing interest in outcomes funding for FSPs and mirrors the innovative work under the Board of State and Community Correction's Pay for Success grant program (2016-2021), and other local and federal models. It would transform the system by embedding accountability and transparency into every funded approach while promoting effective local collaboration and innovation. The urgency is connected to the core goal of Behavioral Health Transformation to improve accountability, and this approach would allow local counties to propose creative solutions that address the Commission's vision while maintaining a focus on measurable results.

Concept: Working with All Constituents (Being Inclusive)
Proposed by: Mental Health Connections

This concept was submitted with minimal detail, simply stating "Working with all constituents" and "Being inclusive" as the concept and how it supports behavioral health transformation, respectively. More information and detail is necessary to assess the specific problem, proposal, system change connection, or urgency of this concept.

Concept: BH Institute for Sustainable Financing
Proposed by: Commissioner Carnevale

This concept calls for the establishment of an innovation fund to link and leverage public and private investments to accelerate scale up of key initiatives and priorities, such as early psychosis/Coordinated Specialty Care, to bridge access and quality gaps in the service continuum. The approach recognizes that health conditions and risk factors for behavioral health challenges often overlap and co-occur, and thus are intrinsically linked to social determinants of health. As such, population-based prevention, early intervention, and treatment of behavioral health diagnoses must focus on policy and systems change that cut across sectors (e.g. housing, education, community economic development). Thus, an Institute for Sustainable Financing would not focus solely on expanding behavioral health services and supports, but aim to seed and support multi-sector collective impact efforts.

Concept: Strategic Fiscal Sustainability Planning
Proposed by: The Fresno County Department of Behavioral Health

This concept addresses the need for long-term fiscal planning to sustain behavioral health transformation efforts. The problem it tackles is that without strategic financial planning, the goals of transformation may be achieved initially but could falter in the face of future fiscal challenges. The proposal suggests developing a learning collaborative, organized by regions or county size, supported by organizations like CBH, CBHDA, and CalMHSA. This collaborative would identify fiscal challenges in the next 5-8 years and develop viable strategies with

policymakers to mitigate these challenges. This would transform the system by creating models based on regions or size, improving efficiencies, driving true integration, and drawing from effective approaches in other sectors. The urgency is linked to the need for behavioral health transformation to be an ongoing journey rather than a destination, requiring sustainable financial strategies that extend beyond one-time efforts.

Concept: Strategic Plan to Reduce Disparities
Proposed by: California Health and Human Services Agency

This concept addresses the behavioral health system's lack of readiness to serve California's diverse populations, especially within managed care. The proposal recommends a 10-year strategic plan to achieve measurable equity goals, including investments in workforce training, system redesign, and policy change—with Medi-Cal at the center. This would transform the system by embedding equity into all aspects of BHSA, ensuring culturally responsive, accessible care. The urgency stems from long-standing disparities and a critical window of opportunity to influence managed care reform for structural change.

Concept: Housing
Proposed by: Commissioner Contreras

One of the largest changes in the BHSA is the new county spending requirement for housing, which will be a significant challenge for local communities. The Department of Health Care Services has recognized the need for Housing Flex Pools—funding mechanisms that combine multiple funding sources to provide flexible, person-centered housing solutions for individuals facing homelessness or behavioral health challenges. The potential for innovation and system-wide change with Housing Flex Pools is significant, as they can drive resource efficiency, improve housing access, and enhance long-term outcomes. The Commission could explore a public-private partnership in this space to better address the root causes of homelessness and support long-term recovery. The potential for system transformation is that this solution addresses the difficulty in financing construction costs for new housing unit.


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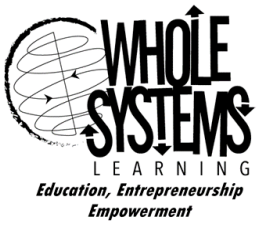
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Racial and Ethnic Mental Health Disparities Coalition

May 15, 2025

Chair Mayra Alvarez
Commission for Behavioral Health
1812 9th Street
Sacramento, CA 95811

Re: Recommendations for Principles to Ensure Equitable Commission Decision-Making in the Innovation Partnership Fund

Dear Chair Alvarez,

On behalf of the undersigned organizations, we are writing to urge the Commission to adopt a set of foundational principles to guide the development and implementation of the Innovation Partnership Fund under the Behavioral Health Services Act. We appreciate the Commission's efforts thus far to engage stakeholders in shaping the Fund and its goals, and we see this as an important opportunity to ensure that innovation in behavioral health meaningfully serves the public good, especially communities most impacted by systemic inequities.

The transition from the Mental Health Services Act to the Behavioral Health Services Act (SB 326) represents a significant shift in how Innovation funding is administered and allocated. With the elimination of the county-administered 5% Innovation allocation and the creation of a centralized Innovation Partnership Fund, the Commission now holds sole responsibility for determining how these public dollars will be distributed.

While this centralized structure may create opportunities to fund scalable systems change, it also introduces new risks, especially around equity, access, and accountability. We are especially concerned about the inclusion of for-profit and venture-backed entities as eligible applications, which could potentially marginalize grassroots, community-based organizations in the absence of clear principles and public guardrails.

To help move this opportunity in the direction of equity and transparency, we offer the following principles for the Commission's consideration. These principles are consistent with the intent of SB 326, which directs the Commission to prioritize community-defined evidence practices, public consultation, and reducing disparities. The undersigned organizations recommend the following framework of principles to operationalize that intent:

Principles for the Innovation Partnership Fund

1. ***Prioritize funding for public agencies, nonprofit entities, and tribal organizations***
   The Innovation Partnership Fund should prioritize funding for public agencies, nonprofit entities, and tribal organizations, especially those serving and led by historically marginalized communities. For-profit applicants should only be considered if public

agencies', nonprofit entities', or tribal organizations' capacity is unavailable, or as subcontractors under these entities.
We urge the Commission to exercise caution in funding venture capital-style models of innovation, which may prioritize proprietary ownership and private return on investment, often at odds with long-term goals of community wellness and public accountability.
If partnerships with for-profit entities are considered, they must be accompanied by enforceable transparency provisions, community governance, and guarantees that all innovation funded with public dollars will deliver clear, measurable public benefit.
Intellectual property, data, and tools developed with public funding must remain accessible to communities without private licensing costs.

2. ***Guarantee meaningful support for community-defined evidence practices***
SB 326 requires that the Fund support programs designed to improve BHSA services for underserved, low-income, and disparity-impacted populations. These are the groups that CDEPs have been developed for and shown to be effective. To ensure the Fund fulfills its mandate, we recommend either establishing a minimum allocation for community-defined evidence practices (30%) or incorporating a strong scoring preference to ensure these proposals are prioritized during review. This would help ensure the Fund reaches the communities where those practices are developed and most needed. Moreover, CDEPs were among the most frequently cited priorities in the Commission's own online survey, with multiple respondents emphasizing their importance. This further reinforces the need to prioritize CDEPs within the Fund. We urge the Commission to take this stakeholder input seriously, particularly as it reflects the perspectives of community-based organizations and representatives who are closest to, and most trusted by, the underserved populations the Fund is intended to reach.

3. ***Prioritize BIPOC and LGBTQ+ populations***
The target populations for the Innovation Partnership Fund, as outlined in W&I Code Section 5845.1(c)(2)(A), include underserved populations, low-income populations, communities impacted by other behavioral health disparities, and other populations as determined by the Commission. Projects specifically targeting Black, Indigenous, and people of color (BIPOC), LGBTQ+ individuals, and immigrant, refugee, and non-English speaking communities should be prioritized. This prioritization is especially urgent in response to recent federal actions that disproportionately and adversely affect these communities. The state must act to protect and uplift these communities through meaningful investment and equity-driven innovation.

4. ***Design a participatory and transparent process***
Impacted communities must be empowered as co-creators of the Fund's design and strategy, not only consulted through surveys. SB 326 outlines the Commission's obligation to engage the public in shaping this Fund. The engagement must involve co-design with affected community leaders and CBOs to define funding criteria, evaluate proposals, and monitoring outcomes. In addition, the Fund must be governed by a transparent process. All funding decisions should be accompanied by publicly accessible

documentation, including scoring criteria and rubrics, reviewer notes, and rationale for award decisions. Transparency is essential to build public trust and ensure accountability to the communities the Fund intends to serve.

5. ***Define innovation through an equity and systems change lens***
   Innovation must be defined broadly to include community-defined, non-clinical approaches, not only medical models. These definitions should reflect the lived experiences and healing practices of BIPOC, immigrant, queer and trans, disabled, and low-income communities. Additionally, the Commission should define "systems change" in terms that center equity, sustainability, and long-term community impact, not just scalability and speed. Systems change should involve the transformation of power relationships, funding flows, and culturally responsive infrastructure. Innovation must not simply add new programs, but shift how behavioral health systems operate in relation to the communities they serve.

6. ***Ensure equitable and proactive outreach***
   To ensure that the Innovation Partnership Fund is truly inclusive, the Commission must engage in proactive, equitable outreach when releasing future opportunities, whether surveys, concept calls, or formal funding solicitations. Outreach should include culturally and linguistically appropriate dissemination strategies across statewide channels and community platforms. Information should be accessible, timely, and disseminated widely so that every eligible organization has an equitable chance to engage.

7. ***Protect against conflicts of interest***
   Any Commissioner or staff involved in the Innovation Partnership Fund decisions must disclose potential or perceived conflicts of interest including financial interests and fully recuse themselves from all deliberations and decisions involving related applicants. These disclosures and recusals must be formally documented and accessible to the public. Ethical integrity is a baseline expectation when managing public funds.

We offer these principles as an invitation to lead with integrity, transparency, and equity. With the right guardrails in place, the Innovation Partnership Fund can be a powerful tool for healing and transformation. Without them, it risks replacing the inequities it was created to address. We urge the Commission to formally adopt these principles before the development of scoring criteria/rubrics or award decisions. We welcome the opportunity to work with the Commission to co-create a Fund that reflects the diversity of California's communities.

Thank you for your leadership and commitment to inclusive and equitable innovation.

Sincerely,

Ruqayya Ahmad
California Pan-Ethnic Health Network

Stacie Hiramoto
Racial & Ethnic Mental Health Disparities Coalition

Dr. Corrine McIntosh Sako, PsyD, LMFT
Individual

Angela Tang
RAMS, Inc.

Natalie T. Ah Soon
Regional Pacific Islander Taskforce

Dr. Patsy Tito
Samoan Community Development Center

Leafa T. Taumoepeau
TAULAMA

Dr. Dani Soto, Deputy Director
Openhouse

Roland S. Moore, PhD
PIRE Native American TA Provider

Claudette Carroll
The Village Project, Inc.

Ramon Bieri
Individual

Eba Laye
Whole Systems Learning

John Alita
San Joaquin Pride Center

Paul Masotti, PhD, MS.HSA, BA, BPHE
Individual

Mandy Diec
Southeast Asia Resource Action Center

Sonya Young Aadam
California Black Women's Health Project

Seng S. Yang
Hmong Cultural Center of Butte County

Solicia Aguilar
LGBTQ Connection

Alex Filippellli
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Fareshta Quedees
Individual

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Be Smooth, Inc.

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Level Up NorCal

Pysay Phinith
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Mar Velez
Latino Coalition for a Healthy California

Sery Tatpaporn
A.B.L.E Community Development Foundation

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Myron Dean Quon, Esq.
Pacific Asian Counseling Services

Cc:
Commissioner Al Rowlett
Commissioner Pamela Baer
Commissioner Michael Bernick
Commissioner Mark Bontrager
Commissioner Sheriff Bill Brown
Commissioner Keyondria Bunch
Commissioner Robert Callan, Jr.
Commissioner Steve Carnavale
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Commissioner Karen Larsen
Commissioner Mara Madrigal-Weiss
Commissioner Glady Mitchell
Commissioner James Robinson
Commissioner Marvin Southard
Commissioner Jay'riah Thomas-Beckett
Commissioner Gary Tsai
Commissioner Jevon Wilkes

AGENDA ITEM 10

Action

May 22, 2025 Commission Meeting

Impacts of Firearm Violence Project Report

Summary:
The Behavioral Health Services Oversight and Accountability Commission will hear a presentation and consider adoption of the Impacts of Firearm Violence (IFV) Project Report. This report describes the process and learnings from the IFV project and puts forth three main findings and recommendations to drive progress in California's strategy for firearm violence prevention.

Background:
In California, more than 3,200 people die from firearm violence each year, and thousands more are wounded. Firearm injuries are now the leading cause of death for children and youth, particularly for youth of color. Firearm suicide rates have increased in recent years across demographic groups. The incidence of mass violence with a firearm has also spiked since 2020.

In addition to direct exposure, firearm violence harms millions more Californians indirectly. Like an earthquake, incidents of violence cause immense damage to those at the center, but they also cause ripple effects (including physical, mental, and behavioral health challenges) on survivors, their family and loved ones, those who respond to incidents of violence (including law enforcement, first responders, and physical and behavioral health providers), and the broader community.

Mental illness is often cited in the context of violence, particularly as a facilitator of mass shootings. However, the reality is that while firearm violence and behavioral health are intimately linked, the relationship is complicated. The Commission's IFV project was established to explore this relationship and answer two main questions: 1) What is the relationship between firearm violence and behavioral health? And, 2) given the relationship, what is the role of behavioral health systems in reducing the incidence of firearm violence and its associated harms?

Project:
The IFV subcommittee was formed by the Commission in August 2022, to lead a community-informed research initiative to explore the intersection of firearm violence and behavioral health, identify and collaborate with key firearm violence prevention and recovery partners, and develop an action agenda with recommendations to address the impacts of firearm violence. Through an intensive, iterative process of literature review, consultation with experts,

collaboration with key partners, and engagement with impacted communities, the Commission has learned several key lessons:

Finding 1: Firearm violence is a persistent threat to behavioral health, but California is not treating it that way.
Firearm violence has severe negative impacts on physical, behavioral, and social health and wellbeing. Although these harms are well-known, California has not identified and monitored firearm violence as a key indicator and outcome of its behavioral health initiatives.

Finding 2: California faces challenges for effective firearm violence prevention stemming from misconceptions, cultural tensions, and fear.
There are opportunities to prevent and mitigate the negative impacts of firearm violence. One key strength is California's robust public health system, which can be leveraged to improve awareness about the risks of firearm access and understanding of the context of firearm violence. Another key strength is the lived experience and potential of California's diverse communities who are impacted by firearm violence, including the firearm-owning community.

Finding 3: California's public investments have not been coordinated effectively to address the underlying causes of violence and other public health concerns.
The conditions that put a person at risk of behavioral health challenges are often the very same factors that increase their risk for involvement in firearm violence. These conditions are also highly preventable through public health strategies.

These three key areas represent a transformative opportunity for the State to take a leadership role in addressing firearm violence from an integrated public health approach. The Commission has identified three corresponding recommendations for action:

Recommendation 1: California must establish trauma-informed violence prevention as a public behavioral health priority.

Recommendation 2: California must deploy a public engagement initiative to regain trust and build relationships with firearm-owning communities and communities impacted by violence.

Recommendation 3: California must develop a unified statewide strategy, with an appointed leader to guide a public health approach to firearm violence prevention that integrates data, resources, and partners from across sectors.

Presenter(s): Courtney Ackerman, Senior Researcher, BHSOAC

Enclosures (2): (1) *Stopping the Hurt: Preventing the Harms of Firearm Violence via Public Behavioral Health (The Impacts of Firearm Violence Project Report)*, (2) Transmittal letter for the Impacts of Firearm Violence Project Report

Handouts: PowerPoint presentation

Proposed Motion: That the Commission adopt the Impacts of Firearm Violence Project Report.

Stopping the Hurt: Preventing the Harms of Firearm Violence via Public Behavioral Health

The Impacts of Firearm Violence Project Report

BEHAVIORAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
1812 9th Street, Sacramento, CA 95811 | (916) 500-0577 | bhsoac@bhsoac.ca.gov | bhsoac.ca.gov

Commission for Behavioral Health

About the Commission

The Behavioral Health Services Oversight and Accountability Commission, known as the Commission for Behavioral Health (CBH) and formerly the Mental Health Services Oversight and Accountability Commission, was initially established to oversee implementation of the Mental Health Services Act of 2004 and to drive innovation and accountability in California's behavioral health system.

The CBH champions wellbeing for all Californians through behavioral health prevention and intervention, including mental health and substance use disorders. By working with community partners, individuals with lived experience, family members, State agencies, and the Legislature we help to increase public understanding, catalyze best practices, and inspire innovation. Our goal: accelerating transformational change.

Commissioners

Mayra E Alvarez
Commission Chair
President, *The Children's Partnership*

Al Rowlett
Commission Vice Chair
Chief Executive Officer, *Turning Point Community Programs*

Pamela Baer
Lifetime Director, *San Francisco General Hospital Foundation*

Michael Bernick
Counsel, *Duane Morris LLP*

Mark Bontrager
Behavioral Health Administrator, *Partnership HealthPlan of California*

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Jay'Riah Thomas-Beckett
Executive Principal

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Councilmember, *California's Child Welfare Council*

Impacts of Firearm Violence Subcommittee

Subcommittee Chair Keyondria Bunch, Ph.D.
Supervising Psychologist, *Los Angeles County Department of Mental Health*

Subcommittee Vice Chair Bill Brown
Sheriff, *Santa Barbara County*

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Special thanks to: Itai Danovitch, M.D., Former Commissioner; Ashley Mills, Former Staff Support

Contents

Executive Summary

With the recent news that firearms are the leading cause of death for children in the United States[1] paired with significant increases in firearm ownership,[2] there is a clear need for a better understanding of the complicated relationship between mental health and firearm violence. It is also an opportune time for rethinking the violence prevention approach in general, in a country and a world that is still grappling with mental health, substance use, and other concerns exacerbated by the COVID-19 pandemic.[3]

Against this backdrop of tension, uncertainty, and fear, the State of California's Behavioral Health Services Oversight and Accountability Commission embarked on an exploration of the relationship between firearm violence and mental health. The Commission's aim was to inform a new, evidence-based strategy to address these distinct but overlapping problems, and to identify gaps in understanding as well as areas of great opportunity for advancing the intersecting goals of violence prevention and mental health promotion simultaneously.

With the passage of Proposition 1 in March 2024, California is making a renewed commitment to mental and behavioral health, acknowledging the myriad factors that influence our wellbeing. California has been making great strides in understanding the integrated nature of our physical, mental, and behavioral health and investing in policies and programs that contribute to better overall health, but there is much more work to do – particularly on the impacts of firearm violence on Californians.

Under the Biden administration, the White House unveiled a new effort to address firearm violence through the federal Office of Gun Violence Prevention, with a call for collaboration across all levels of government to focus on evidence-based practices for preventing violence and its related negative outcomes.[4] Dr. Vivek Murthy, President Biden's surgeon general, released a public advisory on firearm violence in 2024, calling it a public health problem that should be addressed as such.[5] It remains to be seen how firearm violence will be addressed under the Trump administration, although the recent removal of this public advisory from the Surgeon General website indicates that it will be treated with a different approach, if any. Regardless of the federal government's approach, there is momentum; several states have implemented targeted violence prevention plans in the last few years, indicating that it is recognized as a priority at the state and

local levels.[6] With renewed interest in addressing firearm violence, it is an opportune time to tackle firearm violence with renewed energy.

Firearm violence leaves trauma, pain, and suffering in its wake, but it's not inevitable. Firearm violence *is* preventable, as are its associated negative outcomes. To address the complex and sensitive problem of firearm violence from a mental and behavioral health-informed perspective, California must develop a comprehensive and integrated public health strategy for firearm violence prevention statewide.

The strategy must be **integrated**, in that it is built in and implemented across systems. It must weave together the services and supports that are impactful for violence prevention, including housing supports, employment services and job training, food and nutrition, health care services, access to transportation, mental and behavioral health services, and peer support services. The most promising and impactful strategies are often those that provide wraparound support, addressing multiple needs and gaps in a cohesive way.

The strategy must also be **collaborative**, meaning that it brings together partners from public health, health care services, employment, education, housing, transportation, social services, law enforcement, criminal justice, and mental and behavioral health, among others. Effective violence prevention happens in all domains of life and all branches of government, and it happens throughout the community with public and private partners. Preventing firearm violence is not the job of one department – it is the job of all departments.

Finally, the strategy must be **trauma-informed**, because any solution must fit the problem it means to address for it to be effective. Underneath a significant portion of violence lies trauma, and trauma can be treated – but it requires tools, resources, and care, not punishment and separation from those who can best help people heal.

Fortunately, there are many trauma-informed tools and programs that are promising and feasible to implement. There are also many integrated and collaborative approaches that have been implemented effectively in local pockets in California as well as other states and countries. California must take steps to identify, prioritize, and sustainably adopt, adapt, and scale these approaches to foster peace and promote healing in struggling communities across the state.

To implement this integrated, collaborative, and trauma-informed approach, California can:

1. Establish trauma-informed violence prevention as a public behavioral health priority.

2. Deploy a public engagement and awareness initiative to regain trust and build relationships with firearm-owning communities and other communities impacted by violence.
3. Develop a unified statewide strategy, with an appointed leader to guide a public health approach to firearm violence prevention that integrates data, resources, and partners from across sectors.

Together, we can address firearm violence and its devastating impacts, halting the ripple effects of violence and fostering resilient, healthy communities.

Introduction

On May 24, 2022, Robb Elementary School in Uvalde, Texas experienced a mass shooting event. Twenty-one people – children and adults – lost their lives that day, and countless others experienced life-changing loss, grief, and trauma that followed the event.[7]

On that same day, four people were killed and nine people wounded by firearms in California.[8]

Around the same time, a teenage girl in Kansas was building her confidence and adjusting to life's recent challenges through the marksmanship and firearms safety training from her local 4-H shooting club.

Meanwhile, a firearms range in San Diego county was doing its part to prevent suicides by implementing a firearm storage program for people to use during times of crisis.

The history and cultural tapestry of the U.S. includes firearms – to a far greater degree than many other developed nations.[9,10] Firearms are deeply embedded in American culture and they are used in many ways and for many reasons, most of which do not cause harm.[11] Rather, for many people, using or owning a firearm can have a positive impact by helping them acquire skills, food, safety, and community.[12]

However, they are also sometimes used to cause harm.

These incidences of firearm violence are examples of the broad spectrum of harms that result from firearms being used inappropriately. When the term "firearm violence" is used in this report, it refers to that broad spectrum of outcomes, including death, sustaining gunshot wounds, witnessing firearm violence, and what is being termed the "ripple effects" of firearm violence: the far-reaching physical, mental, and emotional impacts experienced by those who are directly and indirectly exposed, up to and including the broader national and international population.

There are a litany of theories around when, why, and by whom firearms are used to cause harm.[13,14,15] One of the most frequent theories – particularly salient in the politically charged discussions after mass shootings occur – is that mental illness is the cause. [16,17,18,19] The narrative

says a serious mental illness is what drives an individual to commit violence, and therefore diagnosing and treating serious mental illness will solve the problem of firearm violence.

It can be tempting to buy into the popular narrative that mental health challenges are responsible for such types of violence, but it's not that simple. And though it is true that some mass shooters suffer from some type of mental health challenge[20] – evidence suggests that 20 - 30% of mass shootings are committed by someone with psychosis or a serious mental illness[21,22,23] – a copious amount of research demonstrates that mental health is not solely responsible for the vast majority of firearm violence nor is it a particularly significant predictive factor at the individual level among other, far more powerful factors, such as childhood exposure to violence, impulsivity, and substance misuse.[24,25,26,27,28,29,30,31]

There is a danger in overemphasizing the connection between mental health challenges and violence in that it can increase stigma against those with a diagnosis, leading to real and damaging impacts for patients, providers, and the public.[32] It also diverts attention from the factors that are not only more significant in predicting firearm violence, but also more changeable.[33]

Yet, it is undeniable that an intersection does exist between mental health and firearm violence. This intersection can be difficult to quantify and discuss, as it's a topic plagued by stigma, fear, and tension. Beneath this tension lies the key reason why our society has continued to struggle with addressing firearm violence:

There is a fundamental misunderstanding of the drivers of firearm violence, and subsequently a failure to adopt strategies that effectively address it.[34]

And, as long as these misunderstandings persist, there is little reason to expect significant reductions in firearm violence and the ripple effects it leaves in its wake. There are myths and misconceptions around what kinds of firearm violence are most common, where it most often happens, who it impacts, how it impacts them, and more.[35,36] In order to truly implement effective solutions, these myths and misconceptions must be corrected and a cohesive, evidence-based narrative that promotes the reality of firearm violence must be realized.

The Impacts of Firearm Violence Project

In light of this nuanced and not widely understood relationship between mental health and firearm violence, the Behavioral Health Services Oversight and Accountability Commission took action.

The Commission was initially established to oversee implementation of Proposition 63 (the Mental Health Services Act of 2004) and to drive innovation and accountability in California's mental health system. The Commission champions wellbeing for all Californians through behavioral health prevention and intervention, including mental health and substance use disorders. By working with community partners, individuals with lived experience, family members, state agencies, and the Legislature, the Commission aims to increase public understanding, catalyze best practices, and inspire innovation with the overarching goal of accelerating transformational change in the mental and behavioral health landscape in California. This landscape includes service delivery systems, policies, investments, and organizations related to mental and behavioral health, including State and local agencies and community-based organizations.

In August 2022, the Commission established the Impacts of Firearm Violence (IFV) project to define the overlap of mental health and firearm violence, improve understanding of the underpinnings of firearm violence, and identify gaps and opportunities for effective violence prevention, with the collaboration of key public and partners. The project was carried out under the direction of the Impacts of Firearm Violence subcommittee, chaired by Commissioner and psychologist Dr. Keyondria Bunch with Commissioner and Santa Barbara County Sheriff Bill Brown as vice chair.

The goals of the IFV subcommittee were to:

- Explore the impacts of firearm violence on mental health using data and information from State and local programs, systems, and policies.
- Collaborate with firearm violence prevention partners to leverage existing efforts and consider policy recommendations that public health entities and others developed.
- Develop an action agenda with research, policy, and practice recommendations that show promise in addressing the impacts of firearm violence on mental health and wellbeing, while reducing mental health stigma and discrimination.

Like all Commission projects, the IFV project was conducted with meaningful community engagement as a guiding priority. The following methods were used to gather information:

- In-depth literature review
- Interviews with over 100 key informants
- Written testimonials
- Public engagement
    - Group engagement (including site visits, focus groups, listening sessions, town hall-style events, and Commission panels)
    - Conferences and other learning events

For more information on the methodology and project timeline, refer to Appendix 1: IFV Project Timeline and Appendix 2: IFV Project Methodology. The findings from these engagement activities are summarized in the Findings and Recommendations section of this report.

The goal of this report is to identify and lift up opportunities for effective violence prevention and outline the next steps forward for California to effectively capitalize on these opportunities on a systemic level. These next steps may occur in a wide range of domains, including policy changes, enhancements to the behavioral health care and violence prevention workforces, process changes in the way government agencies and private partners work together, and new or updated programming. However, perhaps the most important outcome from this report will be its contribution to a deeper understanding of the nuanced relationship between firearm violence and mental health and instilling confidence in the collective ability of public, private, and community partners to tackle this problem together.

To work toward the goal of a cohesive and evidence-based narrative on firearm violence, this report was written for the benefit of and with input from Californians across a broad spectrum of beliefs, cultures, and demographics, including people who legally own and use firearms. It aims to identify opportunities to address firearm violence that neither threaten the rights nor undermine the responsibilities of those who use firearms safely and sensibly.

Those who responsibly own firearms are key partners in this work, and their engagement is a vital part of the process of reducing firearm violence.

This report will tell the story of firearm violence, starting with death and injury rates within California, the United States, and similar countries before moving on to the more far-reaching ripple effects on the physical, mental, and behavioral health of all Californians. An important part of this story is the shared risk and protective factors that drive both firearm violence and other negative outcomes. It will also identify some of the key challenges in preventing firearm violence and its associated negative outcomes in California, along with outlining some key opportunities for harm prevention and mitigation, healing, and resilience-building.

Background

Key Concepts and Definitions

Mental health is a state of wellbeing in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community.[37]

Mental health challenges are circumstances in which a person's mental health needs negatively impact their daily life or functioning, including conditions characterized by cognitive and emotional disturbances, abnormal behaviors, or any combination of these that cause distress or impair functioning.[38] When mental health challenges are not supported or treated, people and their communities are at greater risk for experiencing negative outcomes.

Negative mental health outcomes are the outcomes of experiencing mental health challenges without comprehensive and appropriate treatment or effective coping strategies. These negative outcomes can include a diagnosable mental illness (a disorder diagnosed based on criteria in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders)[39] and/or other negative outcomes, like school failure, unemployment, engaging in harmful behavior (including violence), and difficulty forming and sustaining meaningful relationships.[40]

Behavioral health is an umbrella term that refers to mental health, suicidal thoughts or suicide attempts, and substance use or substance use disorders.

Behavioral health systems facilitate access to resources and services to promote wellbeing, prevent mental distress, and treat behavioral health conditions.

Violence is "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[41] Violence is often used to refer to intrapersonal and interpersonal violence, but it can also include structural (or systemic) violence. (See next definition.)

Structural (or systemic) violence is violence which is perpetrated through the systems, policies, and practices enacted by those with power that lend advantage to some groups while depriving others of opportunities to meet their basic needs.[42] California's most disadvantaged groups (particularly Black and Hispanic or Latino adolescents and young adults) live in communities that are underinvested, have experienced redlining (a discriminatory practice in which financial services are withheld from otherwise credit-worthy people living in neighborhoods that have significant numbers of racial and ethnic minorities),[43] suffer from mass incarceration, and live with inequities in food security, safety, and health care, all of which are systemic barriers that can inhibit people from getting their basic human needs met.[44]

Firearm violence is violence that involves the use of a firearm (e.g., a gun, pistol, or rifle) to threaten or cause harm to oneself, others, or both. This harm may be in the form of physical injury or death and/or in the form of harming one's mental health.

Intent refers to the motivation behind using a firearm to cause harm:

- ***Homicide/assault***: the use of a firearm with the goal of harming another person.
- ***Suicide/self-harm***: the use of a firearm with the goal of harming oneself.
- ***Unintentional***: the use of a firearm without the goal of harming oneself or others.
- ***Defense***: the use of a firearm with the primary goal of defending oneself or others.

Firearm injuries are injuries caused when a person is shot by a firearm, either by oneself or by others. They can be intentional or unintentional.

Firearm deaths are deaths that occur from the use of a firearm, either inflicted by oneself or by others. They can be intentional or unintentional.

Exposure to firearm violence includes being shot, threatened, or otherwise harmed with a firearm, including hearing gunshots in the neighborhood, knowing someone who has been shot, being a part of a group targeted by a mass violence incident, or even hearing about firearm violence that has affected one's friends, family, neighbors, or broader community.

Mass shooting: This definition is not settled, as the organizations that collect data on mass shootings use slightly different definitions,[45] but in this report it is used to refer to incidents in which a perpetrator(s) injures and/or kills at least four individuals in one episode.

In the last several years, there has been a sharp uptick in harm perpetrated with firearms in the United States.[46] The number of mass shootings has doubled nationwide since 2019,[47] but it's not just mass violence that has increased: domestic violence with a firearm[48] and firearm deaths overall[49] have also spiked in recent years, particularly since the start of the COVID-19 pandemic.[50] The increases in violence have also manifested in California.[51] Firearm violence increased overall in California in 2020 and 2021.[52] Firearm suicides in particular have also increased in recent years, with notable rate increases for some minority and disadvantaged groups, including people who identify as female or Black and young adults (although firearm suicide rates are still highest for men and older adults in general).[53]

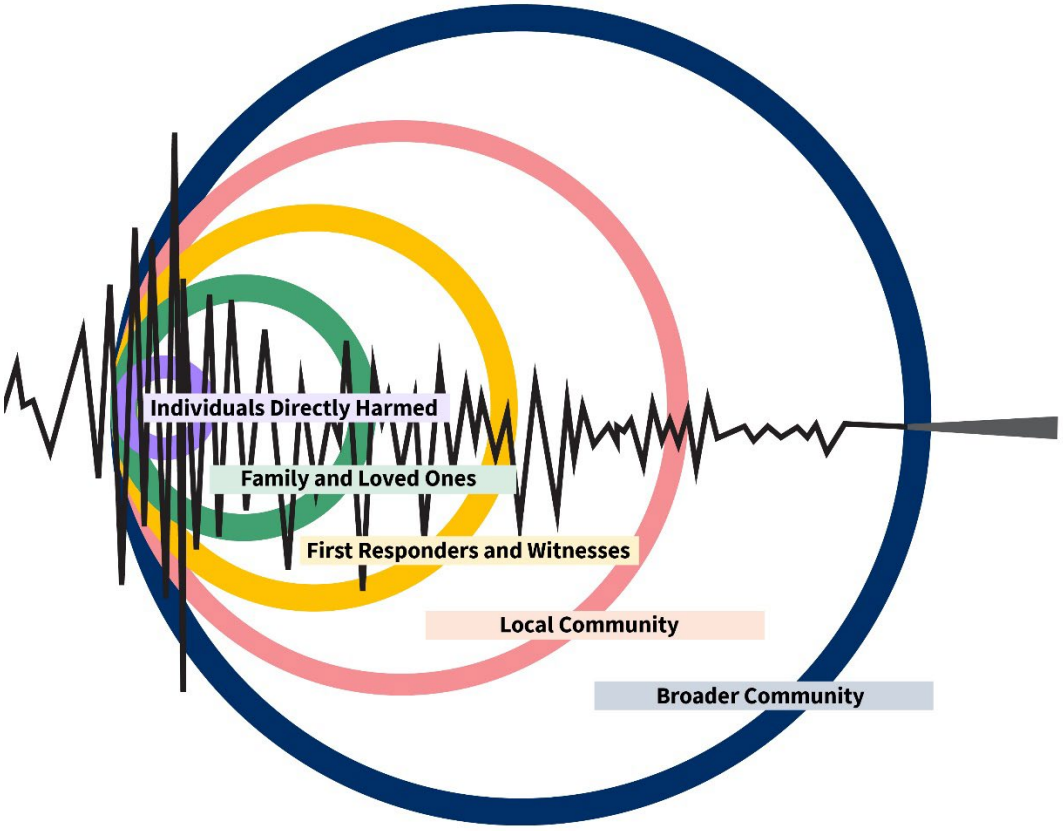
In the midst of the COVID-19 pandemic, firearm ownership in California spiked following periods of general unrest, fear, and racial tension.[54] With more firearms in circulation, there is greater potential for firearms to be used in unsafe ways.[55] During this same timeframe, mental illness and mental health challenges also increased markedly, largely driven by the disruption of the COVID-19 pandemic.[56]

This confluence of factors means the time is ripe for reconsidering the dominant narrative and approach on firearm violence and its intersection with mental health.

The Ripple Effect: Firearm Violence in California

While the damage caused by firearm violence is generally thought of as physical injury or death, it can also damage someone's mental health and wellbeing. Furthermore, although direct damage is debilitating for the individual harmed, a person does not have to be directly exposed to firearm violence to experience its associated negative effects. Firearm violence is like an earthquake, a violent and damaging event that causes immense damage at the epicenter but also creates outward ripples wounding victims, their loved ones, and the communities in which they live.

Figure 1. The ripple effects of firearm violence



The rest of this section will provide an overview of the harms associated with firearm violence, starting with the familiar outcomes of deaths and injuries, and ending with the more indirect but also devastating ripple effects on physical, mental, and emotional health.

Firearm Violence: Deaths, Injuries, and Intent

California's firearm death rate is significantly lower than that of many other states.

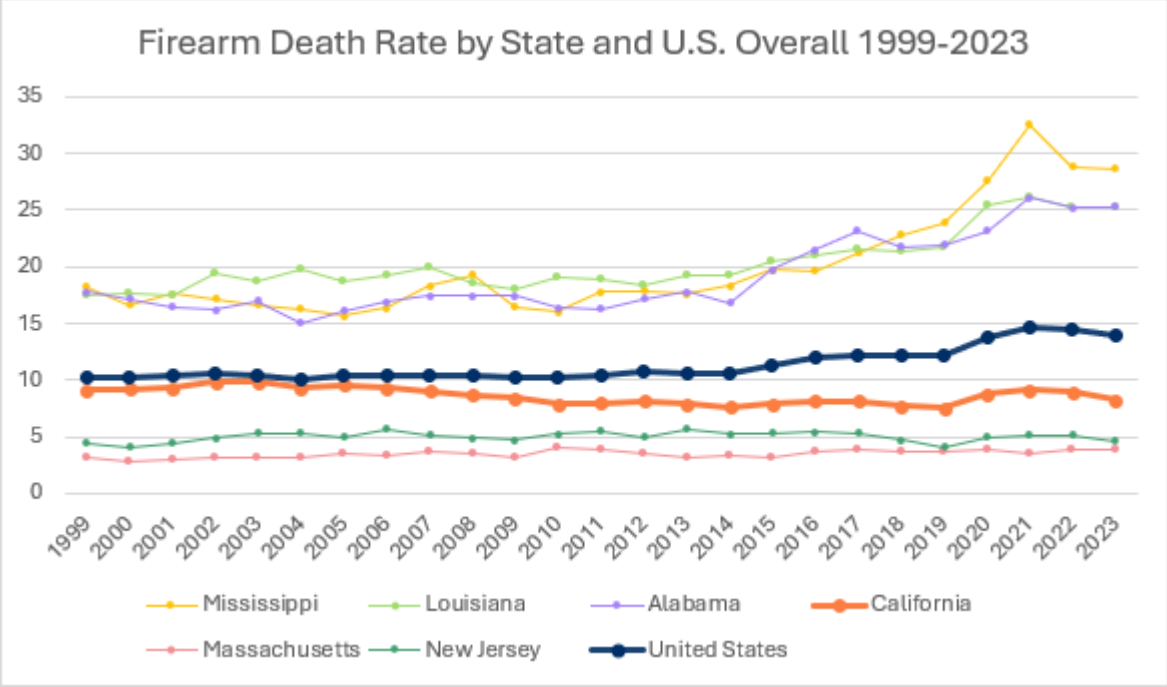
Each year in California, 3,250 people die from firearms. This equates to a firearm death rate of 8.8 per 100,000 people in 2023 (the last year for which full data are available), ranking the seventh lowest of all U.S. states.[57] The nationwide average is 13.6, with highs of 27.6 in Mississippi, 26.4 in

Wyoming, and 25.5 in Louisiana. On the other end of the spectrum, the states with the lowest firearm death rates include Hawaii at 3.6, Massachusetts at 3.9, and New Jersey at 5.0.[58] To compare, California experienced 5,014 deaths from traffic accidents in 2023, a death rate of 12.9 per 100,000 Californians.[59]

As Figure 2 shows, California hasn't always had such a low incidence of firearm violence compared to other states; in fact, California's firearm-related mortality rate used to closely mirror that of the rest of the country until around 2005. This is even more pronounced for firearm homicides, which dropped 30% in California from 2000 to 2015.[60] The decrease is likely due to a range of factors, but measures aimed at gang- and group-affiliated violence are certainly one factor.[61] Reductions in firearm deaths have also been linked to California's increased public health spending to address firearm violence in high-risk areas, even as criminal justice reforms dramatically reduced the number of people incarcerated.[62]

However, like in other U.S. states, this downward trend reversed in 2020 amidst the backdrop of COVID-19 pandemic fears, racial tensions, increasing political division, and other unrest.

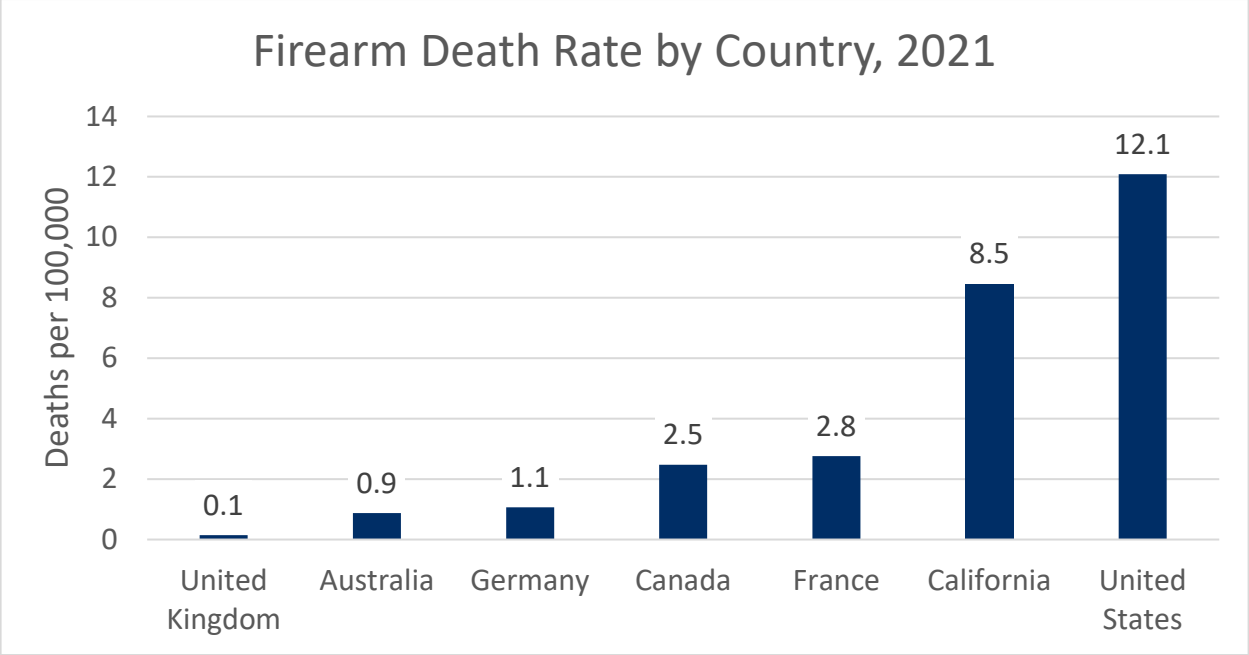
Figure 2. Firearm death rate per 100,000 in U.S. and by selected states, 1999-2020.



While California was a national leader in reducing firearm deaths over the first two decades of the 21st century, Figure 3 shows that these rates are still far higher than those in similar countries.[63]

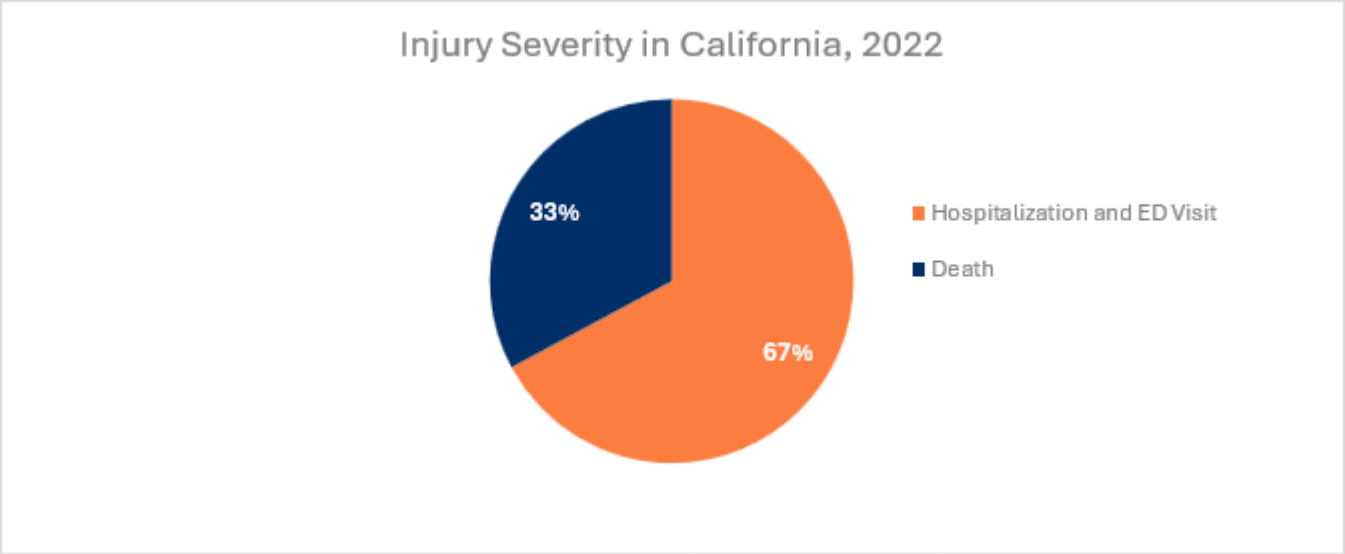
Compared to countries with similar democratic systems of government and high average income (like Canada, Australia, and many large European countries) the U.S. has up to 10 or even 20 times more deaths per 100,000 people.[64]

Figure 3. Firearm death rates per 100,000 in selected countries, 2021



However, deaths alone tell only one part of the story. The broader story is about the ripple effects of firearm violence, which happens not only through deaths but also through survivable injuries. Figure 4 shows the proportion of deaths and injuries by firearm in California for 2022, the most recent year for which data were available. Deaths make up only one-third of the firearm injuries in California each year, not including the unknown number of firearm injuries that don't show up in emergency departments.

Figure 4. Firearm injuries by type in California, 2022



Overall firearm deaths and injury rates are important context, but it's vital to understand how these rates vary by intent. [65]

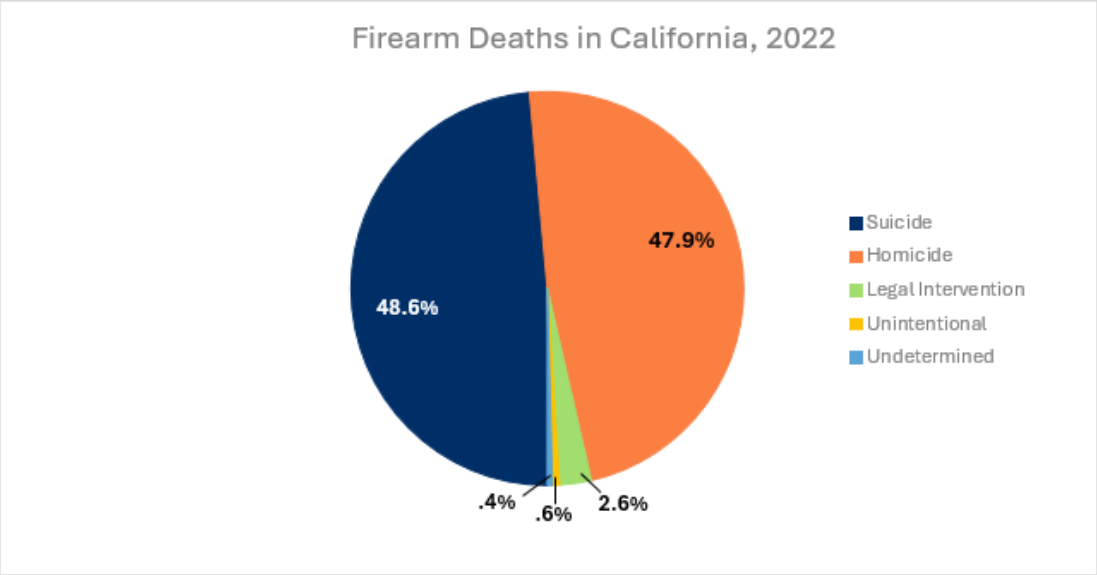
Intent of Firearm Use

Firearm violence varies widely between and within countries, across demographic groups and state, county, and city lines, and these variations are influenced by intent of firearm use. There is a familiar narrative that is popular on mainstream media that mass shootings and other homicides are the main drivers of firearm injury and death.[66]

Although mass shootings tend to get the bulk of media coverage, they make up about one percent of all firearm-related deaths in the United States.[67]

The truth is that the majority of firearm deaths in the U. S. do not occur in school shootings, mass shootings, or even community or group-affiliated shootings – the majority of firearm deaths are suicides. Figure 5 shows that around half of all firearm deaths in California are the result of suicides.[68]

Figure 5. Percentage of firearm deaths in California by intent, 2022.

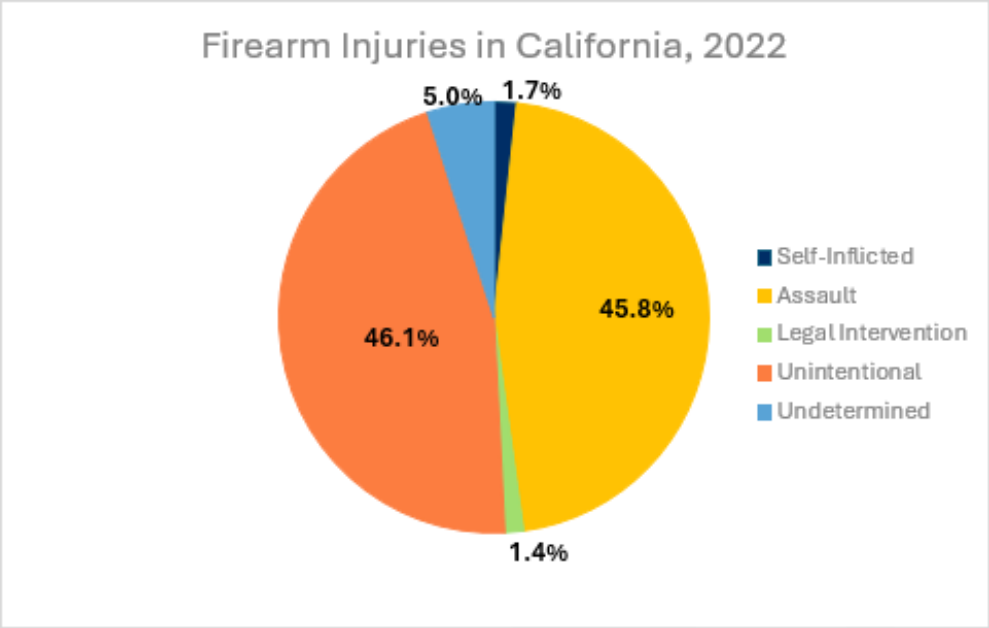


In addition to the tragic loss of life, firearm violence causes life-changing harm for its survivors. There are around 7,000 nonfatal firearm injuries in California each year, leading to thousands of emergency department visits and hospitalizations.[69,70]

In 2022, there were 5,281 Emergency Department (ED) visits, leading to 3,599 hospitalizations due to firearm-inflicted wounds.[71] Figure 6 displays the stark difference compared to firearm deaths: almost half of all injuries are assault (46.1%), another 46% are unintentional, and self-inflicted injuries make up only 1.7% of the ED visits and hospitalizations.[72,*] This change in ratios is due to the high lethality of firearms as a tool for self-harm; around 90% of suicide attempts using a firearm result in death, while assaults and unintentional injuries with a firearm are much more likely to be survivable and treatable.[73]

Figure 6. Percentage of firearm injuries in California by intent, 2022

[*] Additional categories include legal intervention (1.4%) and firearm injuries of undetermined intent (5%).



Although California's firearm death and injury rate is low compared to other states, the incidence of violence is not uniform throughout the state. California's counties experience sizable differences in deaths and injuries, particularly by intent. As Figure 7 shows, self-harm and suicide rates are low in southern California and the Bay Area, but spike in northern California and the Sierras. [74]

Figure 7. Firearm self-harm and suicide rates across California counties (data from CDPH)

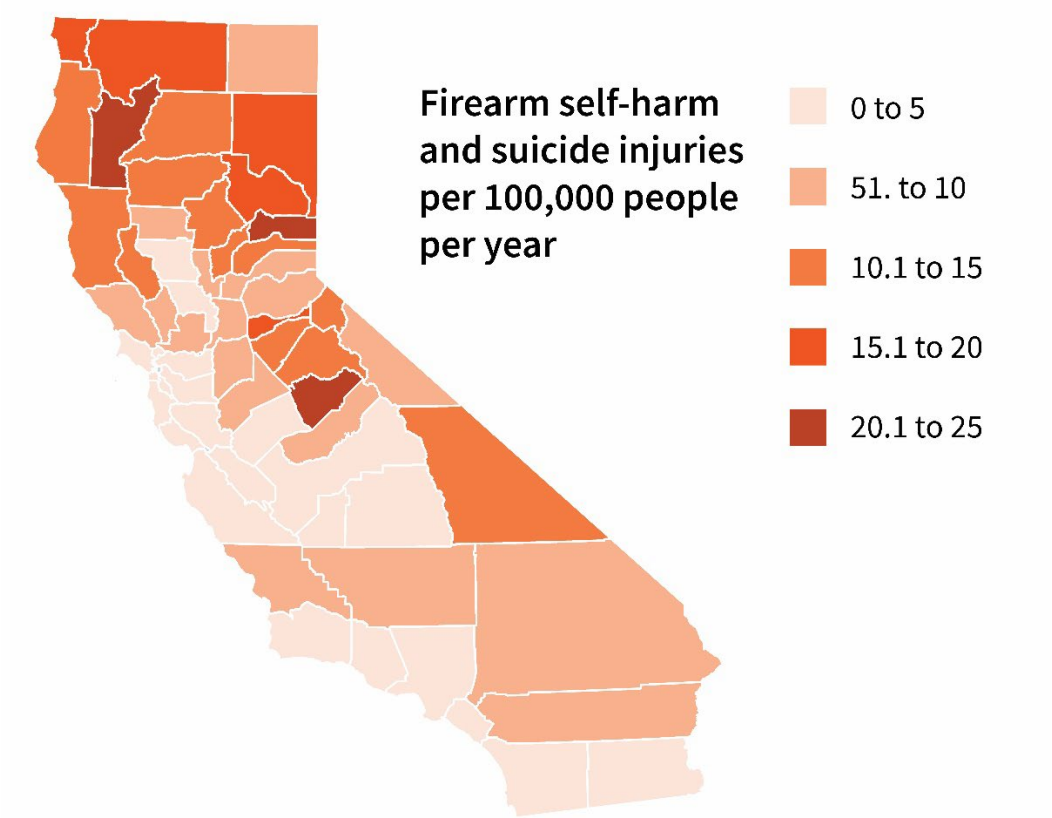
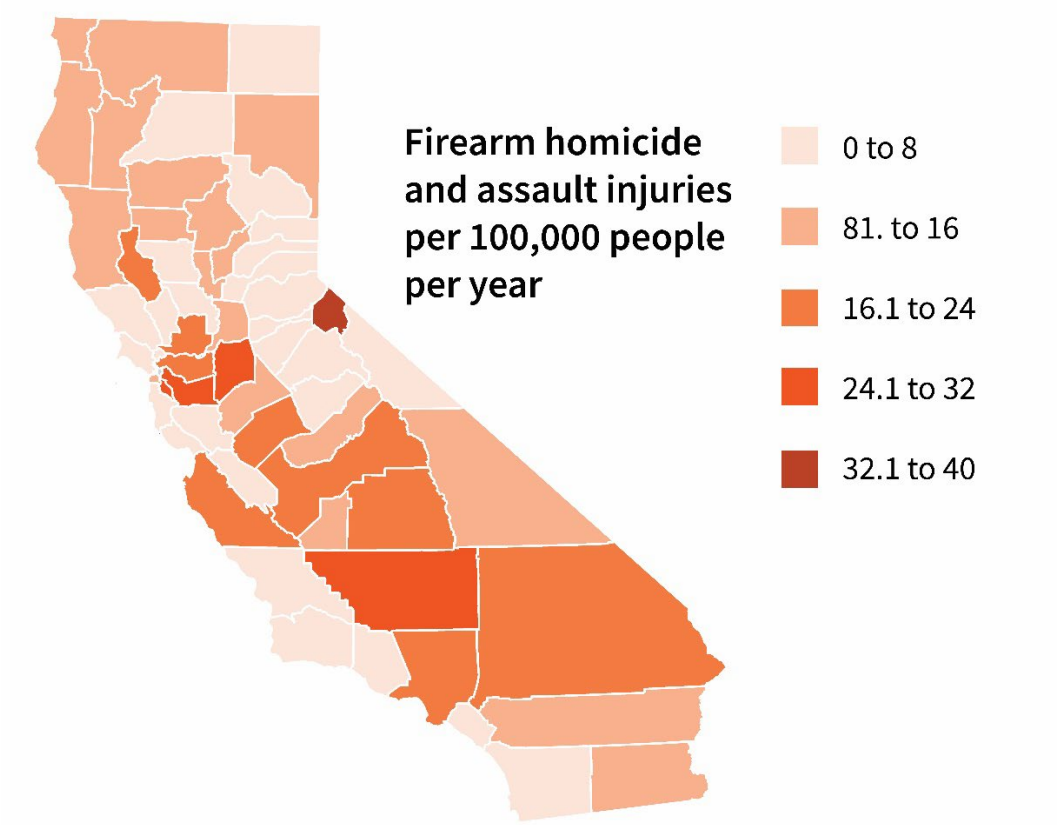


Figure 8 shows a strikingly different trend, with assault and homicide rates low in the northern counties but peaking in counties in the East Bay, Central Valley, and Inland Empire areas (with the exception of Alpine County; this outlier has the smallest population in the state).[75]

Figure 8. Firearm assault and homicide rates across California counties (data from CDPH)



The stark variation in risk for firearm injury and death by county speaks to the nuance of firearm violence.

Although it occurs everywhere, its context and its impacts are not the same – and the solutions will not be the same.

The nature of the problem and the strengths and resources of the community to solve it vary according to many individual and community-level factors.

Disparate Impacts: Demographic and Community Factors

Beyond the numbers on injuries and intent, there are additional important factors for understanding firearm violence. Even in California, where average injury and death rates are significantly lower than in many other states,[76] a person's risk of being harmed by firearm violence

depends greatly on a variety of factors, including their age, veteran status, their neighborhood, income, education level, and – in particular – gender identity and racial or ethnic identity.[77]

Gender Identity

Gender identity plays a substantial role in perpetration of firearm violence. People who identify as male are far more likely to be involved in firearm violence (as perpetrators or as victims) than people who identify as female, which holds across all racial and ethnic groups.[78] Firearm violence is one facet of the larger trend, where men and boys are more likely to be perpetrators of all types of violent crimes.[79] In 2023, people who identified as male made up over 88% of the firearm-related deaths in California.[80]

Those who identify as transgender are at higher risk for experiencing firearm violence than those who are cisgender; compared to 1% of all Californians experiencing direct firearm violence in the past year, 6% of transgender Californians faced firearm violence.[81]

Race/Ethnicity

Firearm death rates vary drastically by race and ethnicity as well. From 2000 to 2020, California's Black and Hispanic men died by firearm homicide at a rate nearly six times greater than that of white men and about 15 times greater than that of Asian or Pacific Islander men.[82] In 2020, Black men in California died by firearm at a rate of 43.1 per 100,000, compared to an overall rate of 8.8 per 100,000.[83] Black men accounted for about 29% of all firearm homicides in 2020, although they make up less than 3% of the population.[84] Hispanic and Latino men account for 31% of all firearm homicide deaths but make up just 13% of the population.[85]

Age

Recent research by the Centers for Disease Control and Prevention have highlighted another important piece of context: age.[86] Over the last few years, firearms have been the leading cause of death among children and teens age one to nineteen in the U.S., and this holds true for California as well.[87,88] This finding is even more alarming for young Black men and boys, who are twenty times more likely to die by firearm than their white counterparts.[89]

However, the rates on age must be considered with the context of intent. In general, children and young adults are at the highest risk for dying by firearm homicide, while older adults are at the highest risk for dying by firearm suicide.[90] While firearm suicide has traditionally been associated

with older white men, that may be changing; from 2017 to 2021 in California, firearm suicide increased among women, young people, and people identifying as Black.[91] This is occurring against a backdrop of suicide decreasing overall, but firearm suicide is increasingly taking up a larger share of all suicides.

Veteran Status

Another group that experiences disproportionately high firearm suicides is veterans. While suicides have been decreasing in recent years, suicides among California veterans increased by 2% in 2022.[92] Suicides by veterans made up 14% of all suicide deaths for those over 18 in California,[93] compared to their 4% share of the population.[94] Overall, suicide is one of the leading causes of death for veterans and the method of completion is overwhelmingly a firearm.[95]

Social and Economic Inequality

Income inequality (how evenly income or income growth is distributed across the population)[96] has also been found to correlate with firearm violence. Areas with greater income inequality have higher firearm homicide rates, even after controlling for contextual factors like age, gender, race and ethnicity, crime rate, neighborhood deprivation (a multidimensional variable measuring a neighborhood's income, employment, health, education, and crime levels, among other variables),[97] social capital (the sense of community and reciprocity that leads to the cooperation of residents for mutual benefit in a neighborhood)[98], urbanicity, and firearm ownership.[99]

Community instability can also lead to social disintegration and reduced social capital. Social capital is associated with rates of firearm violence; areas with lower social capital have higher firearm violence, even when controlling for poverty and firearm access.[100] Further, higher rates of community economic distress is a significant predictor of firearm violence in youth.[101]

Similarly, economic disadvantage has been associated with greater firearm violence. Those living in public housing are over twice as likely to suffer from firearm-related violence as those living in other communities.[102] Areas with higher food insecurity are significantly more likely to experience gunshot injuries.[103] Increased economic distress also contributes to increased rates of firearm violence through unemployment.[104] Continuing the cycle, areas that experience firearm violence often lose job opportunities as a result, leaving its residents with fewer legal options to meet their basic survival needs.[105]

The Price Californians Pay

Every act of firearm violence comes with a price.

The most recent analysis estimates that firearm violence costs Californians $37 billion each year.[106]

The portion of financial costs that is due to directly measurable costs – including healthcare, police and criminal justice, employer, and lost income costs – add up to $6.5 billion per year.[107]

> *"We need to invest in prevention because it's expensive to have homicides in your community… in terms of investigation, hospitalization, prosecution, devaluation of homes, impact on businesses." – Refujio "Cuco" Rodriguez, Chief Strategist and Equity Officer at the Hope and Heal Fund, May 25, 2023*

But the financial toll is only one part of the burden of firearm violence. Like the after-effects of an earthquake, the impacts ripple through the lives of individuals, families, communities, and society, causing wounds that are often invisible yet lasting.[108]

Nearly 3,500 Californians lose their lives to firearms each year and thousands more are wounded.[109,110] In addition to physical injuries, survivors of firearm violence often face deep wounds to their mental and emotional health. Many report feelings of persistent fear, paranoia, insomnia, hypervigilance, post-traumatic stress disorder (PTSD), and thoughts of suicide.[111] Chronic physical health issues are also common among survivors.[112]

> *"The impact isn't just the direct survivor. There are reverberations for their immediate family, for their community, and beyond." – Dr. Sarah Metz, PsyD, Director of the UCSF Division of Trauma Recovery Services, May 25, 2023*

The direct effects can be debilitating for those harmed, but the subsequent effects of these incidents ripple out even farther, and they are not limited to any person, group, or generation. They affect all Californians. Public survey data show that 1 in 4 people consider gunshots and shootings

to be a problem in their neighborhood.[113] Even more striking, roughly 1 in 5 Californians know someone who has been shot on purpose.[114]

Indirect firearm violence impacts a broad range of people, including those who witness a shooting, people living in the neighborhood where it occurs, people who have lost a loved one to violence, and those belonging to a group targeted by mass violence.[115] Nearly half of Californians who are exposed to violence in their neighborhood experience social functioning problems, including issues with their job, school, or interacting with their friends and family.[116] People helping victims of violence, such as first responders, hospital workers, and behavioral health providers, are also impacted.[117,118] These and other forms of indirect exposure to firearm violence can cause anxiety, fear, depression, difficulty focusing, and a host of other trauma- and anxiety-related symptoms.[119,120]

"Community violence doesn't involve the entire community, [but] the entire community is involved in the aftereffects." – Sam Vaughn, Deputy Director of Community Services in Richmond's Office of Neighborhood Safety, October 26, 2023

Firearm violence also harms people in their communities by creating fear and diminishing their sense of overall safety.[121] Those living in a high-crime neighborhood suffer from social isolation and loneliness.[122] People from all areas are impacted when they fear going to a mall or shopping center. Parents and children are affected when they are afraid to go to school. Community members are impacted when they feel anxiety over gathering in public places. People of faith are impacted by concerns over attending a worship service or a religious gathering. Media can also exacerbate the effects of trauma. For example, media coverage of mass violence has been linked to trauma and stress, even for those who were not part of the impacted community.[123]

Although mass shootings are statistically rare, the possibility of a mass shooting is a very real concern for most Californians.[124] Such fears are having a disproportionate impact on both youth and adults, making it harder for community members to feel safe as they live, learn, work, and play.

"Our mental health challenges in Oakland are not new. It's been passed down from generation to generation. … We've never had a space for healing." – Janiesha Grisham, Violence Prevention Educator, October 26, 2023[125]

When these negative outcomes are experienced by multiple generations and entire communities, they create a self-perpetuating cycle from which it is exceedingly difficult to escape. This cycle disproportionally affects those who are already at a disadvantage, including people of color, young people, and people living in poverty.[126]

The Cycle of Violence in Detained Youth

The ripple effects of this self-perpetuating cycle of violence and the context of firearms were clear when speaking with youth detained at the Youth Detention Facility in Sacramento.

Residents in this facility came of age in communities and homes where nearly everyone around them owned a firearm, and in many ways, firearms were just part of the culture. But, in contrast to the sportsmanship and community associated with firearms in many firearm-owning communities, detained youth said firearms in their neighborhoods were not considered recreational, but as tools necessary for survival: as a way to make ends meet, to settle conflict, and for protection from others using firearms.

Detained youth reported that they often picked up firearms from family members or friends. They did not receive any training or mentorship from adults on firearm use, and they learned about firearms through their peers and/or social media. The use of firearms to resolve conflict was common, with one youth stating that he had not even heard about other methods for solving conflicts or disagreements until he arrived at the detention facility. Many only received "opportunities" after committing a crime with a firearm. As one detained youth reflected:

"[It] sucks that I have to commit a crime to qualify for these resources. Once you come in here, that's when the ultimate opportunity comes in. Housing, school… all these doors open up to you."

The disproportionate impacts of firearm violence on the most disadvantaged Californians is not a coincidence. It's part of a larger systemic problem of inequity, disinvestment, and cyclical negative outcomes.

The (Shared) Root Causes of Violence and Mental Health Challenges

As noted earlier, mental health is often invoked as an explanation – or scapegoat – for shocking incidents of violence.[127] While a mental health diagnosis does not inevitably lead to violence, and exposure to firearm violence will not inevitably lead to mental illness, there is undeniable overlap between violence and mental health challenges.[128] A framework for understanding that overlap is the cycle of trauma and violence. Before explaining the cycle in detail, it's important to highlight some of the factors that are involved in this cycle.

Mental health challenges and involvement in violence share underlying factors, also known as risk factors.

There are certain individual-level factors that are strongly associated with mental health challenges, like traumatic experiences, stressful life situations, substance misuse, adverse childhood experiences (ACEs), and ongoing medical conditions.[129,130] Someone who faces challenges in these areas is more likely than others to experience persistent challenges with their mental and emotional state. The same is true for factors that are associated with greater risk for firearm violence.

The reality is that the risk factors for firearm violence have considerable overlap with the risk factors for mental health challenges.[131,132,133,134,135]

In other words, the individual, social, and environmental factors that put a person at risk for picking up a firearm to cause harm are often the very same factors that put them at risk of developing or exacerbating mental health challenges.[136]

Level	Risk Factors for Both Mental Health Challenges and Violence

Individual	• Being a member of a marginalized group (including racial or ethnic minority groups)[137,138] • Living in a single-parent household[139,140] • Childhood abuse and neglect[141,142] • Isolation or "profound estrangement"[143,144] • Feelings of grief and loneliness[145,146,147] • Substance use[148,149]
Family	• Family stress and parental trauma experiences or mental illness[150] • Low family cohesion (low emotional connection amongst family members)[151] • Substance abuse in the family[152,153,154] • Growing up with socioeconomic disadvantage[155,156,157]
Community & Environmental	• Living in a neighborhood with high levels of distress, disadvantage, or instability [158,159,160] • Living in an area with high poverty (particularly high child poverty)[161,162,163] • Living in an area with little economic opportunity and high-income inequality[164,165,166] • Living in a high-crime neighborhood[167,168] • Intergenerational mobility (the likelihood of a change in social status between generations)[169,170]

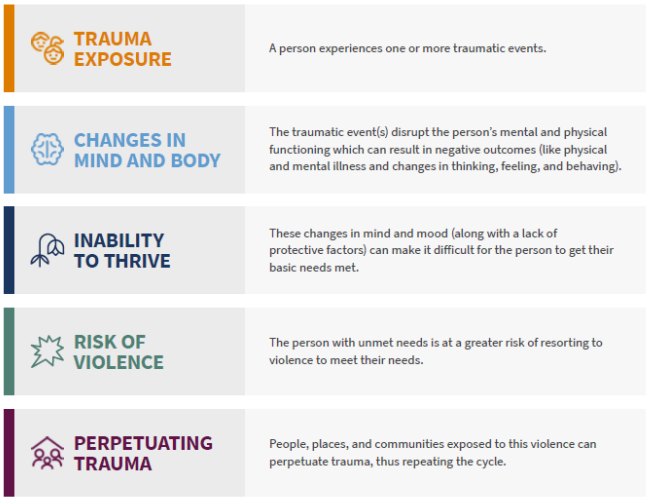
Not only is there considerable overlap between risk factors for developing mental health challenges and involvement with violence, but these very same factors are also at play in recovery, hindering healing from violence and other traumatic events and threatening to entrench survivors in a cycle of suffering and violence.[171]

Unhealed trauma is the mechanism that overwhelmingly contributes to continuing the cycle of violence.

The Cycle of Trauma and Violence

While it may seem like firearm violence happens spontaneously – when someone "just snaps" – this is almost never the case.[172] According to internationally renowned trauma expert J. Kevin Cameron, people nearly always show signs before an episode of violence. Violence, Cameron explains, is not an inscrutable event; it's an evolutionary process that is grounded in pain and unmet needs.[173]

The increased risk for both victimization and perpetration of violence after experiencing violent trauma makes sense when understood within **the cycle of trauma and violence**.



The cycle plays out as follows:

1. **Trauma Exposure**: A person experiences one or more traumatic events (e.g., the unexpected death of a loved one, an experience of violence or sexual assault, witnessing or participating in combat, childhood abuse or neglect, or living through a natural disaster).
2. **Changes in Mind and Body**: Without intervention, the traumatic event(s) disrupt the person's mental and physical functioning which can result in negative outcomes (like physical and mental health disorders and changes in thinking, feeling, and behaving).
3. **Inability to Thrive**: These changes in mind and mood (along with a lack of protective factors) are often not understood by the individual as trauma-generated and can make it difficult for the person to fully understand what their basic needs are and how to get them met.
4. **Risk of Violence**: Untreated depression, anxiety and PTSD often leave the person feeling mentally and emotionally isolated from others (even if surrounded by others) where their unmet needs place them at a greater risk of resorting to violence, suicide or a combination of both to meet their needs or end their pain.
5. **Perpetuating Trauma**: People, places, and communities exposed to ongoing violence can unconsciously become part of this self-perpetuating trauma-violence cycle.

This is how exposure to childhood trauma and adversity can increase risk for **both victimization and perpetration of violence**, within that person's lifetime and across generations.[174,175,176] Prior victimization does not necessarily lead to future perpetration, but it does act as a risk factor.[177]

Addressing the underlying causes of mental health challenges and violence is critical from a primary prevention perspective, including addressing the demographic and geographic factors known as the social determinants of health.

But trauma, the "low-hanging fruit," is the factor with the most immediate potential for preventing firearm violence and its associated harms.

The way that this cycle plays out in cyclical community violence is as follows: Children are exposed to violence early and often, and they grow up with fear and self-preservation as their main drivers, leading to struggles in school, work, and relating to others – sometimes receiving a mental health diagnosis along the way, but often living with undiagnosed and unaddressed mental health challenges.[178,179,180] They emulate those around them, using familiar violent strategies in an effort to meet their needs. This reinforces the default of violence as a way of life, and they end up caught in the same domestic struggles, group-affiliated conflict, and violent problem-solving that caused their initial trauma as children.[181,182]

> *"It is not very palatable to look at perpetrators of gun violence and try to give them what they need, but we [violence interrupters] have always understood that every perpetrator of gun violence was first a victim." – Sam Vaughn, Deputy Director of Community Services in Richmond's Office of Neighborhood Safety; October 26, 2023*

Furthermore, participating in this way of life embeds them deeper into this cycle, as they experience additional trauma by causing harm to others.

> *"Some of the greatest trauma that I have endured… is the trauma that happened to me when I inflicted violence upon other human beings." – Jose Osuna, loss survivor, past perpetrator of violence, and violence intervention expert; May 25, 2023*

This cycle can also play out in other areas, like intimate partner violence, other domestic violence, and self-harm. [183] Survivors of family violence and suicide loss struggle with lasting negative impacts that can become risk factors for future violence against oneself or others.[184,185] [186] This cycle can also be applied to perpetrators of mass violence; those who have experienced bullying can suffer from toxic stress and subsequent mental health challenges that can become risk factors for perpetrating violence in some circumstances.[187]

This information on the effects of trauma is not new. The devastating impacts of the trauma that violence causes have been known for over a century, going as far back as "shell shock" in soldiers coming home from World War I, "battle fatigue" after World War II, and post-traumatic stress disorder (PTSD) after the Vietnam War ended – but soldiers' struggles did not.[188] However, it is only in the last few decades that trauma-informed perspective has gone mainstream.[189] A new understanding of the contextual relationship between trauma and further violence is also gaining ground.[190,191]

Violence as Contextual

The existence of this cycle of trauma and violence underpins the idea that violence is a widespread human experience that nearly anyone could perpetrate under the right circumstances. The contextual nature of violence is foundational in the field of risk assessment, which has moved from an antiquated understanding of the risk of violence as "dispositional (residing within the individual), static (not subject to change) and dichotomous (either present or not present)" to the current understanding of risk as "contextual (highly dependent on situations and circumstances), dynamic (subject to change) and continuous (varying along a continuum of probability)."[192]

This reframing underpins the optimistic truth that the cycle of trauma and violence is not inevitable but **can be broken**. Effective violence prevention (like violence intervention or interruption programming) breaks the cycle by meeting people where they are and helping them get their current needs fulfilled. Good violence prevention strategies intervene within the cycle to break the cycle, bolstering mental health and supporting the surviving and thriving of those affected.

Effective violence prevention does not impose strict penalties or harsh punishments for resorting to violence, it removes the need to resort to violence.

Intervening at any point in this cycle will avoid significant negative outcomes, but the earlier the intervention, the greater its potential for impact. Behavioral health services are one such intervention, as those with lived experience can attest.

> *"I was a perpetrator of gun violence, (but) from the moment I received mental health services, picking up a gun has never been an option in my head. Prior to that, it was always the first instinct." – Jose Osuna, loss survivor, past perpetrator of violence, and violence intervention expert; May 25, 2023*

Seeing the cycle of trauma and violence that underpins a significant portion of firearm violence and understanding that the cycle *can be broken* fuels an optimistic outlook on the twin problems of firearm violence and mental health challenges. The two are related and intertwined, meaning that solutions can also address both at the same time – they just need to be designed with the intersection in mind.

With this understanding, the Commission has identified three main findings and recommendations to move toward the goal of reducing firearm violence and its negative health and mental health impacts.

Commission for Behavioral Health

Findings and Recommendations

The Commission has identified three main findings and a set of corresponding recommendations to guide an integrated, trauma-informed public health approach to firearm violence prevention in California. These findings arose from an intensive research and engagement process conducted in partnership with public officials, advocates, researchers, and other experts from communities across California and the United States. Special consideration was given to those with lived experience as victims and/or perpetrators of firearm violence and to those from law-abiding firearm-owning communities.

Finding	Recommendation
Finding 1: Firearm violence is a persistent threat to behavioral health, but California is not treating it that way.	**Recommendation 1:** California must establish trauma-informed violence prevention as a public behavioral health priority.
Finding 2: California faces challenges for effective firearm violence prevention stemming from misconceptions, cultural tensions, and fear.	**Recommendation 2:** California must deploy a public engagement and awareness initiative to regain trust and build relationships with firearm-owning communities and communities impacted by violence.
Finding 3: California's public investments have not been coordinated effectively to address the underlying causes of violence and other public health concerns.	**Recommendation 3:** Under an appointed central leader, California must develop a unified strategy to guide a public health approach to firearm violence prevention that integrates data, resources, and partners from across sectors.

While not exhaustive, these findings and proposed solutions serve as a starting place for advocates, providers, lawmakers, and other change agents working at the epicenter of firearm violence and behavioral health, with a focus on mitigating the ripple effects.

When implementing these promising strategies, the most important feature to consider is the return on investment. With the scarce firearm violence prevention funding that exists, funds must be invested in a thoughtful and intentional way to realize the greatest impact. Most often, the greatest impact is made by focusing on the small portion of the population that is at highest risk for perpetrating firearm violence – to the self, others, or both.

Firearm Violence and The Prevention Spectrum

Prevention efforts are categorized by the stage in which they aim to intervene. Related to firearm violence, the categories are:

1. **Primary prevention**: efforts to reduce risk factors for firearm violence in an entire population through a focus on improving social and environmental conditions to prevent firearm violence from ever occurring.
2. **Secondary prevention**: efforts aimed at a susceptible population or individual to reduce the likelihood of firearm violence in high-risk groups.
3. **Tertiary prevention**: efforts to intervene, prevent further harm, and promote recovery after firearm violence has occurred.

On the spectrum of prevention, secondary and tertiary prevention are the levels at which such investments have the greatest return. This is not to say that primary prevention methods are not also effective – they can be highly effective at a population level – but that interrupting the cycle of trauma and violence is most impactful when it intervenes at the moments with the highest stakes. Primary prevention work can happen in tandem with other, existing funding aimed to prevent other, related negative outcomes.

When funding is limited to tackle the specific problem of firearm violence, it is the intervention programs and policies that must be prioritized with firearm violence prevention funding.

Although there is an artificial separation between primary, secondary, and tertiary strategies, the reality is that they are not mutually exclusive. The greatest return on investment is when they function harmoniously.

Findings

Each finding combines relevant literature, data, and testimony to describe the following:

- A formulation of the problem with key definitions and concepts.
- How it impacts Californians with attention on needs, gaps, and opportunities for prevention.
- Examples of promising strategies in effective firearm violence prevention and harm mitigation. The key features are identified in each of the promising strategies. These key features can be found in Table 1.

Table 1. Key features of promising strategies for firearm violence prevention and harm mitigation

Key Feature	Description
Collaboration	Partners from multiple sectors, disciplines, and organizations to work together on violence prevention.
Community engagement	Actively involving and collecting information from the population(s) being served, ensuring solutions reflect community needs and values.
Community-driven	Initiatives designed, embraced, and/or implemented by the communities they aim to serve, ensuring solutions are not imposed from outside.
Coordination	Conducting a comprehensive approach that coordinates and aligns resources and initiatives into one consistent effort.
Credible messengers	Employing people with similar lived experiences to those being served to build trust and deliver supports.
Education	Strategies aimed at providing new information to target population(s) with the goal of sparking intrinsically motivated behavioral changes.
Empowerment	Strategies that recognize and reaffirm the capacity of those most impacted by a problem to affect positive change in their lives and communities; often paired with education to build skills.
Evidence-based practices	Practices that have research- or science-based evidence for their effectiveness.
Flexible funding	Offers supports that attend to a community's unique needs, rather than being restricted to set programs or activities.
High-risk individuals	Efforts and supports focus on intervening with the people who are at highest risk for causing harm to themselves, others, or both.

Infrastructure	Physical spaces, systems, policies, and technology with adequate capacity to address large-scale problems.
Leadership	Using expertise from high-level leaders who will drive efforts and guide implementation.
Leveraging other funding	Some violence prevention efforts can be funded by leveraging existing funds in other areas, including Medi-Cal and public health sources.
Long-term support	Ongoing support that extends beyond brief interventions, designed to address the enduring effects of violence with sustained care over time.
Mentorship	Mentors (more experienced, and often older, adults) provide a positive role model, guidance, and advice to adolescents and young adults.
Peer support	Support offered by people who share similar demographics and lived experiences with those served.
Person-centered	These strategies provide supportive environments that emphasize the unique experiences of the person served, focusing on their needs, priorities, and values.
Place-based	Making changes to the physical environment to produce desired outcomes.
Public health approach	An evidence-based framework that addresses violence by defining and monitoring the problem, identifying risk and protective factors, developing and testing prevention strategies, and ensuring widespread implementation.
Research	Strategies that leverage planned, systematic information-gathering to inform understanding.
Stigma reduction	Strategies that normalize mental health challenges and their treatment.
Targeted violence prevention	Efforts to prevent violence that is pre-meditated and directed at a specific individual, group, or location.
Timely data	Effective solutions depend on data that are shared and available for prevention and intervention efforts in real time or shortly after being collected.
Training and development	Includes job training, skills training, and other personal development that builds skills and offers feasible paths to a productive future.
Trauma-informed approach	An approach that recognizes how past traumatic experiences shape functioning, and uses strategies designed to address these impacts while promoting healing.

Voluntary	Strategies that provide community members with freely chosen options rather than mandated interventions; often paired with education to foster informed decision-making.
Wraparound supports	Offer comprehensive and coordinated assistance such as cash allowances, food assistance, shelter or housing subsidies, job training, transportation, or other basic necessities.

Finding 1: Firearm violence is a persistent threat to behavioral health, but California is not treating it that way.

A wealth of evidence has shown the profound effects trauma can have on a person's physical and mental health.[193,194] Cumulative traumatic experiences can initiate a chronic stress response, known as toxic stress, that may disrupt a person's social, emotional, and cognitive functioning long after the events that caused them.[195,196,197]

Firearm violence is one form of trauma that profoundly affects the mental health of individuals, families, and communities.[198] Victims and witnesses are at risk of post-traumatic stress disorder (PTSD), anxiety, and depression as they grapple with the fear and pain associated with violent encounters.[199,200] Children exposed to firearm violence are particularly vulnerable, and may experience emotional dysregulation, academic challenges, and difficulty forming relationships – all of which can contribute to behavioral health challenges later in life.[201,202,203]

Beyond individuals, communities affected by firearm violence face collective trauma, leading to fear, mistrust, and social fragmentation. [204] High-violence neighborhoods often experience economic decline, reduced community engagement, and strained resources, reinforcing instability and distress across generations.[205,206,207,208,209]

As noted earlier in this report, the individual and community effects of trauma are the same conditions that lead to violence.[210] Without intervention, the cycle of violence and trauma will continue.[211] There is a great need for effective strategies to disrupt these cycles, not only to prevent violence, but also to improve behavioral health outcomes. When people are pulled out of the cycle, it doesn't just improve their wellbeing – it also has positive ripple effects on those around them, replacing the violence and trauma cycle with a new cycle of safety, wellbeing, and mental health promotion.

"The first step […] is funding. These programs have been chronically underinvested in, undervalued, underpaid to do difficult and dangerous work that is vital to reduce violence." – Ari Freilich, Director of California's Office of Gun Violence Prevention, October 23, 2025

Violence Prevention is Missing from California's Behavioral Health Strategy

Through recent investments in service delivery, workforce, infrastructure, and public awareness, California has committed to improving mental and behavioral health care access and outcomes across the state. Advancing this effort, California voters passed the Behavioral Health Services Act (BHSA) in March 2024 which ensures ongoing funding to support Californians living with the most significant behavioral health needs.[212] This funding prioritizes services for people at risk of homelessness, incarceration, or hospitalization. It also prioritizes youth and emphasizes prevention and early intervention to prevent the incidence and consequence of behavioral health challenges.

Parallel short-term investments have been made, such as California' Children and Youth Behavioral Health Initiative (CYBHI), a multi-year, $4+ billion investment to enhance workforce, services, infrastructure, and public awareness for youth behavioral health.[213] The State is also building capacity in service delivery systems as demonstrated in its Behavioral Health Continuum Infrastructure Program (BHCIP), which funds projects to increase treatment capacity.[214]

While these investments are key to bolstering the behavioral health of California's population, they make virtually no mention of violence as a related outcome. Despite the established relationship

between violence, trauma, and behavioral health, California's behavioral health funding and programs have not been leveraged to promote trauma-informed violence prevention strategies. Embracing such strategies through the behavioral health system would not only provide a welcome opportunity to address high rates of violence for certain unserved and under-served populations, it would also act as protection against the development of future behavioral health challenges and foster individual and community resilience.

Opportunity: Prioritize Violence Prevention as Behavioral Health Promotion

Prioritization of firearm violence within the state's mental and behavioral health strategy would require implementing approaches that intervene within the cycle of trauma and violence to prevent violence and its negative impacts on mental health, prioritizing communities who are most vulnerable or at risk. To be most effective, these strategies would 1) center the person and their needs within the strategy, rather than systems, 2) intervene early in the cycle of trauma and violence, and 3) promote recovery after firearm violence occurs.

Person-Centered Strategies

Violence happens within and between individuals, and the solutions need to fit within this space. As mentioned earlier, the most up-to-date understanding of violence is that anyone has the potential for committing violent acts if the conditions are ripe for it. Community violence intervention strategies are designed to address the contextual factors that lead individuals to use a firearm to cause harm. Usually, these programs are operated by community-based organizations and may struggle to maintain consistent funding. In Richmond, CA, one such strategy is embedded within the local city government.

PROMISING STRATEGY #1

The Operation Peacemaker Fellowship: Embedded Youth Intervention

Intervention, Secondary and Tertiary Prevention

The Peacemaker Fellowship is a program offered to youth in Richmond, CA who are currently involved in or at high risk of involvement in group-affiliated violence. It offers a "fellowship,"

which includes wraparound support, mentorship, skills and job training, mental/behavioral health supports, and other services to turn youth toward safe, legal, and empowering life choices. Unlike other intensive, youth-focused intervention programs, it is funded through and implemented by the city in which it operates, making it one-of-a-kind in California.

Director Sam Vaughn knows how to support these fellows because he draws from his own experiences growing up in a neighborhood plagued by violence. From his perspective, it's clear what they need: people who love them, meet them where they are, and hold them accountable.

This model is intensive, requiring significant investment into the fellows who participate. Thus, it is only appropriate to recruit individuals who have been identified as being at high risk for involvement in group-affiliated violence. But for these fellows, it can change everything.

The change happens through meeting fellows where they are. The heart of this model is care and compassion for the fellow, seeing the young men as human beings instead of lost causes. Most of these youth live in a community where violence is seen as the ultimate problem-solver. Sam Vaughn says, "*We slowly chip away at that [belief], providing resources with no ulterior motive except we want their life to be better.*"[215]

The fellowship program offers wraparound, customized supports to fellows, guided by mentors who put in the time necessary to get to know their mentees and their unique needs. Mentors must have similar life experiences to be effective, as the transformation is highly relationship-driven. But once the trust is built, mentors can guide fellows into job training, attending sessions with a therapist, seeing a doctor for health care, or even going on trips with members from rival communities in a strategy that simultaneously builds empathy and expands the fellow's horizon of what is possible (called "transformational travel").

Key Features: credible messengers, high-risk individuals, flexible funding, wraparound supports, mentorship, training and development

Person-centered strategies are not only effective with adults; they are also successful with addressing the challenges and needs of youth. Behavioral Threat Assessment and Management (BTAM) is a powerful person-centered strategy that wraps around youth to pave the path to a better future.

PROMISING STRATEGY #2

Behavioral Threat Assessment and Management: Behavioral Health Approaches to Violence Intervention

Secondary Prevention

When a person – particularly a young person – shows signs of potential impending violence, the message is "if you see something, say something." The work that happens after a concerned person says something is called Behavioral Threat Assessment and Management, and it can change lives.

Dr. Melissa A. Reeves, a leading national expert in BTAM in schools, explained that BTAM is a systematic process designed to 1) identify persons or situations of concern, 2) inquire and gather information, 3) assess the situation, and 4) manage the situation or mitigate risk.[216] It is collaborative process comprised of a multidisciplinary BTAM team to include teachers/educators, school administrators, mental health professionals, and law enforcement (usually a school resource officer), at a minimum. Other professionals with expertise may also be included (i.e., behavior interventionist, special education professional, community mental health, etc.,). This team focuses on conducting an inquiry to verify the concerns and identifying the contributing factors to potential targeted violence considering the background and needs of the person(s) of concern and the dynamic life factors impacting behavior The BTAM team also distinguishes between *making* a threat (the result of temporary dysregulation, a misunderstanding or something taken out of context, mimicking others' behaviors without understanding of the implications, etc.,) and *posing* a threat (actual intent to harm). This distinction is critical to determining if consequences are appropriate and necessary and – if they are – whether alternatives to discipline could be utilized or an intervention and management plan must be implemented to address stressors and/or actual intent to harm.

The first three steps are typical of any risk or threat assessment model, in which a situation of concern is brought to the attention of authorities at school or in law enforcement and a careful process of information-gathering is undertaken. The BTAM team also engages parents and caregivers as partners to better understand the situation and to work collaboratively to mitigate risk.

Dr. Reeves describes BTAM as an intervention process, not a disciplinary process. This means that, rather than defaulting to punitive measures like suspension or alternative placements, the BTAM process aims to engage interventions and supports. Once the situation is assessed and immediate safety is secured, BTAM leverages individual, family, educational, and external supports to develop an intervention and support plan. This plan includes interventions to reduce stressors while also meeting the student's (and sometimes family's) needs. Intervention considerations include educational, behavioral, family, and social supports; mental health interventions; behavior management strategies; building connections and relationships; and addressing school climate and culture. The ultimate goal of BTAM is to help youth off the path of violence and onto a more positive pathway.

The person-centered approach and multidisciplinary and collaborative nature of BTAM makes it a highly effective tool for not only neutralizing the threat of violence, but for intervening to create a more positive cycle of resilience and safety within families and schools. BTAM also helps to mitigate disproportionality within disciplinary and legal systems, as the available evidence shows that punishment alone does not change behavior. Rather, it is building skills and relationships that move the individual away from violence and toward being a contributing member to society.

Key Features: high-risk individuals, wraparound supports, collaboration, person-centered, targeted violence prevention

Many schools and school districts currently use some type of BTAM process, but there is currently no consistent standard for BTAM in California, within schools or elsewhere. This process can be applied successfully in a wide array of settings and for a broad range of populations, including in workplaces and other organizations.

"Systems work[...] no one has died in Santa Barbara because of a fire in 30 years. [The fire prevention system] is effective[...] we don't have that in terms of a mass shooting." – Refujio "Cuco" Rodriguez, Chief Strategist and Equity Officer at the Hope and Heal Fund, May 25, 2023

Early Intervention

When it comes to firearm violence, supporting a person's mental health isn't just important for recovery – it's also important for the prevention of future violence.

Understanding the underpinnings of firearm violence, which often lie in trauma and unmet needs, the link between firearm violence and mental health is clear. Having unmet needs – physical, mental, and emotional – is a known risk factor for both perpetrating and being victimized by firearm violence, which in turn is associated with negative physical, mental, and emotional outcomes.[217,218] This creates an often self-perpetuating cycle that can easily trap people within and inhibit their recovery and rehabilitation. Violence prevention efforts must break this cycle.

To do this, initiatives need to intervene at opportune moments in the cycle – the earlier the intervention, the greater the impact. Intervening early not only mitigates harm for a person caught within that cycle, it also interrupts the trajectory of violence and prevents future harm.

One such early intervention program is the REACH Team in Los Angeles.

PROMISING STRATEGY #3

The REACH Team: Early Intervention to Break the Cycle of Trauma and Violence

Secondary and Tertiary Prevention

The REACH Team is a collaborative effort of the Los Angeles City Attorney's Office, the Children's Institute, Inc.; the Los Angeles Police Department's Community Safety Partnership Bureau (CSPB); Tessie Cleveland Community Service Corp.; Bryant Temple Community Development Corporation; and other community partners and schools. The team mobilizes in cases where children have been exposed to violence with a goal of providing immediate, trauma-informed, crisis response services – including counseling – to mitigate the impact of trauma and promote healing and resilience.

"*My priority is protecting children and addressing childhood trauma in the moment is the most effective way to achieve better outcomes. The REACH Team is a model that works as a prevention and violence intervention approach.*" – Los Angeles City Attorney Hydee Feldstein Soto

After the REACH Team is alerted to a child being exposed to violence, a counselor and a case manager are deployed to meet with the child and their family where they are – both literally and figuratively. Counseling services are offered upfront, although families are often hesitant to

accept them. Knowing this, the team also comes with other offers and supports, including a care package for each child residing in the home to help build trust and rapport. The team might also offer supports like vouchers or money for a hotel if the home was the site of the violence or if retaliation is expected, groceries or diapers, and linkages to services for the health, mental health, food benefits, or employment of other family members.

Los Angeles Deputy City Attorney Lara Drino established the program after years of working as a prosecutor revealed the insidious cycle of trauma and violence: children witnessing trauma, struggling with its aftermath and generally not receiving the support they need to heal, and often continuing the cycle or suffering other negative outcomes later in life. She saw the chance for intervention that a tragic situation can create and built the REACH Team to fit perfectly into this window of opportunity.

Drino explained, "*I want the crisis counseling right there. Not a phone call, not a referral, (but) a person. A person that holds that family's hand, a person that works with that kid right when it happened.*"

The REACH Team is both secondary and tertiary prevention, as it addresses both the immediate aftermath when violence has already occurred (tertiary prevention) and also works to mitigate the risk factors of future violence in those who were exposed (secondary prevention). It is a strategy that also promotes healing and resilience, as it links individuals and families to services for long-term recovery.

The REACH Team thrives due to their dedicated staff and connections within the community. The team is alerted to incidents through a partnership with the Community Safety Partnership (CSP), a bureau of the Los Angeles Police Department that focuses more on building community relationships and offering support than on citing or detaining community members. Families are referred to local services through the team's rich network of community organizations. Collaboration is the key ingredient in the REACH Team's work.

Key Features: collaboration, trauma-informed approach, flexible funding, wraparound supports

As with all prevention strategies, the earlier an intervention happens within the cycle of violence, the larger its potential impact. However, there is also vital need for tertiary prevention and recovery strategies that intervene later in the cycle.

Strategies Promoting Recovery and Resilience

Another opportune place to intervene in the cycle is after violence has occurred. Those who are directly or indirectly harmed by violence are at higher risk for continuing health and mental health challenges if their trauma is not addressed. The necessary ingredients for healing this trauma vary by person, but one of the most evidence-based factors for healing is community. The Rebels Project was built on this understanding, and it's been helping people heal from mass violence for over a decade.

PROMISING STRATEGY #4

The Rebels Project: Long-Term Trauma and the Healing Power of Community

Healing and Recovery

The Rebels Project was formed by Columbine survivors who banded together to provide outreach and support to survivors of the 2012 Aurora, CO movie theater shooting. Having experienced their own traumatic and life-altering mass shooting, they knew that survivors would need a level of support that would not be offered to them through official channels.

Missy Mendo, one of the founders of the Rebels Project, noted that with the high rates of death in the survivor community, she's been to more funerals than birthday parties. Survivors of mass violence are at a far greater risk of premature death than the general population – many of them due to suicide.

Mendo described peer support programs as "astronomically helpful." She referred to the cartoon Care Bears as a metaphor for survivors meeting one another, with their hearts "lighting up" as they connect.

Peer support is absolutely vital for survivors to heal, but peer support alone is not enough. It takes an entire community to help survivors heal and build resilience for long-term wellbeing. Mendo noted that survivors need flexible support for their mental health, not just mental health services; the Rebels Project tries to offer alternative supports, such as money for groceries so they can afford mental health treatment, a creative outlet for self-expression, a pen pal program,

or funding for acupuncture or massage therapy. Healing doesn't happen entirely in a therapist's office; for many, that's only one part of the journey.

Support also needs to be long-term. Most resources for survivors of mass violence are only offered for the first 6 to 12 months. Both Mendo and Clare Senchyna, a member of a similar group of survivors and advocates – Everytown Survivors – noted that experiencing violence or loss has ripple effects throughout a person's life. They have continuing needs, sometimes for years or decades. Approaches that operate in the long term like the Rebels Project are necessary to provide that continuing support and help survivors heal, recover, and hopefully thrive.

Key Features: community-driven, peer support, wraparound supports, long-term support

The overlap between firearm violence and mental health is nuanced, but it's clear that the cycle of trauma and violence is entrenched in California's people and communities, particularly those who are already disadvantaged. Addressing firearm-related harms to California's physical, mental, and behavioral health requires an understanding of the complexity of this relationship in order to create strategies that intervene effectively in the cycle. Fortunately, there are many such strategies that work to effectively intervene, including those that aim to break the cycle in its early stages and those that focus on recovery and resilience after violence occurs. Prioritizing these strategies will likely have the biggest return on investment for bolstering Californian's mental health and wellbeing in the face of firearm violence, and with a relatively small investment compared to the larger and more sweeping reforms to address the poverty, structural inequality, and unmet needs that are also fueling the cycle.[219,220] However, making forward-thinking investments like these has been difficult to do in the current political and cultural climate of divisiveness and tension.

Finding 2: California faces challenges for effective firearm violence prevention stemming from misconceptions, cultural tensions, and fear.

Firearm violence is a hot topic, but one that is not well understood. Myths and misconceptions abound, most notably about the "who," "where," and "why" of firearm violence.[221] It is often considered something that mainly affects specific groups of nefarious people, or something that is limited to specific depleted communities or blighted neighborhoods, which results in firearm violence being considered a niche problem that can be avoided by avoiding those groups or those locations. But the reality is that – while firearm violence does impact some groups more than others – it happens everywhere across the state, to a wide swath of individuals, and for many different reasons.

Some of the most common and damaging myths include:

1. A common myth is that the **majority of firearm violence is urban,** occurring in city centers; while urban areas have a high share of injuries and many deaths, the reality is that firearm deaths occur more often in rural areas in the U.S.[222] This is true in California as well; in fact, the data show that the highest rates of firearm injury and death in California over the last five years are found in Alpine, San Joaquin, Kern, Lake, Solano, and Lassen counties – nearly all rural or suburban counties.[223]

> *"… the risk of gun suicides in the most rural U.S. counties exceeds the risk of gun homicides in the most urban U.S. counties." – Reeping et al., 2023*[224]

2. That leads to another common misconception, that **firearm homicides drive the firearm mortality rates**; however, suicides by firearm are slightly more common than homicides by firearm, both in the United States overall and in California.[225,226] Older people are the group with the highest risk for firearm suicide (particularly those who identify as male), although veterans and people who identify as American Indian or Alaska Native are also at higher risk than the general population.[227]

3. A third misconception is that firearm violence is **mainly a mental health problem**. As noted earlier, mental health has an important role to play, but it is still only one piece of the puzzle.[228] Expanding and improving access to mental health care will likely have a positive effect on violence (and other negative outcomes), but there is no evidence that it will solve all or even a majority of cases.

> *"After mass shootings, we frequently hear that mental health treatment is paramount. [...] But as Elliot [Rodger]'s case makes evident, conventional therapy and counseling are no magic solution when it comes to detecting and preventing planned violence."*[229] *– Mark Follman, investigative journalist*

4. Finally, a particularly pernicious myth about firearm violence is that **effective solutions are limited to firearm access policies**; however, access policies alone miss some of the key considerations of violence prevention, including the immense value of primary prevention, the role of trauma and unmet needs in violence, and the reality of easy access to firearms from other states or alternative sources.[230]

These myths and misconceptions feed into a highly politicized perspective on firearm violence that not only hampers understanding, but also acts as a barrier for even discussing effective prevention.

Taking misconceptions like these into account, the need is clear for a reframing of the conversation around firearm violence. A conversation that is focused only on preventing assault and homicide will lack the nuance that comes from understanding the many different experiences that lead to the use of a firearm to cause harm – to oneself, to others, or both. Additionally, the reality that behavioral health is only one piece of a larger, more comprehensive solution means that an approach of simply increasing referrals for psychiatric prescriptions and therapy may help, but it will not solve the broader problem of firearm violence. Approaches must be comprehensive to

achieve maximum impact, but most importantly, they must be understood and embraced by the communities they affect – particularly members of the firearm-owning community.

Ownership, Safety, and Access

Compared to countries with similar democratic systems of government and high average income, the United States is an outlier in its people's unique relationship with firearms.[231] With significant links between access to firearms and incidence of violence by firearms,[232,233] it's tempting to assume that simply reducing access to firearms will solve the problem of firearm violence. For some Californians, the answer seems clear: to double down on restricting access to firearms.

Indeed, California has been a leader in firearm violence reduction, transforming from a state with one of the highest rates of gun violence to a state with one of the lowest in the past 30 years,[234] and California's leadership in adopting new firearm access legislation is largely responsible for these transformations.[235,236] Just as there is a logical understanding that owning a car increases the likelihood of causing a driving accident, there is no denying that owning or having access to a firearm increases the likelihood of a person being involved in firearm violence.[237] Firearm access significantly escalates the likelihood of violence in circumstances with existing risk factors.[238] A male partner with elevated risk for violence who has access to a firearm is 10 times more likely to kill their female partner than those without access to a firearm.[239] Strong data suggest that legislative mandates barring perpetrators from gun ownership offer crucial protection for domestic violence survivors.[240]

In a context of funding scarcity, maintaining these targeted mandates that protect those at the highest risk of being harmed by or involved in violence is necessary to prevent immediate violence and save lives.

Yet, the reality is that most people who own a firearm will never use it to perpetrate violence.[241] In addition, imposing any new restrictions or mandates related to firearms is a contentious subject. While limiting access may seem like a straightforward solution to the high rates of firearm deaths in the United States, it's a complicated strategy for three reasons:

1. For many people in the United States, firearms play an important cultural role as a way to bond and build community, grow and learn, feed their families, and defend and protect. Removing firearms and hampering the positive ways they can impact a community could result in significant negative effects.

2. Making policies limiting firearm access does not solve the problem of all firearm violence, as even countries with far stricter access policies still experience firearm injuries and deaths.[242] (It should also be noted that although similar countries with more restrictive firearm laws and fewer firearms per capita experience far fewer firearm deaths, they have been experiencing an increase in knife-related homicides over the last decade that is reminiscent of the United States' increase in firearm homicides.[243,244])
3. Firearm access limitations don't address the higher rates of violent crime in the United States, regardless of the weapon used.[245]

While policies that aim to limit access can be effective – and many of them are already implemented in California[246] – there are certain considerations that must be weighed before implementation: 1) they must be constitutional, 2) they must appropriately serve the populations that are most impacted by firearm violence, and 3) they must be implemented according to plan. This has proven difficult to do.

Resistance to access limitations is often viewed as political, but it is not necessarily due to partisan beliefs.[247] The vast majority of voices in the firearm debate want the same thing: to see reductions in firearm violence.

The conflict is not from differing goals, but from disagreement over the effectiveness of specific gun policies.[248]

Responsible Firearm Ownership and the Importance of Context

The Commission visited Lassen County in November 2023 to tour the local gunsmithing program and hear from residents in a town hall-style engagement. Community members shared their insights on the culture of safety, recreation, and utility related to firearms. They were strong in their perspective on firearms as primarily tools rather than weapons. Residents believe the real cause of firearm violence is not the firearm itself, but that which leads up to the use of a firearm as a weapon: things like economic insecurity, feeling lost and left behind, a diminished sense of community, ineffective or insufficient coping mechanisms, and a dearth of mental health services and supports in the area.

These are all things community members are struggling with in Lassen County. Economic insecurity has amplified in recent years after the deactivation of Susanville's California

Correctional Center in June 2023, a closure which left many local residents in the small rural town without jobs. Representatives from a local mental health organization reported that they could no longer provide services to youth free of charge due to budget concerns, which echoed residents' concerns about the availability of mental health services. As one resident noted, in a place with little hope and high firearm ownership, it's not surprising that firearm suicide is high – but the hopelessness cannot be blamed on firearm ownership rates.

Although it's tempting for some lawmakers and advocates to focus on restricting access to firearms as the major tactic for reducing firearm violence, engagements like these point to the reality that it is an insufficient strategy on its own. Furthermore, restriction strategies that are not well-designed can even inhibit or impede upon some of the benefits of firearm usage, such as youth development and teaching personal responsibility.

Dissatisfaction over firearm access policies has been bubbling in some firearm-focused communities.[249,250] Law-abiding firearm owners often feel targeted in firearm violence prevention efforts, through stricter rules, more sweeping mandates, and specific firearm bans, many of which firearm owners find frustratingly out of touch with the realities of firearm ownership.[251] Tensions around firearm owners – particularly between firearm owners and firearm violence prevention advocates – have created barriers for effective prevention.[252] Often, the conversation derails into group-based confrontation, and this adversarial atmosphere takes away from a little known truth: that most firearm owners actually agree on many firearm safety policies.[253,254] Even with disagreement over specific strategies, there has been significant agreement – along with some compromises, presumably – in the form of federal policies pertaining to prohibitions against firearm ownership for certain domestic violence or mental health issues, background checks before purchase, minimum age requirements, mandatory waiting periods, and more.[255] These restrictions have been effective in barring the purchase of firearms by those who may use them to do harm. However, once the firearms have been purchased, much of the responsibility for continued safety has rested in the voluntary actions of firearm owners, relying on them to choose safe storage and transport options.

Unfortunately, with recent spikes in firearm ownership rates, there have not been accompanying increases in firearm safety habits.[256]

Californians purchased just over 800,000 firearms in 2019, a number which leapt to 1.25 million in 2020 amidst COVID-19 pandemic-era fears and unrest over rioting.[257] Results from the 2020 California Safety and Wellbeing Survey show that 110,000 California adults reported acquiring

firearms in response to the COVID-19 pandemic that year, and 43% of them were first-time buyers.[258] Along with increases in firearm sales, unsafe storage practices increased; of those surveyed, 18% stored at least one firearm in the least safe way – loaded and unlocked.[259]

As firearm ownership has risen, so have firearm deaths – both homicide and suicide.[260] This relationship is not incidental; the presence of a firearm in a home drastically increases the likelihood of a person within that home dying from a gunshot wound.[261,262] Furthermore, living in a home with a firearm – particularly one that is stored unsafely – greatly increases the risk of suicide by firearm.[263] While the vast majority of firearms in the U.S. are never used to cause harm,[264] the increase in availability of such an effective tool for causing bodily harm necessitates renewed efforts in promoting awareness about precautions and strategies for safety, particularly for new firearm owners. To promote awareness in an effective, culturally competent way, California needs a new, community-driven strategy for firearm violence prevention.

Taking the common misconceptions and tensions around firearm violence into account, the need is clear for a reframing of the conversation.

California has some of the strongest firearm access laws in the nation, and the relatively low rates of firearm injury and death point to the overall success of these efforts. However, it remains a significant and controversial issue affecting Californians, and it will require an updated understanding to address.

A conversation that is focused only on preventing assault and homicide will lack the nuance that comes from understanding the many different experiences that lead to the use of a firearm to cause harm – to oneself, to others, or both. Additionally, the reality that mental health is only one piece of the larger puzzle means that an approach of simply increasing referrals for psychiatric prescriptions and therapy may help, but it will not solve the firearm violence problem on its own. Importantly, efforts that focus on limiting access alone will be controversial, difficult to implement, and will likely have limited success.

Solutions must have the buy-in of the communities they will affect. This will require engagement and collaboration from across the broad range of beliefs and backgrounds that exist in California, leveraging the lived experience of California's communities to collectively problem-solve.

"If we're serious about creating change, we must uplift and support community-led programs that take a holistic approach to reducing gun violence. That's the best way to save more lives." – Josiah Bates, author and TIME magazine reporter[265]

Opportunity: Implementing a Whole-Community Approach

Violence happens within the context of communities, and that is where the solutions also exist. This is especially true for firearm violence, which manifests in disparate ways in different communities, meaning that there is truly no "one-size-fits-all" approach; instead, firearm violence requires a whole-community approach.

A whole-community approach is one that is led by the community. It leverages the strengths of the entire community to solve problems, rather than delegating responsibility to one group (often law enforcement or criminal justice in the case of firearm violence).[266] Solving community problems requires intentional investment throughout the community and, most importantly, from community members themselves. Designing these solutions can be achieved through methods like participatory action research, which brings experts, changemakers, and community members together to create the most promising strategies for that particular community.[267]

The whole-community approach to firearm violence combines community-driven strategies, education and awareness strategies, empowerment strategies, and place-based strategies enacted in the physical space where they hope to foster change. This comprehensive approach surrounds the problem from all sides and engages and empowers those who have the most at stake.

Community-Driven Strategies

To create strategies that are thoughtful, effective, and embraced by the community, they must be designed with meaningful engagement from those they are intended to impact. Community voice is vital in building public trust and reducing tension and aggression. When people feel connected to and embraced and supported by their community, the risk of firearm violence is reduced.[268,269]

In the case of firearm violence, this means the involvement of the firearm-owning communities, rural communities where firearm suicide rates are high, neighborhoods with the highest rates of

firearm assault and homicide, community-based organizations serving these groups, first responders, behavioral health professionals who treat those exposed to firearm violence, law enforcement, gun shop and gun range owners and operators, and more. The voices of these groups are indispensable for designing solutions that work, because they will be the ones most impacted by those solutions.

In a promising strategy that succeeds in largely rural areas across the country, youth and firearms are brought together with positive youth development and community-building in mind.

PROMISING STRATEGY #5

4-H Shooting Sports: The Positive Youth Development Model

Primary Prevention

After a difficult intrastate move, a teen found herself struggling to adjust, and began turning toward questionable peer groups and self-destructive behavior. When her mother noticed the normally happy and scholastically minded youth starting to change, she intervened by giving her daughter a choice: she had to select an extracurricular activity that she could use to focus her time and energy. The youth chose the 4-H shooting sports. Within a few months, things were turning around; she found community, built relationships with other teens in the program, and discovered that she not only enjoyed practicing marksmanship – she was good at it. After her positive experiences with the program, she improved her grades and found balance, much to her mother's relief. She is now one of the most promising 4-H shooting sports youth in the country.

This story is familiar to youth in the 4-H shooting sports, as many of them found similar benefits from participating. Focus groups conducted with the teens revealed that, while youth enjoy practicing with firearms, it's about much more than having fun: it's about sharpening their focus, building mastery, improving their discipline and self-control, and enhancing their communication skills with peers and adults alike.

The 4-H shooting sports offers a time-tested firearms safety and marksmanship curriculum to youth, delivered from trusted adults in a safe setting with peers. Although the 4-H shooting sports program mixes teens – an age group with one of the highest firearm violence rates – with firearms, there has never been a single death throughout the decades that the program has been active, and they boast a drastically lower injury rate than any

other 4-H program.[270] But the 4-H shooting sports program does more than keep kids safe around firearms; they use firearms as a tool to teach discipline, focus, self-control, self-confidence, responsibility, and leadership.

This strategy is promising because it is driven by the community, it involves peer support and mentorship from trusted adults, and it encourages self-development and skill-building along with safety and responsibility.

Key Features: peer support, community-driven, mentorship

Often, firearm owners are confused and frustrated by legislation related to firearm access that was not created by or in consultation with people who actually use firearms.[271] Including this population in the development of solutions is absolutely critical for the success of those solutions.

A promising example of the involvement of firearm owners can be seen in gun ranges within California.

PROMISING STRATEGY #6

Voluntary Firearm Storage in Times of Crisis: Suicide Prevention at the Gun Range

Secondary Prevention

Unsurprisingly, firearm owners are the group at highest risk for firearm suicide.[272] This means that any strategies implemented to reduce firearm suicide need to be understood and embraced by firearm owners to be effective. According to firearm owners, many of the policies sponsored by lawmakers are not designed with the reality of firearm ownership in mind.

One strategy that is not only designed with firearm ownership in mind, but truly championed by firearm owners across the country, is voluntary firearm storage in times of crisis. Danielle Jaymes, operator of the Sacramento Gun Range in Sacramento, CA, and the Poway Weapons and Gear Range in Poway, CA, has instituted one such program at these gun ranges. Jaymes gave an overview the firearm storage program during the Commission's site visit in May 2023, highlighting the customer-centered program.

If someone who owns a firearm (or someone else who may have access to their firearm(s)) is experiencing a mental health crisis, they can bring any number of firearms into the gun range for temporary safe storage, all for a fixed cost that is substantially lower than the usual per-firearm rate for storage. Jaymes says the range takes a voluntary loss on this program, because it's not about the money – it's about helping people stay safe, while also respecting their fundamental rights as Americans.

Firearm owners may be hesitant about access policies that they see as slippery slopes to losing their gun rights,[273] but they are open to strategies that respect their beliefs and are designed with their needs and values in mind.[274] Firearm owners and Second Amendment advocates promote temporary safe storage outside the home in times of crisis, as long as it's voluntary and reversible once the crisis has passed.[275,276]

However, these strategies must respect the privacy of firearm owners, or they will not be utilized. Any policy that requires reporting of the voluntary safe storage to authorities will be met with mistrust, and often the firearm owner will opt not to use the program. Currently, dealers with a federal firearm license (FFLs) in California are required to report the voluntary storage of firearms to the Department of Justice under such a temporary storage program, which Jaymes says has curtailed use of the program with her customers. Changing the regulations to remove the need for FFLs to report temporary storage under the crisis exception to the DOJ would likely improve the confidence of firearm owners in using these programs.

Key Features: high-risk individuals, education, empowerment, community-driven, voluntary

To create and implement a comprehensive, impactful strategy to address firearm violence, it is absolutely vital to build it with the meaningful community engagement with the groups most impacted by violence and by the efforts to address it.

Education and Awareness Strategies

To get buy-in from community members on firearm violence prevention strategies, the community needs to first possess a good understanding of the problem of firearm violence. With the common

misconceptions and myths on the subject mentioned earlier, a good place to start is in promoting awareness and education, correcting myths, and building a better foundation of understanding.

This can start with education and awareness campaigns on the reality of firearm violence, correcting common myths and misconceptions. It also looks like education on the warning signs of impending firearm violence (both assault and self-harm) and who to contact if these warning signs are spotted. It also includes education on lethal means safety, providing resources on how to reduce and mitigate risks when someone in a firearm-owning household is in crisis.[277]

Other promising education and awareness strategies include normalizing the discussion of firearm safety as a normal part of health and mental health care.

PROMISING STRATEGY #7

Medicaid Funding for Firearm Counseling: A Practical and Empowering Approach

Secondary Prevention

In 2024, the Biden administration released guidance allowing providers to bill Medicaid (Medi-Cal in California) when they counseled their patients who have children and firearms in their home on the topic of firearm safety. This was a departure from current norms, in which firearms are rarely mentioned in a health care facility unless the patient is brought in with gunshot wounds. It's also a practical strategy, grounded in the public health approach of educating the public, and treating violence as a preventable outcome.

This strategy is promising and also paves the way for the reframing of firearm violence that must happen in order effectively address the problem. It chips away at the stigma of discussing firearms in everyday settings, normalizing frank discussions that focus on outlining risks and mitigating actions that can be taken rather than the more controversial – and often heated – political arguments. It also emphasizes where the responsibility for firearm safety lies: with owners. Instead of questioning the right to own firearms, it encourages safety-minded practices with those who already own them. Rather than relying on access control and mandates, the strategy underscores awareness and education, which are far more likely to be embraced by a population that often feels unfairly burdened

with regulations that were not designed with the practicalities of firearm ownership in mind.

Finally, it also expands the boundaries of what is considered feasible in terms of funding for firearm violence prevention in that it pulls dollars from an unconventional source. When firearm violence is more broadly considered as the public health issue that it is, there will be more opportunities to leverage funding from a wider range of sources.

Key Features: education, empowerment, stigma reduction, leveraging other funding, public health approach

Education and awareness strategies must be designed in accessible and culturally appropriate ways if they are to be successful. There are several resources available to guide these discussions on things like safe and responsible firearm ownership (such as resources from the Bullet Points project on health care providers talking to their patients about their firearms)[278] and advocating for effective violence prevention strategies (such as this guide from the Berkeley Media Studies Group and the Hope and Heal Fund).[279]

They also need to make sense for firearm owners and address their key concerns. Another effective firearm owner-driven strategy comes from a trusted messenger in the firearm space: the National Shooting Sports Foundation.

PROMISING STRATEGY #8

Project ChildSafe: Restricting Access Through Responsible Firearm Storage

Primary Prevention

The National Shooting Sports Foundation (NSSF) is a leader in the firearm industry, sponsoring the largest annual firearm industry trade show and providing education and awareness on firearm-related topics.

In 1999, the NSSF launched Project ChildSafe, a program to promote safe and responsible firearm ownership. Project ChildSafe contributes to safety in many ways, including providing safety education for firearm owners, young adults, and children on how to safely

transport and store firearms. They also work with local law enforcement agencies nationwide to distribute free firearm safety kits to firearm owners across the U.S. – and have already distributed over 41 million in total. These safety kits can include lock boxes or cable locks (also called trigger locks), which run through the barrel or action of a firearm to prevent it from being fired by anyone who doesn't have the key or combination to unlock it.

This strategy's voluntary nature and focus on education and choice is what makes it so successful with firearm owners. Instead of a mandate, it provides information and options so the owner can make an informed and responsible decision on how to maintain safety while also respecting their original purpose for firearm ownership.

"With our collective voice, we are amplifying the following message to gun owners: 'Store firearms responsibly.'" – NSSF

Strategies like these engage the firearm-owning community and can foster trust and increase credibility instead of straining an already tense relationship between those who own firearms and the lawmakers that may not understand their culture. Further education and empowerment strategies can expand on this type of education and responsible ownership promotion to get the buy-in of firearm-owning communities.

Key Features: education, empowerment, voluntary

Education and awareness campaigns around firearm safety build the necessary understanding in those who have the most power to affect community safety: those who have access to firearms.

Empowerment Strategies

Education is a powerful tool for promoting positive change, and it pairs well with strategies that recognize and foster empowerment. Empowerment strategies build on education, emphasizing the agency of people over their own lives and wellbeing.

Empowerment strategies are key to firearm violence prevention. When implemented well, firearm owners feel respected. Empowerment strategies can also mobilize community members to take charge of their own safety and wellness. In areas with the greatest risk of firearm injury and death, they can be monumental in adding to community engagement and wellbeing.[280,281]

One such promising example of an empowerment strategy comes from Donna's Law, a law that originated in Washington State but has since spread to several other states.

Promising Strategy #9

Donna's Law: Safety Through Empowerment

Secondary Prevention

Donna's Law allows people who perceive themselves to be at risk for suicide to place their names on a voluntary "do not sell" list, suspending their ability to purchase a firearm. It was first passed in Washington State in 2019 and now exists in four states. At least 132 people have invoked the law for their own protection.

When a person who has placed their name on the "do not sell" list attempts to purchase a firearm, they are blocked from doing so and, in some states, friends or family (chosen by the individual) are alerted to the attempted purchase. This creates a branching point in the path that may be leading towards suicide, offering a chance for intervention and support.

The promise of this strategy lies in its person-centered approach and voluntary nature. It leaves control in the hands of those who are best suited to make decisions about their capacity: the individual. It's also reversible; individuals can take their own name off the list with a few straightforward steps.

This strategy has been used on a small scale so far and though it is not far-reaching from a population-level viewpoint, it has likely already saved lives. And, even more importantly, it exemplifies voluntary, person-centered approaches that are both effective and have garnered broad bipartisan support.

California is currently considering this as a legislative opportunity in the form of Senate Bill 320, which would create a voluntary "do not sell" list in the same vein as Donna's Law.

Key Features: high-risk individuals, person-centered, voluntary, empowerment

Strategies with bipartisan support are especially promising, as they provide examples of paths forward that both sides of the political aisle can agree on.

Place-Based Strategies

As mentioned earlier, the most up-to-date understanding of violence is that anyone has the potential for committing violent acts under specific circumstances. In addition to implementing person-based strategies to address individuals' needs, place-based strategies also work by addressing the conditions that lead to violence. These strategies operate within the immediate environment where violence tends to occur, changing the conditions to make violence a less likely occurrence.

These strategies are surprisingly effective at reducing violence and other crime [282,283] and are particularly valuable strategies because they can lead to a host of other positive downstream benefits. Such potential outcomes include: increasing social connectedness, boosting property values, and decreasing negative mental health symptoms in residents.[284]

PROMISING STRATEGY #10

Greening: Reducing Violence by Enhancing the Physical Environment

Primary Prevention

Greening is gaining traction as an effective violence prevention tool in governments across the nation. City neighborhoods with higher levels of firearm violence tend to lack green spaces, disproportionately affecting residents that identify as low-income and Black or Latino.[285] Greening is the remediation of vacant lots and the creation of green spaces in urban areas, including efforts like removal of trash and debris, grading the land, planting new grass and trees, installing low wooden perimeter fences, and maintaining newly treated lots.[286] Studies find that greening is significantly associated with decreases in firearm violence.[287,288,289]

While further studies are needed to better understand the relationship between greening and violence prevention, scholars find that green spaces mitigate many of the precipitating factors of gun violence, producing reduced stress, better mental health outcomes, and improved perceptions of public safety.[290,291] Green spaces are also believed to improve social cohesion in a neighborhood, and reduce violence through "busy streets"[292] or more foot traffic and opportunities for communities to monitor illicit activities and less

opportunities for perpetrators to hide these activities.[293] By modifying the physical and social environment, greening thus creates conditions for community-level protection.[294]

Greening is not just effective, it's also cost-effective. According to one study in Philadelphia, PA, greening vacant lots yielded significant savings for the criminal justice system: approximately $43,000 in savings per lot.[295] Taxpayer and social returns on investment for gun violence amounted to $26 and $333 for every dollar spent.[296]

Key Features: place-based

There are multiple barriers and challenges to implementing effective firearm violence prevention, and many of them stem from misunderstandings and tensions between community members, firearm violence prevention advocates, and lawmakers. Working together, California can implement a whole-community approach that builds awareness, educates, and empowers community members along the way. The best solutions are those with the understanding and buy-in from those they are intended to serve.

There are some community-driven strategies already in place, improving conditions in local pockets throughout the state. However, they need to be aligned and coordinated efficiently to maximize their impact.

Finding 3: California's public investments have not been coordinated effectively to address the underlying causes of violence and other public health concerns.

California's investment into its citizens' health, safety, and wellbeing outpaces that of most other states.[297] However, problems in public health and wellbeing persist, along with downstream

problems like violence, homelessness, substance use disorders, and prolonged suffering. These problems persist in part not because of a dearth of funding, but because the available funding has largely been designed and deployed one at a time to address the downstream problems one by one, rather than adopting a unified approach to addressing upstream factors, including poverty, inequality, and trauma.

Among California's current large public behavioral health funding initiatives, firearm violence (and violence in general) is largely absent. While these resources are made available for addressing some of the upstream drivers of violence, the missed opportunity is in offering them piecemeal instead of coordinating these funding sources into a comprehensive package of violence prevention services and supports that focuses on the real root causes of firearm violence.

Firearm Violence Prevention in California

Credit must be given where it is due: California has already established key instances of violence prevention leadership that offer key opportunities for more coordinated approaches. The California Department of Public Health's (CDPH) Injury and Violence Prevention (IVP) Branch leads epidemiological investigations and program implementation for a public health-oriented violence prevention approach.[298] CDPH launched the Violence Prevention Initiative in 2015 to reduce violence and create safer and healthier communities for all Californians, and they are looking at where opportunities exist to highlight public health, community-led strategies, that could reduce and prevent violence.[299] CDPH's Office of Suicide Prevention coordinates and aligns statewide suicide prevention efforts and resources.[300]

The California Department of Justice's (DOJ) Office of Gun Violence Prevention (OGVP) expanded a holistic approach to reducing gun violence, launched with its first Director and only staff member in May 2023.[301] The OVGP leverages collaboration across federal agencies, California state agencies, local government partners, and non-profit organizations through multiple channels, including data and research. As directed by AB 1252 (Wicks) enacted in 2024, the OGVP must leverage collaboration to produce a report identifying recommendations and priorities from across California's many communities. This report, due by July 1, 2026, must outline a strategic plan and recommendations for the legislature and other stakeholders to reduce gun violence. CDPH is a key data provider for OGVP publications, and both agencies regularly exchange information and resources.

The OGVP also coordinates prevention efforts with a variety of California offices. The OVGP and CPDH hold regular meetings to identify opportunities for synergy that could support violence prevention efforts in California. Multiple California DOJ teams meet regularly and collaborate closely with the Judicial Council of California to implement protection orders for survivors and targets of gun violence, involving joint policy recommendations to the Legislature and training court staff and law enforcement agencies. Legislative mandates also require coordination in grant-making and development, including the California Violence the Intervention and Prevention (CalVIP) Grant, requiring close collaboration between the OGVP and the Board for State and Community Corrections (BSCC).

These are all promising steps towards designing and deploying a firearm violence prevention strategy that will require a multidisciplinary, multisystem, public health approach.

Opportunity: Advancing a Comprehensive Public Health Approach to Firearm Violence

The public health approach is the most effective tool that exists for addressing large-scale health problems. This approach has been applied to tackle broad social issues that once seemed insurmountable – such as the high rates of death from car crashes and tobacco use through the middle of the 20th century – and has led to significant declines in injuries and death.[302,303] The public health approach aims to enhance the health and wellbeing of entire populations, employing both universal strategies for all as well as targeted strategies for closing the disparities gap in underserved and vulnerable populations.[304]

> *"Gun violence is a public health problem. Not just in terms of the toll it takes on death and injury […] but also the impact on trauma and behavioral health of those that are immediately affected and the community that's affected by this trauma." – Rita Nguyen, Assistant Health Officer at the California Department of Public Health, October 26, 2023*

Tackling firearm violence from a public health approach aims to systematically address the contributing factors to firearm injury and death through a broad spectrum of interventions aimed at reducing and mitigating risk factors while building and enhancing protective factors at multiple levels (individual, community, and state).[305] The approach must address the true root causes, and

strategies must be implemented across systems rather than limited to the areas traditionally considered to have purview over violence (e.g., law enforcement and the justice system). Currently, most government systems have a separate violence prevention initiative or division – if they have any dedicated violence prevention program at all. Moreover, while there have been recent efforts to apply a public health approach to address firearm violence, they are often missing the key component of behavioral health.

To make transformational impacts to California's experience of firearm violence, violence prevention efforts must be prioritized and coordinated to tackle the real root causes of not only violence, but the same causes at the root of most of society's negative outcomes: poverty, inequality, limited social mobility, limited access to high-quality education, housing instability, unemployment, and trauma.[306,307,308,309,310,311,312]

"The [REACH Team] model is working, but we need funding across systems." – Lara Drino, Deputy City Attorney for the City of Los Angeles and Director of the REACH Team in south Los Angeles

Tackling such broad statewide (and nationwide) problems does not happen through narrow investments or in local pockets; effectively addressing such problems requires a coordinated, data-driven approach that aligns key partners into one cohesive front. This will require establishing leadership, building out the infrastructure, and expanding collaboration, coordination, and data capacity statewide.

Leadership and Coordination

The most important part of building a cohesive, upstream approach to addressing the shared risk factors of firearm violence and other negative outcomes is establishing leadership and coordinating efforts. As noted earlier, violence is a contextual problem that is influenced by a variety of factors spanning multiple domains of public and private life. Effective violence prevention must operate from a central hub, bringing together partners and coordinating resources in all of these areas to build and implement a holistic approach.

While most states are still operating on the assumption that violence is a law enforcement and justice system issue, there are some places where a coordinated approach is being implemented. One such example is the Building Blocks program in Washington, D.C.

PROMISING STRATEGY #11

Building Blocks, D.C.: Leadership and Coordination for Firearm Violence Prevention

Leadership

This is a whole-government, public health approach to firearm violence prevention that is person-centered and place-based, leveraging collaboration and coordination across the District of Columbia government to address firearm violence through a comprehensive approach that spans the prevention and intervention spectrum.

It started with research, using crime data to identify the 151 blocks in Washington D.C. with the most firearm violence. Next, Building Blocks, D.C. took a place-based approach by assessing environmental and infrastructure issues that could contribute to public safety threats in the community. They implemented a person-centered approach through identifying the individuals in the community who were at the highest risk of involvement with firearm violence and offering them education, mental health support, employment services, financial and legal support, along with – and this is perhaps the most impactful piece – fostering a sense of community and belonging.

In addition, community engagement is an important piece of Building Blocks, D.C.'s strategy, including:

- Awarding mini-grants to members of the community who take an active role in addressing firearm violence.
- Dispatching Safety Go Teams during holiday weekends and when large crowds are anticipated to provide support and implement de-escalation strategies when necessary.
- Facilitating 202forPeace, a District-wide firearm violence awareness campaign that brings together community leaders, youth, and agencies across the city.

The key factor in this strategy is the central leadership and coordination of efforts. The cross-government coalition was established to be a one-stop shop on firearm violence. It leverages resources and knowledge from law enforcement, public health, behavioral health, transportation, schools, public works, and other areas of government to build a multi-pronged

approach to providing services and supports to "reverse troubling trends, save lives, and better support residents and communities most impacted by gun violence."[313]

Key Features: leadership, research, coordination, collaboration, community engagement, person-centered approach, place-based

Data-Based Strategies

Like any public health approach, collecting the right data to help inform firearm violence prevention efforts is critical to 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions. National and state-level systems exist such as the National Violent Death Reporting System (NVDRS) and California's Department of Public Health Firearm Injury Dashboard. However, state-level surveillance is not as useful for tribal or county jurisdictions trying to act in their own communities. Additionally, data are at least two years old when published so they do little to inform violence response strategies.

Luckily, investing in State and local data infrastructure would greatly improve the collection of meaningful, timely data to guide action around both firearm homicide and suicide prevention.

PROMISING STRATEGY #12

Suicide Fatality Review Process: Using Suicide Data to Build Prevention Strategies

Secondary and Tertiary Prevention

Some counties are working to strengthen local suicide prevention initiatives through the use of the Suicide Risk Factor Surveillance System (SRFSS). The SRFSS is a nationally recognized suicide surveillance system that allows communities to track near real-time trends, determine who in the community is most at risk, and consider systemic changes that could potentially prevent future suicides.

The SFRSS involves a unique collaboration between various branches of county government, specifically the county medicolegal death investigators (MDIs), coroners, and epidemiologists. This system contains a Suicide Fatality Review (SFR) process, which

gathers information regarding the circumstances surrounding a suicide death to inform local suicide prevention activities. At the population-level, SRFSS facilitates detection of suicide clusters, trend identification, and robust prevention planning based on the fastest, most reliable, and granular data possible. Combining the information in SRFSS with the system-level interventions found in SFR, provides a county with highly actionable data for little financial effort that can demonstrably save lives. Strategies like this could be used statewide, with investment into building the data infrastructure, building collaborations, and technical assistance to guide implementation.

This strategy has been promoted as a promising practice through the State's Department of Public Health, Office of Suicide Prevention as part of their community of practice. Yet implementation has been slow as many counties do not have the necessary partnerships, infrastructure, or funding to support this system.

Key Features: timely data, evidence-based practices, collaboration, infrastructure

Another promising data strategy comes from the federal level, leveraging opportunities to collect valuable data from emergency departments across the country.

PROMISING STRATEGY #13

FASTER: Collecting Timely Firearm Injury and Mental Health Data

Tertiary Prevention

The availability and dissemination of timely information is a huge obstacle in effective firearm violence prevention.[314] Health official and policymaker access to timely, granular information was prohibited by a 1996 federal rule barring the CDC from using federal funds to advocate or promote gun control, stifling government research into firearms violence and prevention.[315] However, after a congressional compromise over the 1996 Dickey Amendment, the Center of Disease Control's (CDC) Division of Violence Prevention launched the Firearm Injury Surveillance Through Emergency Rooms (FASTER) Program in 2020 to support a national initiative to more speedily collect, analyze, and disseminate data on firearm violence-related emergency (ED) visits.[316,317] FASTER's provision of near real-time state- and local-level data supports jurisdictions in quickly responding to emerging and dynamic violence problems. The FASTER: Advancing Violence Epidemiology

in Real-Time (FASTER: AVERT) initiative expanded on FASTER in 2023, tracking firearm violence, other violence-related injuries, and mental health conditions.[318]

Employing a public health approach, FASTER: AVERT's data support both better violence prevention and the ability to identify, track, and address disparities in ED visits. Accurate surveillance methods are needed to define the problem's scope, while trends and disparities communicate information on risk and protective factors.[319] Currently, 11 state public health agencies and one research foundation are recipients of FASTER: AVERT grants, including in Arizona, District of Columbia, Georgia, Illinois, Kansas, Kentucky, Michigan, Mississippi, Oregon, Rhode Island, Utah, and Washington. In exchange for grants, participating health departments share detailed data, down to individual visits, with data becoming available within one to two days.[320]

AVERT has helped states streamline data collection and use that information for prevention. While in New Mexico, the data informed a statewide strategic plan to address gun violence, in Utah, health officials used FASTER to launch a tailored public service campaign.[321,322] In Oregon, the data guided legislation to provide funding for hospital- and community-based violence intervention programs. In Georgia, health officials developed a data dashboard to support violence intervention efforts down to the neighborhood level.[323] A key to the program's success is that it builds on existing federal-state partnerships to track infectious diseases and other public health threats – such as the Zika virus and the COVID-19 pandemic – an early warning system known as the National Syndromic Surveillance Program (NSSP).[324]

Because it relies on data already being collected by state and local health departments, AVERT can be rapidly implemented and scaled across the country.[325] AVERT also builds on, instead of duplicating CDC NSSP work, and ensures that state and local health departments are agents over the collection and use of the data, effectively leveraging their extensive local knowledge. AVERT also standardizes data sharing between the CDC and health departments.[326]

Key Features: timely data, evidence-based practices, infrastructure

Although California has some of the most upstream and innovative thinking around preventing violence and bolstering mental health, these efforts are often happening in silos. Establishing leadership and building the infrastructure necessary to align these investments and promote

collaboration, data collection and sharing, and coordination of resources will give rise to an approach that is more than the sum of its parts, creating an upward spiral of improved outcomes to combat the downward spiral of trauma and violence.

Recommendations

To address the overlapping problems of firearm violence and mental health, California must develop and implement an integrated, collaborative, and trauma-informed public health strategy for firearm violence prevention statewide. The Commission has identified three areas in which California can make an impact moving forward: prioritizing trauma intervention as a violence prevention strategy, public awareness and education, and coordinated state leadership.

Recommendation 1: California must establish trauma-informed violence prevention as a public behavioral health priority.

As California works to reduce the negative impact of trauma on health and wellbeing, it must incorporate violence prevention as a priority of public behavioral health funding and programming. Toward this goal, the State should consider the following actions:

- The California Department of Public Health (CDPH) should integrate violence prevention as part of its population behavioral health prevention strategy, acknowledging the intersection between firearm violence and mental and behavioral health.
- Firearm violence, and other types of violence, should be measured and monitored as a risk factor and outcome of mental/behavioral health and public health investments.
- The State should provide incentives and technical support to local behavioral health jurisdictions to promote implementation of strategies to intervene within the cycle of trauma and violence, to promote recovery and resilience, and to prevent future violence through person-centered approaches that prioritize Californians who are at greatest risk.

- California should establish statewide standards for behavioral health threat assessment management (BTAM) in school districts, workplaces, and other community settings to prevent and mitigate harm from firearm violence, drawing from the Department of Homeland Security's Center for Prevention Programs and Partnerships resources.[327]

Recommendation 2: California must deploy a public engagement and awareness initiative to regain trust and build relationships with firearm-owning communities and other communities impacted by violence.

To strengthen the scope and impact of firearm violence prevention strategies, the State must do more to build awareness, trust, and safety in communities most impacted by violence, including firearm owning communities. This may include the following actions:

- Develop and deploy a public awareness campaign on the intersection of firearm violence, trauma, and its effects on mental and behavioral health.
- Promote firearm safety and lethal means awareness throughout California, particularly in firearm-owning communities, to increase safe storage behaviors and reduce the likelihood of firearm injury and death.
- Prioritize the involvement of the firearm-owning community in any new policies or programs intended to address firearm violence.
- Empower community members to play a direct role in designing and implementing firearm violence prevention strategies.

- Implement place-based strategies that invest in and improve the physical and social environment of communities in a way that promotes safety and cohesion and reduces the likelihood of violence.

Recommendation 3: California must develop a unified statewide strategy, with an appointed leader to guide a public health approach to firearm violence prevention that integrates data, resources, and partners from across sectors.

- To implement an effective statewide public health strategy for firearm violence prevention, California needs a leadership structure to guide, coordinate, and oversee a continuum of primary, secondary, and tertiary prevention efforts at the state and local level, with attention on addressing shared root causes of violence while prioritizing services for Californians at greatest risk of targeted and community violence.[328] To this end, the State can take the following actions:
- Establish a cross-department home for coordinated firearm violence prevention, perhaps by expanding the current Office of Gun Violence Prevention under the California DOJ or by creating a firearm violence prevention home within CDPH.
- Offer technical assistance to counties, cities, and communities that want to implement firearm violence prevention strategies. This should include establishing a centralized resource hub to disseminate information on the most current evidence-based and community-defined evidence practices (CDEP) for firearm violence prevention strategies.

- Incentivize the piloting and scaling of innovative community-driven, cross sector approaches to address the root causes of firearm violence, helping at-risk Californians meet their basic physical and behavioral health needs.
- Invest in the infrastructure necessary to strengthen the use of data and collaboration in the prevention of firearm violence.

Conclusion

This report comes at a critical time, as firearm violence prevention hangs in the balance of looming federal cuts. There was a resurgence of a comprehensive public health approach to prioritize firearm violence prevention during the previous administration, involving landmark legislation, significant investments in programs, and data collection and dissemination. The current administration is promising to reverse course, including weakening legislation, halting funding, and withholding critical information needed to sustain momentum on firearm safety.[329] In the face of this uncertainty, now is the time for states to take initiative on preventing firearm violence. California can lead on prevention and save lives, improve messaging and education, and tackle the root causes of violence. The promising strategies outlined in this report offer a roadmap of what is possible to achieve transformational change.

Firearm violence is preventable, but not with the fragmented strategy that is currently in place. Effective prevention requires a comprehensive strategy that takes the environmental context and social determinants into consideration. It must be built off the most up-to-date understanding of how violence happens: in a cycle and within systems. Prevention requires intervening at opportune points in the cycle of trauma and violence to provide treatment and promote recovery for those already suffering and to prevent future negative health and mental health outcomes for those at risk. Preventing the harmful effects of firearm violence on mental health will require a mindset that prioritizes prevention, intervention, and recovery over retributive justice and access limitations.

The real, root causes of both violence and behavioral health challenges must be addressed: unmet needs, trauma, systemic disadvantage and oppression, and lack of resources and opportunity. There must be a more well-informed framework to guide how to think, plan, and act around violence prevention. Society's attention must be focused on meeting the needs of community members rather than relegating them to prisons and jails as a default response to violence. This work is not the purview of any one system alone, but of all systems and structures that affect the daily life of Californians.

The most effective way to implement such upstream preventive strategies is to use a public health framework. However, public health alone will not solve this problem – the approach must be integrated and comprehensive. Firearm violence is a community-wide problem that will require the

whole community's participation and collaboration to solve. It is also a problem heavily influenced by trauma, and this understanding should be baked into any strategy that has a hope of being effective.

*California must implement an **integrated, collaborative, and trauma-informed public health approach** to address firearm violence and the damage it causes to its people and communities.*

Firearm violence is preventable, as are the negative physical and mental health outcomes associated with it. With dedicated investment from across the state, the harmful ripple effects of firearm violence can be interrupted and California's communities can heal and thrive.

Appendix 1: IFV Project Timeline

In its policy projects, the Commission seeks to build on the knowledge of experts, including researchers, policymakers, data scientists, and, crucially, those with lived experience of the topic.

- May 2022 – Commission designated a project to examine the impacts of firearm violence
- September 2022 – First Subcommittee meeting
- November 2022 – Site visit to the REACH Team in Los Angeles, CA
- January 2023 – Second Subcommittee meeting
- May 2023 – Site visit to the Sacramento Gun Range in Rancho Cordova, CA
- May 2023 – Site visit to the Los Angeles Police Department's Southeast Division in Watts, CA
- May 2023 – Commission hearing on the cycle of trauma and violence in Los Angeles, CA
- May 2023 – First engagement with the Los Angeles Department of Mental Health's Psychological Services Development Committee; virtual
- July 2023 – Second engagement with the Los Angeles Department of Mental Health's Psychological Services Development Committee in Los Angeles, CA
- August 2023 – Site visit to the 4-H Shootings Sports Teen Leadership Institute and focus groups with youth ambassadors in Alamo, NV
- August 2023 – Listening session with incarcerated youth at the Sacramento Youth Detention Facility in Sacramento, CA
- October 2023 – Commission hearing on the public health approach to firearm violence prevention in San Francisco, CA
- November 2023 – Town hall-style event and site visit to the Gunsmithing Program at Lassen Community College in Susanville, CA
- September 2024 – Engagements with communities in Lassen and Los Angeles counties to review findings and recommendations; virtual
- March 2025 – Final report review with external partners; virtual
- *April 2025 – Report slated to be presented to the Commission for adoption*

Appendix 2: IFV Project Methodology

Key Informant Interviews

Interviews with key informants established the foundation of knowledge in the early phase of the project and continued throughout the project's entirety. These interviews allowed Commission staff to gather rich, open-ended information from experts, providing guidance on the direction of the project and outlining new avenues to explore.

The interviews were mainly held over Teams or Zoom video chats in 30- to 60-minute sessions, although interviews were conducted in person when feasible. Over 100 experts were interviewed during the course of this project. Some key informants provided written testimonials in addition to the interviews and other engagement.

Key informants interviewed represented a wide swath of those with lived experience and expertise. They are listed below.

- Firearm owners and other representatives from the firearm-owning community, including:
    - Claybreakers trap shooting club in Lassen County, CA
    - Hold My Guns, an organization dedicated to temporary safe storage
    - Lassen Community College Gunsmithing Program in Susanville, CA
    - National Shooting Sports Foundation
    - Sacramento Gun Range in Rancho Cordova, CA

  - State 4-H shooting sports coordinators
  - The Gun Range in North Highlands, CA
- Suicide prevention specialists, including:
  - Stan Collins, Youth Creating Change, San Deigo County Suicide Prevention Council
  - Striving for Zero Suicide Prevention County Learning Collaborative
- Community violence intervention specialists from:
  - Advance Peace
  - City of Richmond's Office of Neighborhood Safety
  - Homeboy Industries
  - Hope and Heal Fund
  - National Compadres Network
  - Youth ALIVE!
- People with lived experience perpetrating firearm violence
- Firearm violence loss survivors, including mass shooting survivors:
  - Rebels Project
  - Moms Demand Action
  - Everytown Survivors
- Experts on firearm policy
- Schools and school districts, including:
  - Hemet Unified School District
  - Sacramento County Office of Education
- Behavioral Threat Assessment experts, including:
  - Gene Deisinger, Ph.D.
  - Joseph Holifield, Ph.D.
  - Melissa Reeves, Ph.D., NCSP, LPC
- California county departments and agencies, including:
  - Lassen County Health and Social Services
  - Los Angeles City Attorney's Office
  - Los Angeles Department of Mental Health (LA DMH)
  - Orange County's Health Care Agency
  - Sacramento County Probation Department
  - San Mateo County Health
  - School Threat Assessment Response Team (START) at LA DMH
- Researchers and research groups focused on firearm violence and safety, including:
  - American Foundation for Firearm Injury Reduction in Medicine (AFFIRM)
  - Brown University Center for Digital Health

  - BulletPoints Project
  - Center for Neighborhood Engaged Research & Science (CORNERS)
  - Indiana University School of Medicine
  - Injury and Violence Prevention Center at the University of Colorado
  - Institute for Firearm Injury Prevention at the University of Michigan
  - New Jersey Gun Violence Research Center
  - Regional Gun Violence Research Consortium at the Rockefeller Institute of Government
  - Research Society for the Prevention of Firearm-Related Harms
  - Violence Prevention Research Program at the University of California, Davis
  - University of Pennsylvania Injury Science Center
- Law enforcement, including:
  - Center for Mass Violence Response Studies at the National Policing Institute
  - Lassen County Sheriff's Department
  - Los Angeles Police Department's (LAPD) Community Safety Partnership Bureau
  - LAPD Southeast Community Division in Watts
  - Sacramento Police Department's Chief of Police
  - Sacramento Police Department's Employee Services Unit
  - San Mateo Sheriff's Department
- Community-based organizations
  - ACE (Adverse Childhood Experience) Resource Network
  - Alliance for Community Transformations in Mariposa County, CA
  - California Chaplains Corp
  - Center for a Non Violent Community in Sonora, CA
  - Children's Institute in Los Angeles, CA
  - Empowerment Initiative
  - Greater Santa Barbara Hispanic Chamber of Commerce
  - HOPE (Help Our People Eat) in Sacramento, CA
  - One Community Action in Santa Maria, CA
  - Ventura County Family Justice Center in Ventura, CA
- Business working within the space of firearm violence prevention and recovery, including:
  - Cloud 9 Health
- Partners from California State agencies, including:
  - California Department of Public Health
  - California Office of Gun Violence Prevention
  - California Attorney General's Office
  - California Victims Compensation Board

- Partners from other regions and national agencies, including:
  - Building Blocks, D.C.
  - Department of Homeland Security's Center for Prevention Programs and Partnerships
  - Department of Veterans Affairs
- Other large organizational partners, including:
  - Association of State and Territorial Health Officials
  - California Association of School Psychologists
  - Prevention Institute
  - Public Policy Institute of California
  - California Institute for Behavioral Health Solutions
- Filmmakers working on firearm violence prevention, including:
  - GLOW Media
  - Bonafina Films

Subcommittee Meetings

The Commission hosted two subcommittee meetings on the Impacts of Firearm Violence project to explore relevant data, gather expert and public feedback, and dive deeper into particular topic areas within firearm violence. Both meetings were hybrid, with in-person and Zoom options.

The two subcommittee meetings were:

- Project Scope and Relevant Data: Online, September 2022
  - Guest speakers included:
    - Renay Bradley, Ph.D., Chief of the Epidemiology and Surveillance Section within the Injury and Violence Prevention Branch (IVPB) of the California Department of Public Health (CDPH)
    - Julie Cross Riedel, M.P.H., Ph.D., Research Scientist in the Epidemiology and Surveillance Section within the IVPB
- Behavioral Threat Assessment and Management in Schools, January 2023
  - Guest speakers and panelists included:
    - Melissa Reeves, Ph.D., NCSP, LPC, nationally renowned expert in Behavioral Threat Assessment and Management (BTAM)
    - Michele Custer, Licensed Educational Psychologist and Chair of the California Association of School Psychologists (CASP)

- Jayce Kaldunski, senior at El Dorado High School, Student Leader, and Peer Advisor
- Jerry Wernli, Roseville Police Department Officer and School Resource Officer at West Park High School

Hearings

The Commission held two public hearings on the Impacts of Firearm Violence project during Commission meetings. Both hearings featured a panel of experts who presented on different facets of firearm violence, its underpinnings, and prevention and recovery.

The two hearings were:

- The Cycle of Trauma and Violence; Los Angeles, CA (May 2023)
  - Panelists included:
    - J. Kevin Cameron, M.Sc., R.S.W., B.C.E.T.S., B.C.S.C.R., Executive Director at the Center for Trauma-Informed Practices
    - Jose Osuna, Director of External Affairs and Manager at Housing Justice and Brilliant Corners
    - Refujio "Cuco" Rodriguez, M.Ed., Chief Strategist and Equity Officer at the Hope and Heal Fund
    - Dr. Sarah Metz, Psy.D., Division Director at the University of California, San Francisco Trauma Recovery Center
    - Lara Drino, J.D., Deputy City Attorney for the City of Los Angeles and Director of the REACH Team in south Los Angeles
- Firearm Violence Prevention from a Public Health Approach; San Francisco, CA (October 2023)
  - Panelists included:
    - Dr. Richard Espinoza, Psy.D., Clinical Psychologist and Professor at Pepperdine University
    - Dr. Nicole Kravitz-Wirtz, Ph.D., M.P.H., Associate Professor at University of California, Davis
    - Sam Vaughn, Deputy Director in Richmond's Office of Neighborhood Safety
    - Janiesha Grisham, Violence Prevention Educator with Oakland's Youth ALIVE!
    - Dr. Rita Nguyen, M.D., Assistant Health Director in the California Department of Public Health

- Ari Freilich, J.D., Director of California's Office of Gun Violence Prevention

Site Visits

Site visits provided insight into specific communities, populations, and programming. The Commission conducted four site visits on the Impacts of Firearm Violence project, including:

- Two site visits to the REACH Team, community partners, and the Los Angeles Police Department's Southeast Division; Watts, CA (November 2022 and May 2023)
    - Community partners included:
        - Operation Progress
        - Sisters of Watts
        - Strive
        - Watts Empowerment Center
        - Uplift Sports and Mental Health
        - Nick's Kids
- Site visit to the Sacramento Gun Range; Sacramento, CA (May 2023)
    - Partners included:
        - Danielle Jaymes, range operator
        - Stan Collins, lethal means safety and suicide prevention expert
        - Bill Romanelli, former spokesperson for the National Shooting Sports Foundation
        - Cora Schager, firearm safety instructor
- Site visit to the 4-H Shootings Sports Teen Leadership Institute; Alamo, NV (August 2023)
    - Partners included:
        - State 4-H shooting sports coordinators

Listening Sessions

The Commission conducted several listening sessions, focus groups, and town hall-style events to gather feedback from people who are impacted by firearm violence, people with expertise and lived experience with firearms, law enforcement, and mental health service providers.

The listening sessions included:

- Two listening sessions with the Los Angeles Psychological Services Development Committee to hear mental health service provider perspectives on firearm violence; Los Angeles, CA and online (May and July 2023)
    - Participants included:
        - Dozens of mental health service providers employed with Los Angeles Department of Mental Health
- Focus groups with youth ambassadors from the 4-H Shooting Sports Teen Leadership Institute; Alamo, NV (August 2023)
    - Participants included:
        - Thirty-one youth ambassadors
- Listening session with incarcerated youth at the Sacramento Youth Detention Facility to hear youth and lived experience perspectives; Sacramento, CA (August 2023)
    - Facilitated by Dwight Harvey, Administrator of Court and Community Schools in the Sacramento County Office of Education
    - Participants included:
        - Six incarcerated youth between the ages of 18 and 21
- Town hall and listening session with community members; Susanville, Lassen county, CA (November 2023)
    - Participants included:
        - Teen members of the Claybreakers trap shooting club
        - Lassen County Sheriff's Department
        - Lassen County Behavioral Health staff
        - Lassen County Administrative Office staff
        - Department of Veterans Affairs representative
        - Concealed Carry Weapons (CCW) instructors
        - Local therapy collective staff
        - Local business owners
        - Other community members

Conferences and Other Learning Events

Commissioners and Commission staff attended several conferences and other learning events to hear from experts about firearm violence, its prevention, and recovery and resilience after firearm violence.

These learning opportunities included:

- Webinars and other web series from the California Department of Justice, California Department of Public Health Office of Suicide Prevention, Department of Homeland Security, the Milken Institute, the Prevention Institute, the Rockefeller Institute of Government, Striving for Zero Suicide Prevention Learning Collaborative, the UC Davis Center for Healthcare Policy and Research, and more (2022 – 2025)
- E.R. Brown Symposium: Addressing Gun Violence as a Public Health Epidemic, hosted by the UCLA Center for Health Policy Research; online (February 2023)
- Building Safer Communities Webinar Series hosted by the Hauser Policy Impact Fund; online (February 2023)
- Suicide Research Symposium; online (April 2023)
- Directing Change Youth Mental Health Film Screening; Los Angeles, CA (May 2023)
- Society for the Prevention of Firearm-Related Harms Conference; Chicago, IL (November 2023)
- Suicide Research Symposium; online (April 2024)

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[325] American Economic Association. (n.d.). CDC Advancing Violence Epidemiology in Real-Time (AVERT) -- comments invited to OMB on data collection (by 9/14). EconSpark. Retrieved March 12, 2025, from

https://www.aeaweb.org/forum/3958/advancing-violence-epidemiology-comments-invited-collection

[326] American Economic Association. (n.d.). CDC Advancing Violence Epidemiology in Real-Time (AVERT) -- comments invited to OMB on data collection (by 9/14). EconSpark. Retrieved March 12, 2025, from https://www.aeaweb.org/forum/3958/advancing-violence-epidemiology-comments-invited-collection

[327] U.S. Department of Homeland Security, Center for Prevention Programs and Partnerships. (2024). *Behavioral threat assessment and management in practice*. https://www.dhs.gov/sites/default/files/2025-02/2025_0214_cp3_behavioral-threat-assessment-and-management-in-practice.pdf

[328] U.S. Department of Homeland Security, Center for Prevention Programs and Partnerships. (2024). *Prevention resource: State strategy overview.* https://www.dhs.gov/sites/default/files/2024-07/2024_0716_cp3_prevention-resource-state-strategy-overview.pdf

[329] Clayton, A. (2025, March 17). White House removes advisory defining gun violence as a public health issue. *The Guardian.* Retrieved March 19, 2025, from https://www.theguardian.com/us-news/2025/mar/17/trump-removes-gun-violence-public-health-advisory

Commission *for* Behavioral Health

To the Honorable Governor Gavin Newsom and members of the Legislature:

Firearm violence is harming our state's physical, mental, and behavioral health and impacting how Californians live, learn, work, play, and connect with one another. Firearm violence affects all Californians, but it has ravaged some communities for generations. These impacts cause and deepen existing behavioral health challenges. Firearm injuries currently are the leading cause of death among children and youth. Firearm suicide rates are also spiking, paired with increases in firearm ownership rates. **As firearm violence continues to pose a far-reaching threat to population behavioral health, this report will guide California leadership in how to prevent further violence and heal existing trauma.**

The Behavioral Health Services Oversight and Accountability Commission embarked on an examination of the relationship between firearm violence and behavioral health. The attached report, based on key informant interviews, intensive community engagement, and a literature review revealed that, while a behavioral health diagnosis is a poor predictor of violence, there is indeed significant overlap between the two. The individual, social, and community-level factors that put a person at risk for behavioral health challenges are the very same factors that put them at risk for firearm violence.

To effectively address these issues there must be a deep understanding of both the behavioral health challenges that motivate firearm violence, and of the toll that firearm violence takes on our residents and communities.

In addition, the Commission found that exposure to firearm violence is broader than is widely understood. Like an earthquake, incidents of firearm violence can cause immense damage to those at the center, but the true extent of the damage is far greater. Harms radiate out from the epicenter, affecting survivors, witnesses, victims' families and loved ones, first responders and health care providers, and the broader communities in which violence occurs.

These harms are often traumatic and they commonly lead to negative mental health outcomes across communities and throughout generations.

Firearm violence is not inevitable; it is predictable and preventable. Like heart disease, traffic accidents, and smoking-related illnesses, there are well-known pathways, risk factors, and interventions to reduce firearm violence and mitigate its harms. In the attached report, you will read that the Commission identified three key findings and three recommendations to prevent firearm violence.

1. **Finding 1:** Firearm violence is a persistent threat to behavioral health, but California is not treating it that way.
   Recommendation 1: California must establish trauma-informed violence prevention as a public behavioral health priority.
2. **Finding 2:** California faces challenges for effective firearm violence prevention stemming from misconceptions, cultural tensions, and fear.
   Recommendation 2: California must deploy a public engagement initiative to regain trust and build relationships with firearm-owning communities and communities impacted by violence.
3. **Finding 3:** California's public investments have not been coordinated effectively to address the underlying causes of violence and other public health concerns.
   Recommendation 3: California must develop a unified statewide strategy, with an appointed leader, to guide a public health approach to firearm violence prevention that integrates data, resources, and partners from across sectors.

This report comes at a critical time. The current federal administration is moving away from the previous administration's prioritization of firearm violence, which included landmark legislation, significant investments in programs, data collection, and data dissemination. Firearm violence prevention currently hangs in the balance of looming federal cuts.

But California is ready to take the lead on preventing firearm violence. We are poised to save lives, improve messaging and education, and tackle the root causes of firearm violence. To do this, the Commission calls on State leadership to implement an integrated public health approach that addresses firearm violence and implements the above-listed recommendations. Such an approach should coordinate and align resources and efforts that utilize a wide array of

partners, including policy makers, public health professionals, law enforcement, the criminal justice system, health and behavioral health systems, community-based organizations, and, most importantly, the firearm-owning community.

The attached report provides promising strategies and a roadmap of ways to achieve transformational change in mitigating California's firearm violence. It provides concrete examples of how it can be done while respecting the rights of individuals across our vast geographic and political spectrum, fostering community, increasing feelings of safety, and improving wellbeing for all. Together we can address firearm violence and its devastating impacts and, in doing so, foster resilient, healthy communities. The time to act is now.

The Commission welcomes the opportunity to discuss these recommendations in detail.

Respectfully,

[Signature]

Mayra E. Alvarez
Commission Chair

[Signature]

Alfred Rowlett
Commission Vice Chair

AGENDA ITEM 11

Action

May 22, 2025 Commission Meeting

Early Psychosis Intervention Strategic Plan

Summary:
The Commission will receive and consider adoption of a strategic plan for early psychosis intervention developed by McKinsey & Company.

Background:
In January 2024, the Commission directed staff to contract with a consultant to develop a strategic plan for early psychosis intervention to assess access to care, estimate the cost of expanding services to meet 90% of the need, and create a plan to achieve that goal. McKinsey & Company was selected and began collaborating with Commission staff and experts nationwide to analyze care access, costs, and barriers to early psychosis treatment.

At the July 2024 meeting, the Commission received a presentation on the draft of the strategic plan led by then Executive Director Toby Ewing and Kana Enomoto from McKinsey & Company. The plan aimed to expand access to early psychosis care across California, potentially serving nine times more individuals and saving the state $12 billion over ten years. The presentation detailed the strategic and financial modeling behind achieving 90% access through Coordinated Specialty Care (CSC), the value of early intervention, and the necessary infrastructure, including public awareness, workforce development, data systems, and sustainable funding. Commissioners expressed strong support but raised questions about messaging cost savings versus cost avoidance, the conservative scope of McKinsey & Company's projections, and the broader role of private insurance. There was a consensus on the need to address systemic financing issues, with suggestions for regulatory strategies to require commercial insurance to share the cost burden. Commissioners emphasized early detection and broader surveillance of youth, while acknowledging that current funding streams and insurance structures limit scalability.

Following the meeting, staff gathered additional feedback and incorporated Commissioner input, resulting in the final strategic plan presented today.

Presenter: McKinsey Institute

Enclosures: Strategic Plan - Early Psychosis Care in California

Handouts: PowerPoint Presentation

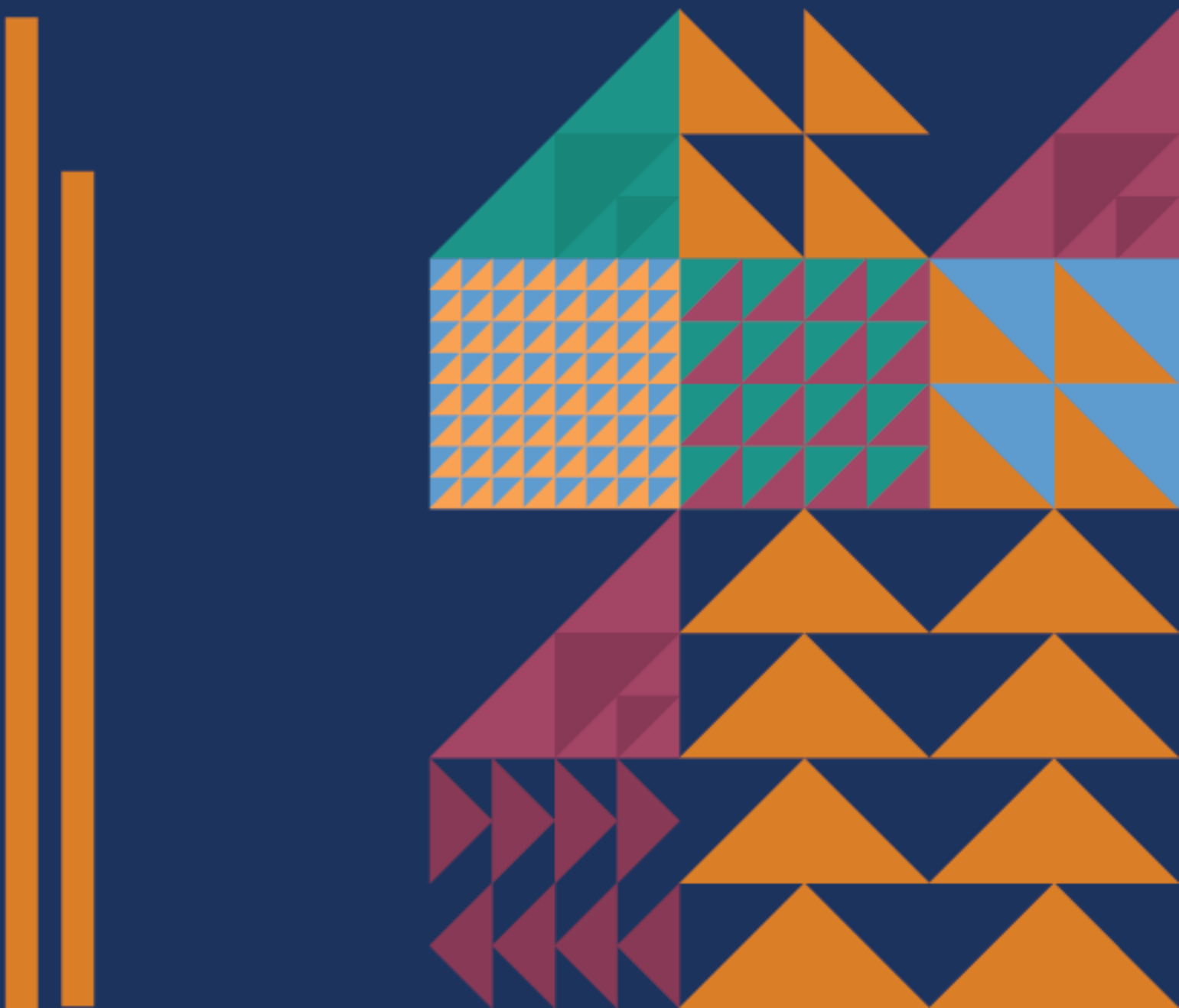
Proposed Motions: That the Commission accept the Early Psychosis Care Strategic Plan.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

STRATEGIC PLAN

EARLY PSYCHOSIS CARE IN CALIFORNIA

DRAFT
DECEMBER 2024



PURPOSE

Draft as October 2, 2024

This document provides preliminary content for the MHSOAC's Early Psychosis Intervention (EPI) Strategic Plan. It facilitates a discussion with MHSOAC about the structure of the Strategic Plan and the initial content to be included in it.

This document has been created at the request of MHSOAC. All information is based on inputs from MHSOAC.

The approaches and considerations included in this document are preliminary and may be further developed based on additional inputs from MHSOAC.

Table of Contents

Key terms glossary

Term	Definition
Coordinated Specialty Care	A multicomponent, evidence-based, early intervention service for individuals experiencing a first episode of psychosis (FEP)[1]
Clinical High Risk/Prodrome	The early symptoms of an illness which may indicate that an individual may be at a higher risk of developing a psychotic disorder[2]
Early Psychosis/First - Episode Psychosis	The initial period of up to five years following the emergence of psychotic symptoms[3]
Early Psychosis Intervention	An evidence-based specialized approach to providing services to individuals affected by first-episode psychosis. It is aimed at early recognition of psychosis, the provision of timely comprehensive treatments that are stage- and age-appropriate, family/caregiver inclusive, and with a client-centered strengths-based approach[4]
Duration of Untreated Psychosis (DUP)	The time from manifestation of the first psychotic symptom to initiation of adequate antipsychotic drug treatment[5]
Psychosis	A collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not[6]
Serious Mental Illness (SMI)	Mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[7]

[1] Evidence-Based Treatments for First-Episode Psychosis: Components of Coordinated Specialty Care
[2] Yale PRIME Clinic
[3] Lundin et al, Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021
[4] BC Early Psychosis Intervention Program: Early Psychosis Intervention
[5] JAMA: Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients A Systematic Review
[6] NIMH: Understanding Psychosis
[7] NIMH

1. Executive Summary

Reasons to Scale Early Psychosis Intervention (EPI)

Approximately **1 in 33 people** will experience a psychotic episode in their lifetimes.[8] Psychosis touches many lives deeply, shaking the foundations of reality for those experiencing symptoms and reshaping their lives and that of their loved ones. In California alone, 21,000 people experience their first episodes of psychosis every year.

According to the National Institute of Mental Health, psychosis represents a collection of symptoms that suggest a loss of contact with reality—reflecting a profound disruption in a person's ability to perceive the world accurately. Every experience with psychosis is unique and the effects vary, with research only able to capture some impacts, including:

- **Unemployment:** Approximately one quarter of people with serious mental illness are unemployed, according to a study by Guhne et al.[9]
- **Criminal and legal system:** A 2017 study found that 37% of patients experiencing first-episode psychosis were incarcerated at some point during their pathway to clinical care,[10] often delaying access to treatment.[11] The costs of incarceration in California (~$70,000 per year) far exceed the cost of treatment for mental health treatment (~$22,000).[12]
- **Homelessness:** Research shows that approximately 20% of people who are experiencing homelessness are affected by psychosis,[13] as compared to 4% of the general population.[14]
- **Chronic disease burden**: Individuals with psychotic disorders are 3.5x more likely to die due to cardiovascular disease, tobacco use, or substance use.[15]
- **Hospitalization**: People with psychotic disorders often have higher utilization of the healthcare system, including higher rates of emergency department visits. These additional healthcare costs amounted to $62.3B in 2019 for those affected by schizophrenia.[16]

[8] NIMH Recovery After an Initial Schizophrenia Episode (RAISE)
[9] Guhne et al, Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, *Apr 2021*
[10] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*
[11] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*
[12] Stanford Justice Advocacy Project: The Prevalence And Severity Of Mental Illness Among California Prisoners On The Rise
[13] Ayano et al, The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, *Nov 2019*
[14] Calabrese: Psychosis
[15] Simons et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[16] Kadakia et. al. The Economic Burden of Schizophrenia in the United States, 2019

- **Death:** Individuals with psychotic disorders have shorter life expectancy by an average of 10-15 years and exhibit a 15x-30x increase in mortality due to suicide.[17]

Family, friends, and communities also experience the impact of psychosis in their roles as caregivers. Beyond the physical and emotional tension, caregivers experience an economic impact due to missed workdays and lost income.

The initial phase of psychosis, known as early psychosis or first-episode psychosis (FEP), marks a critical time in the lives of those experiencing these symptoms as early identification and access to evidence-based care are critical; receiving timely and effective treatment can significantly change both short- and long-term outcomes, offering hope for a healthy, fulfilling life.

Early Psychosis Intervention (EPI) programs like Coordinated Specialty Care (CSC) provide evidence-based care for individuals experiencing psychosis and their families. CSC not only provides symptom relief but also includes supports that help individuals reclaim their lives and pursue their goals without being defined by their condition. CSC improves symptoms of schizophrenia and psychosis over 24 months[18] and fosters stronger, more supportive communities that are informed, compassionate, and proactive. Through individual, group, and family treatment; medication management; supported education and employment; case management; community outreach; and peer and family partners, CSC cultivates environments to uplift those experiencing psychosis and equip their families, friends, and community members to support long-term recovery and resilience. CSC also provides positive impacts on the community and social systems:

- **Reduced hospitalization**: Reduces average inpatient days by 33% and average number of ED visits per year by 36%.[19]
- **Reduced unemployment:** Reduces the likelihood of being unemployed by ~42%.[20]
- **Stable housing:** Reduces the need for homelessness services amongst the FEP population by 48%.[21]
- **Reduced criminal justice system involvement:** Reduces risk of committing first crime by 76%.[22]

[17] Simons et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[18] Dixon LB et a
[19] Rosenheck et al.
[20] Dickerson et al.
[21] Tsiachristas et al.
[22] Pollard et al.

- **Reduced caregiver burden:** Reduces average lost earnings due to caregiving duties by 28% and lowers average incremental healthcare costs through improved health outcomes for caregivers by 29%.[23]

Currently, MHSOAC estimates that only 10% of Californians in need have access to Coordinated Specialty Care (CSC), with many facing barriers to timely, equitable, and affordable care. The State's mission is to expand access to 90% of Californians over the next three years.[24] The State has a pivotal opportunity to guarantee that individuals experiencing psychosis, along with their families, receive equitable, high-quality, and targeted early psychosis care that is appropriately and fully funded. This is vital in addressing mental health needs comprehensively and compassionately across the state.

Impact of Scaling EPI

Expanding access to EPI from an estimated 10% to 90% of Californians in need—an expansion from 2,100 to 19,000 individuals receiving care annually—**could transform lives and livelihoods.** Outside of individual impacts on clinical and nonclinical outcomes, there would also be positive benefits on friends, families, and communities.

In California, scaling CSC may generate $1.7B in annual system cost savings and productivity gains in Year five.[25] These savings arise from shifting costs and reduced expenses related to unemployment, homelessness, and incarceration associated with untreated psychosis:

- ~$45M increase in healthcare costs driven by realigning care from inpatient settings to CSC and ongoing outpatient care for 9x the number of clients.
- ~$865M in caregiver savings from recovered earnings and healthcare costs for caregivers.
- ~$457M in employment savings from recovered earnings and Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) payments.
- ~$355M in criminal justice savings from reduced criminal justice interactions.
- ~$15M in housing savings from reduced homelessness and the need for supportive housing.

Key Solutions to Scale EPI

MHSOAC, in collaboration with advisors, has developed a plan for scaling EPI to ensure that 90% of individuals in need have access to care within their first year of symptoms. The plan

[23] McDonell et al.

[24] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics); Total programs in CA = 43; Clients per program – average 50-75 (assume 60)

[25] See Chapter 4 Opportunity for additional details and model assumptions

includes both strategic objectives required to realize the vision and foundational levers that are critical enablers necessary to expand access to EPI successfully:

Our vision is to ensure Californians experiencing psychosis and their families have equitable access to high-quality, appropriate, holistic early psychosis care.

Strategic Objectives

- **Awareness:** Enhance statewide awareness and understanding of early psychosis symptoms and resources to reduce stigma and elevate expectations for quality EPI. Educate community influencers including teachers, physicians, social workers, law enforcement about psychosis. Destigmatize related conditions and highlight the effectiveness of EPI through comprehensive resource centers, integration of psychosis education into wider health campaigns. Develop communication strategies to boost engagement in psychosis care across healthcare, housing, criminal justice, and social service systems.
- **Access:** Address key challenges to access, including varying levels of service convenience, coverage disparities between public and private insurance, and inconsistent eligibility and intake processes. Define access standards for different community types, establish community-led working groups, address capacity and infrastructure barriers, and refine diagnostic and referral guidelines.
- **Quality:** Ensure services adhere to a stringent level of care, with the CSC model promoted as the standard, to improve the fidelity of intervention models. Provide continuous enhancement of care quality, including leading ongoing trainings for providers, standardizing treatment protocols, and conducting rigorous program evaluation.
- **Equity:** Ensure full and equitable access to high-quality treatment, focusing on vulnerable communities accessing EPI less frequently. The focus of work is cultural and language competency of care through improving workforce diversity, co-designing EPI programs with communities, and establishing and tracking measurable goals around equity metrics.

Foundational Levers

- **Sustainable funding:** Secure sustainable funding and optimize resource allocation to support the expansion and maintenance of EPI programs statewide, to provide timely access to individuals in need regardless of a patient's insurance type. Develop consensus among funding partners, secure programmatic funding to ensure 100% coverage for all CSC components, and advocate for policy changes to increase financial support for EPI programs. Currently, the county-led EPI programs use a

several funding sources and many components of evidence-based coordinated specialty care are not reimbursable by private payers.[26]

- **Workforce and capabilities:** Address California's significant workforce shortages in trained clinicians and prescribers by recruiting new members, optimizing the use of existing staff, and enhancing capabilities through statewide CSC-specific training programs. Conduct a comprehensive assessment of workforce supply and demand, develop and implement recruitment and retention strategies, and expand training opportunities to build a capable, diverse workforce that is prepared to meet the needs of those with early psychosis, regardless of where they live.
- **Accountability:** Establish governance structures to ensure responsibility, measure progress, and facilitate continuous improvement in access, cost, quality, and outcomes of EPI. Refine and implement strategic goals, align efforts across partners, and develop incentives and structures to ensure consistent and accountable care delivery across California.
- **Infrastructure:** Improve the availability and distribution of EPI programs throughout California—including closing the gap for counties without an EPI program—through cutting-edge physical and digital infrastructures and revised public policy. Scale care models, particularly in underserved areas, by identifying infrastructure needs, developing strategic partnerships, and leveraging technology to optimize care delivery and access for individuals experiencing early psychosis.
- **Ecosystem engagement:** Establish an integrated care delivery model for individuals experiencing psychosis and their families, involving a wide range of partners from healthcare, education, housing, and criminal justice systems. Increase awareness and coordination among partners by improving training, sharing information for better care coordination, and strengthening partnerships to ensure seamless and timely care delivery.

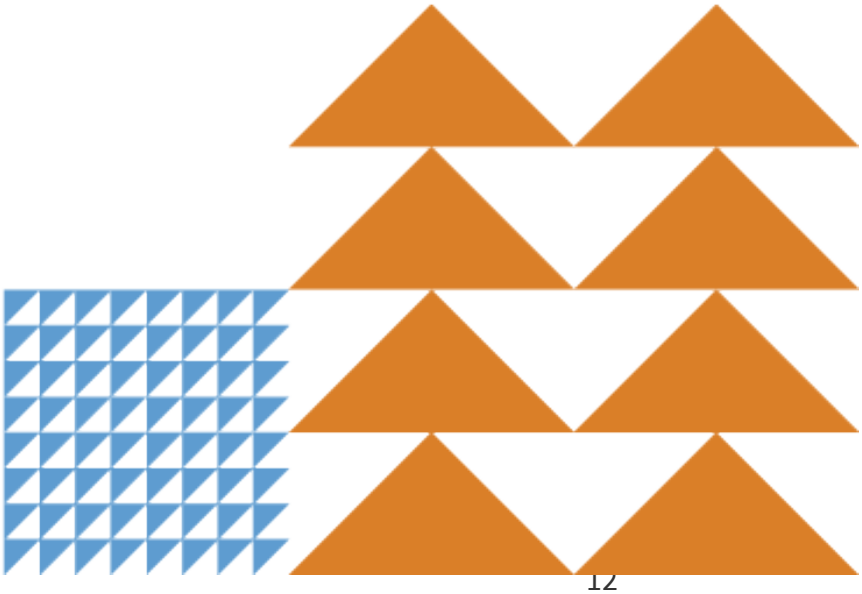
Next Steps

If this strategic plan is supported by the public, the governor and the legislature, execution will involve forming workstreams to support implementation, such as integrated coordination, performance management, communication strategies, and change management to foster ecosystem-wide transformation. Implementation involves a phased approach over three years. The first phase includes forming workgroups and conducting analysis to further understand current state, align on innovative solutions, and design initiatives to execute these solutions. During this phase, working groups will also establish necessary partnerships with public, private, and social sector organizations to implement

[26] Hirschtritt et al., Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, Mar 2024

solutions. Subsequently, the focus will be on developing partnerships before piloting initiatives and refining efforts based on data analytics. The work will be dynamic and regularly incorporate feedback from stakeholders with the aim of widespread access to high-quality early psychosis care in California by the end of the third year of implementation.

2. The need to scale Early Psychosis Intervention in California



It is estimated that each year, over 130,000 individuals in the United States, including nearly 21,000 Californians, experience their first episodes of psychosis.[27]

Early psychosis, also known as first-episode psychosis (FEP), is defined[28] as the initial period of up to five years following the emergence of psychotic symptoms. Early identification and access to evidence-based care is critical, as treatment within this period can improve short- and long-term health outcomes for people with schizophrenia and other psychotic disorders.[29] Studies estimate that approximately **1 in 33 people** will experience a psychotic episode in their lifetimes.[30]

According to the National Institute of Mental Health (NIMH), psychosis represents a collection of symptoms that suggest a loss of contact with reality. When experiencing a psychotic episode, individuals may struggle to recognize what is real and what is not. Psychosis may also result in reduced levels of self-care, educational and professional challenges, disruptions in family and community connections, and an increased risk of harming oneself or others. Psychosis often signals the onset of psychotic disorders like schizophrenia.[31]

Psychosis may be a symptom of a mental illness, such as schizophrenia, bipolar disorder, or severe depression. However, a person can experience psychosis and never be diagnosed with schizophrenia or any other disorder. Individuals affected by schizophrenia have additional symptoms beyond psychosis.
Source: NIMH

Individuals with psychotic disorders face significant **health challenges and higher mortality rates.** Research indicates that the life expectancy of people with psychosis is shorter by an average of 10-15 years, mainly drive by accidental injury, self-harm, suicide, or unintentional overdose.[32] The lifetime suicide rate for individuals with psychotic disorders is 5.6%, with highest risk following initial contact with mental health services.[33] Comparatively, the age-adjusted suicide risk in the United States is 14.1 per 100,000 population.[34]

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[27] Estimated by applying the observed rate in the Medicaid population (Radigan et al.) to the Medicaid and uninsured populations and the observed rate in a sample size with 85% commercially insured population to the commercially insured populations. Methodology based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics)
[28] Lundin et al., Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021
[29] Yale School of Medicine- What is Psychosis
[30] NIMH Recovery After an Initial Schizophrenia Episode (RAISE)
[31] NIMH: Understanding Psychosis
[32] Simon: Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[33] Nordentoft: Suicidal behavior and mortality in first-episode psychosis
[34] U.S. Centers for Disease Control and Prevention

There are also significant economic and healthcare costs associated with psychosis. The estimated excess economic burden of schizophrenia in the United States in 2019 was $343.2 billion, of which, only $62.3 billion was in direct healthcare costs (18.2%). Caregiving ($112.3 billion), premature mortality ($77.9 billion), and unemployment ($54.2 billion) are other significant drivers of economic costs.[35]

The impact of psychosis extends to **employment and education.** People with a serious mental illness (SMI) (defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[36]) are often excluded from employment even though studies show that such individuals can succeed in mainstream employment with effective supports.[37] A study in 2021 estimated that ~25% of people with SMI are unemployed,[38] compared to the 4-6% unemployment rate in the general population.[39]

Psychosis also can affect **housing security.** A 2019 study found that approximately 20% of individuals experiencing **homelessness** are affected by psychosis,[40] as compared to less than 4% in the general population.[41] Similarly, research published in 2022 found the risk of homelessness is ~5 times higher among veterans with schizophrenia compared to those without.[42]

In the **criminal justice and legal system,** the figures are similarly concerning. A study in 2017 found that 37% of individuals experiencing first-episode psychosis (FEP) were incarcerated at some point along their pathway to clinical care. These individuals experienced longer delays to treatment and more severe positive symptoms, and they averaged having more than two episodes of incarceration, mostly for nonviolent, petty crimes.[43] A 2016 study by the Department of Correctional Health Care Services found that approximately 30% of California Prisoners received treatment for a serious mental disorder. Mental health treatment is more effective and less expensive than incarceration, with the average annual cost of incarcerating a state prisoner in California at over $70,000, not including mental healthcare costs, while the cost of treating a person with mental illness in the community is approximately $22,000.[44]

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[35] Kadakia et al. The Economic Burden of Schizophrenia in the United States, 2019

[36] NIMH

[37] Prior: An enhanced individual placement and support (IPS) intervention based on the Model of Human Occupation (MOHO); a prospective cohort study, 2020

[38] Guhne et al., Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, *Apr 2021*

[39] U.S. Bureau of Labor Statistics range for unemployment in 2021

[40] Ayano et al, The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, *Nov 2019*

[41] Calabrese: Psychosis

[42] Lin et al, Unemployment, homelessness, and other societal outcomes in patients with schizophrenia: a real-world retrospective cohort study of the United States Veterans Health Administration database, *July 2022*

[43] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*

[44] Stanford Justice Advocacy Project: The Prevalence And Severity Of Mental Illness Among California Prisoners On The Rise

The impact of psychosis extends beyond individuals and systems to **caregivers.** Family members and other caregivers for people with psychosis report higher levels of emotional or physical tension relative to caregivers for individuals without psychotic disorders. The time needed to care for an individual experiencing psychosis may also impinge on workplace attendance, income, professional aspirations, and personal health.[45]

These challenges underscore the need to make effective evidence-based interventions that can improve outcomes in early psychosis care widely available at the individual, community, and societal levels.[47]

The American Psychiatric Association (APA) in its 2020 updated practice guidelines for the treatment of schizophrenia, recommends Coordinated Specialty Care program for patients experiencing a first episode of psychosis. [46]
Source: American Psychiatric Association

There are treatment models that have been demonstrated to be effective in alleviating symptoms and mitigating the impacts of early psychosis. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies **Coordinated Specialty Care (CSC)** as the standard of care for early psychosis.[48] CSC is a multimodal, team- and community-based, collaborative treatment methodology. It comprises six primary components: psychotherapy, medication management, service coordination (e.g., case management), family education and support, supported education and employment, and peer support services.[49]

[45] Cham et al., Caregiver Burden among Caregivers of Patients with Mental Illness: A Systematic Review and Meta-Analysis, Dec 2022
[46] APA: New Practice Guidelines on Treatment of Patients with Schizophrenia
[47] Hirschtritt et al., Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, Mar 2024
[48] SAMHSA: Coordinated Specialty Care for First Episode Psychosis
[49] SAMHSA: Coordinated Specialty Care for First Episode Psychosis

Access to Early Psychosis Intervention

"**My brother had his first episode six years ago.** He was not in California. My mom and I got a call from my dad, who my brother was living with at the time. He was crying and his voice was trembling as he tried to describe what was going on with my brother. We felt frozen, filled with worry and were inconsolable. We did not know what to expect. We flew to him, unaware of what state he'd be in. At the emergency room, when I saw him in restraints, it broke me. When a bed was available at an inpatient hospital, he moved there. When we brought him back to California, eventually, he didn't want to be in a hospital. My mom was very hesitant; she had no experience with this. We quickly realized how challenging life would be because he was very symptomatic. **After various 5150s[50], a lot of uncomfortable situations in public trying to bring him home, having police visiting our house, dealing with him screaming in our neighborhood, around the fourth or fifth hospitalization, we went to a mental health urgent care, and that's when they told us about the SacEDAPT CSC program.** When he was admitted to SacEDAPT, that's when he started to take medication; that's when we started to understand the process and where he really started his healing journey; that was the first time I had seen him well and relatively stable in a long time." – *Sister, Caregiver, Family Peer Support Specialist*[51]

[50] Under California law, certain **designated professionals** can place a person in a 72-hour psychiatric hold. This hold is also commonly referred to as a "5150," named after §5150 of the California Welfare and Institutions Code. These professionals include police officers, licensed members of a crisis team, or other mental health professionals authorized by the county.

[51] People with live experiences with EPI were identified by MHSOAC for interviews such as this to understand the challenges they faced accessing EPI and their experiences of EPI programs

Coordinated Specialty Care (CSC) has been associated with positive outcomes for participants, including mitigation of symptoms and improvements in occupational and social functioning.[52] Select impacts are highlighted in Exhibit 1 (featured below).

Overview of select patient outcomes from CSC as identified in the literature

Sector	Select examples of observed impact (based on empirical studies) on participants
Healthcare	On average, reduces **inpatient days** by 33% and average number of **ED visits** per year by 36%[1] Improves **symptoms of schizophrenia and psychosis** (based on measures of both PANSS[2]/CDI[3])[4] observed over 24 months[5]
Employment and education	Reduces likelihood of being **unemployed** by ~42% (represents reduction from 50% to 29%)[6,] Increases appropriate access to **social security support** where needed by 37%[1] Improves **education and employment rates** increased by 2x (from 40% to 80% in six months)[7]
Housing	Reduces **need for homelessness services** amongst the FEP population by 48%[8] Reduces average per person cost of providing supportive housing to program participants[8]
Criminal justice	Participants **experience a 76% reduction in the risk of committing a first crime** and are significantly less likely to be convicted of any crime when enrolled in CSC[9]
Caregiving	Reduces average cost of **lost productivity** due to caregiving duties by 28%[10] Reduces average **incremental healthcare costs** through improved health outcomes for caregivers by 29%[10]

Exhibit 1: Overview of select patient outcomes from CSC as identified in the literature

Sources 1. Rosenheck et al.; 2. Positive and Negative Syndrome Scale; 3. Clinical Global Impressions; 4. Kane et al.; 5. Dixon LB et al.; 6. Dickerson et al.; 7. Nossel et al.; 8. Tsiachristas et al.; 9. Pollard et al.; 10. McDonell et al.

Despite the impact of Coordinated Specialty Care, it is estimated that in California, only 10% of individuals in need have access to it.[53]

[52] SAMHSA: Evidence-Based Resource Guide Series Overview

[53] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics); Total programs in CA = ~43; Client per program – average 50-75

Access to high-quality, timely CSC could transform the care journey for individuals experiencing early psychosis.

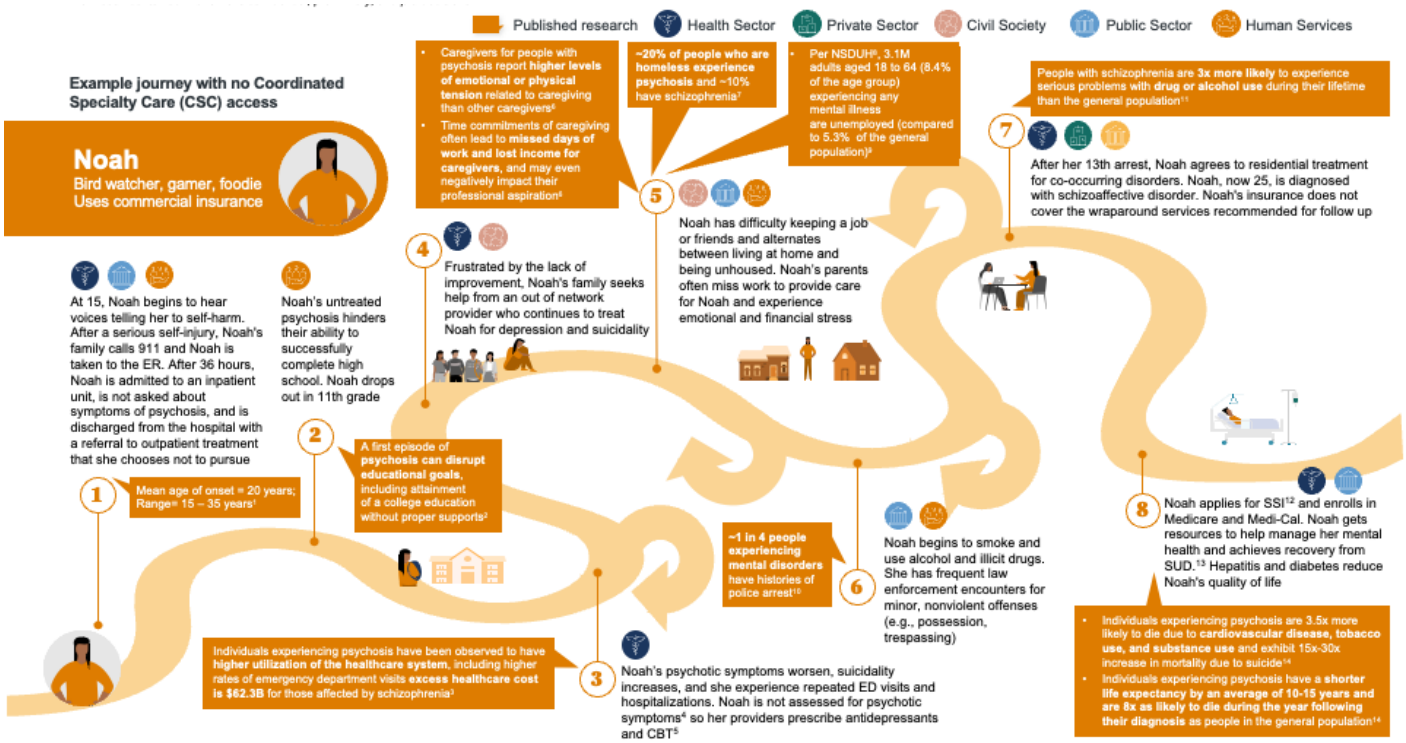


Exhibit 2: Illustrative care journey of an individual experiencing psychosis without access to Coordinated Specialty Care

Sources

1. Heinssen; 2. Shinn et al.; 3. Kadakia et al.; 4. MHSOAC; 5. CBT = Cognitive Behavioral Therapy; 6. Cham et al.; Gupta et Al.; 7. Ayano et al.; 8. NSDUH = National Survey on Drug Use and Health; 9. NSDUH; Guhne et al.; BLS; 10. Livingston; 11. Khokar et al.; 12. SSI = Supplemental Security Income; 13. SUD = Substance Use Disorder; 14. Simon et al.

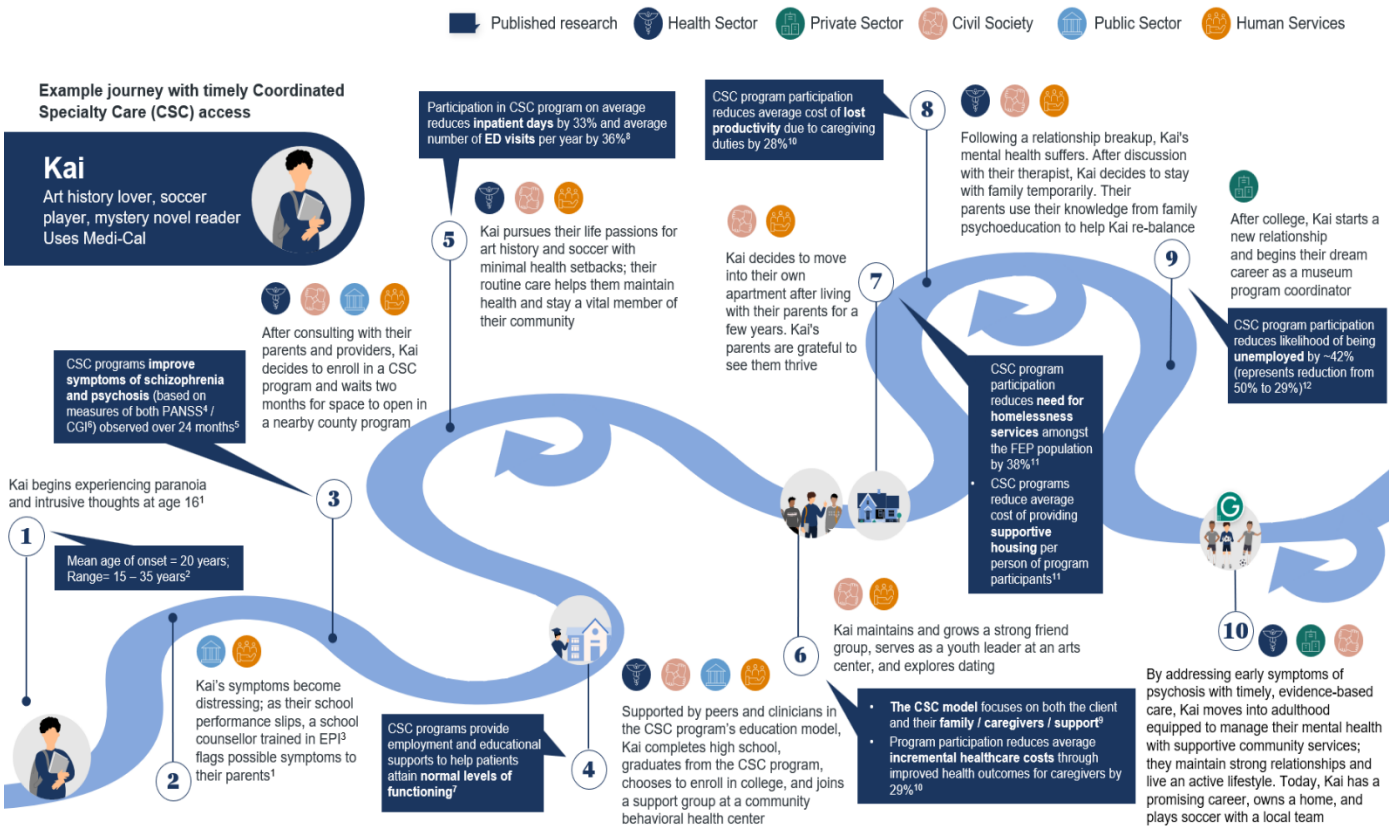
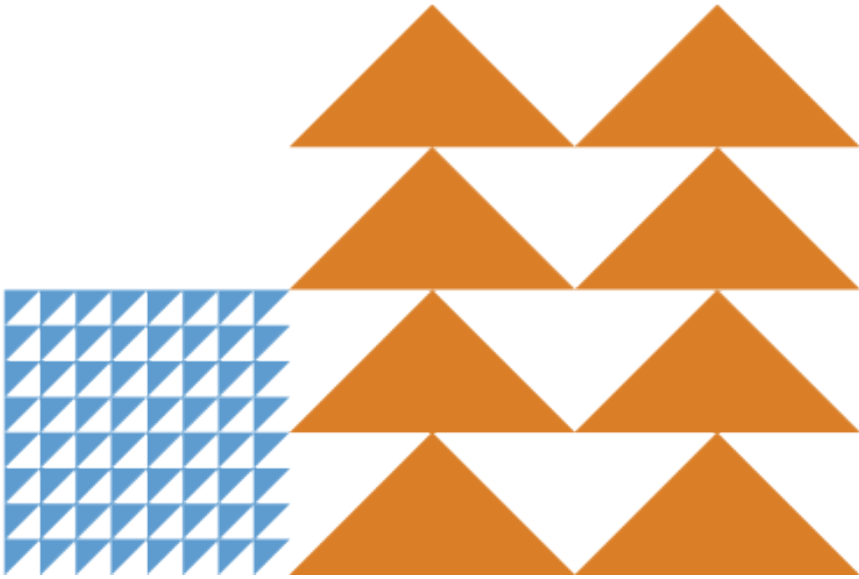


Exhibit 3: Illustrative care journey of an individual experiencing psychosis with access to Coordinated Specialty Care

Sources: 1. MHSOAC; 2. Heinssen; 3. EPI = Early Psychosis Intervention; 4. PANSS = Positive and Negative Syndrome Scale; 5. CGI = Clinical Global Impressions; 6. Positive and Negative Syndrome Scale; Clinical Global Impressions; Kane et al. Dixon LB et al.; 7. Global assessment of functioning; 8. Rosenheck et al.; 9. NAMI; 10. McDonnell et al.; 11. Tsiachristas et al.; 12. Dickerson et al.

There is an opportunity for California to ensure equitable access to high-quality and appropriate early psychosis care for individuals experiencing psychosis and their families.

3. Overview of the current state of early psychosis care in California



California has been a pioneer in expanding access to evidence-based care for early psychosis.[54]

3.1 Efforts in expanding early psychosis care

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was established in 2004 by the Mental Health Services Act. The first of its kind in the United States, the MHSOAC oversees and allocates funds to 59 local mental health departments across California's 58 counties. For each county, approximately 20% of MHSA annual revenues is earmarked to support prevention and early intervention programs and services,[56] which has helped to facilitate the rapid development of early psychosis programs across California.

Proposition 1, an effort to rebuild California's behavioral health system, expands access to funding for BH reforms through a two-bill package – The Behavioral Health Services Act (BHSA) provides funds through a stream of income tax revenue of ~$3.4B, and the Behavioral Health Infrastructure Bond Act (BHIBA) draws from a $6.4B general obligation bond to provide resources for supportive housing and behavioral health treatment.[55] This reform provides a critical opportunity to make high-quality and appropriate EPI available statewide.

[54] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[55] Based on FY23-24 projected expenditures from Mental Health Services Act Expenditure Report – Governor's Budget
[56] MHSOAC, Well and Thriving Prevention and Early Intervention in California, *Jan 2023*

Select milestones are shown in the figure below:

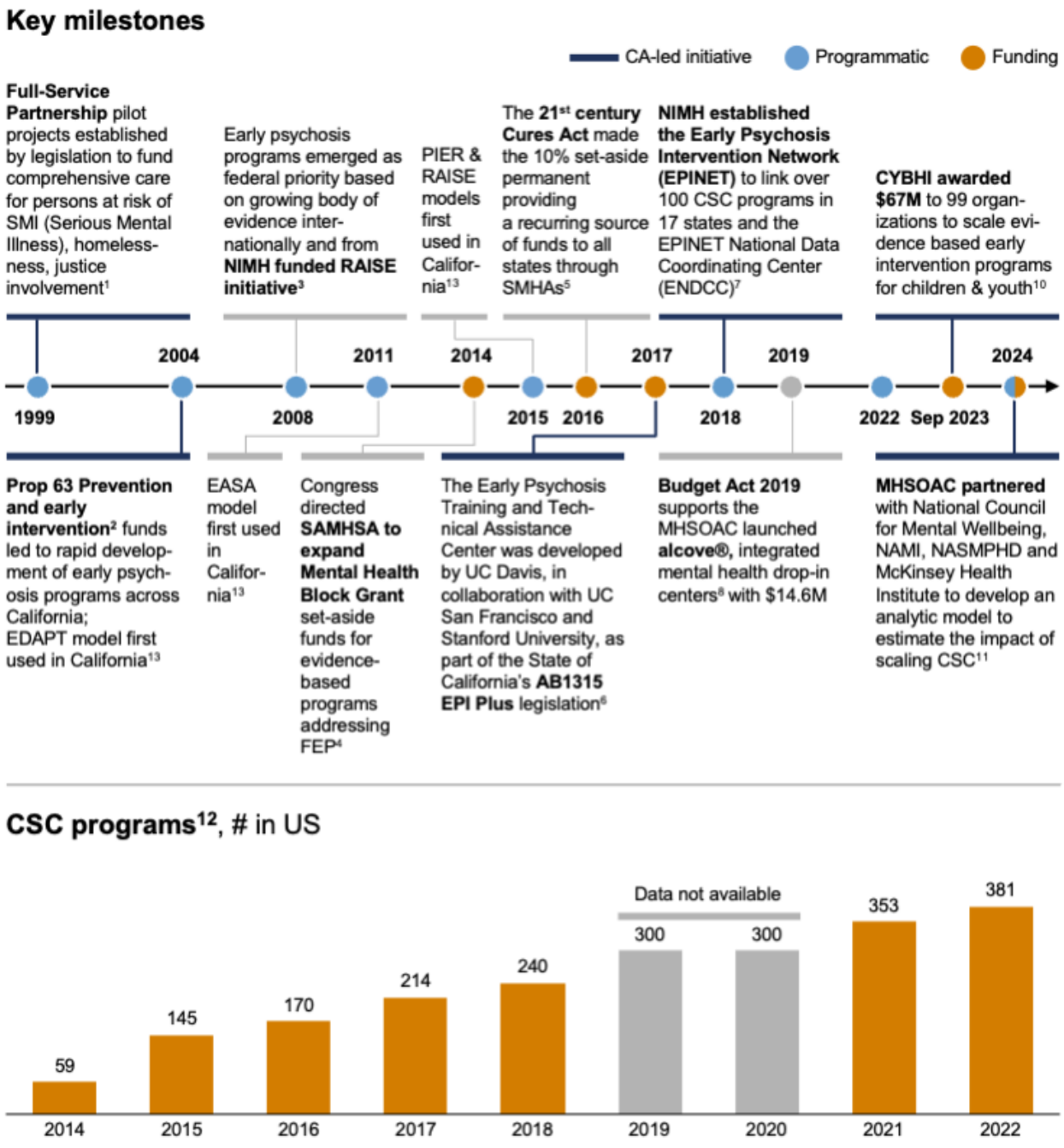


Exhibit 4: Timeline of select investment milestones in Early Psychosis Intervention (EPI) care in California

Sources

1. MHSOAC Report to the legislature on FSP, 2. MHSOAC, 3. NIMH RAISE, 4. SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," Aug. 2023, 5. NIH Cures ACT, 6. MHSOAC EPI Plus, 7. EPINET, 8. MHSOAC allcove, 9. Psychiatry Online, Psychiatric News. Mark Moran, 10. CYBHI, 11. MHSOAC, 12. # of active CSC programs in 2022 as per SAMHSA, 13. Niendam et al.

The MHSOAC ("Commission") supports numerous initiatives to improve access to care for prevention and early intervention, including programs and partnerships intended to strengthen psychosis care delivery and improve public understanding of psychosis.[57] Example Commission activities and efforts include:

- Assembly Bill 1315 established the **EPI+ program** through which the Commission has made investments to support components of existing CSC programming, including care delivery, technical assistance, and data collection/evaluation strategy, and the formation of a multisite learning collaborative.[58] Many CSC programs are operated at the county level using a variety of funds, including Medi-Cal and MHSA.[59]
- The Commission supports **Full-Service Partnerships** (FSPs) that are county-level programs established under the Mental Health Services Act (MHSA). These programs support prevention and early intervention services delivered at the community level, with many services covered by Medi-Cal (California's Medicaid program). FSPs are supported by the Commission through occasional funding for evaluation. Since the MHSA was passed in 2004, numerous statewide evaluations have provided quantified evidence demonstrating the success of FSPs, as indicated by fewer emergency department visits, a reduction in emergency mental health services, and decreased involvement with the criminal justice system.[60] The Commission recently approved a study to evaluate the effectiveness of a "whatever it takes" approach to recovery and management of psychosis and other mental or behavioral health needs through FSPs.[61] The proposed BH-CONNECT demonstration aims to improve coverage for many of these services including supported employment and clubhouse model services through bundled rates.[62] Since the MHSA was passed in 2004, numerous statewide evaluations have provided quantified evidence demonstrating the success

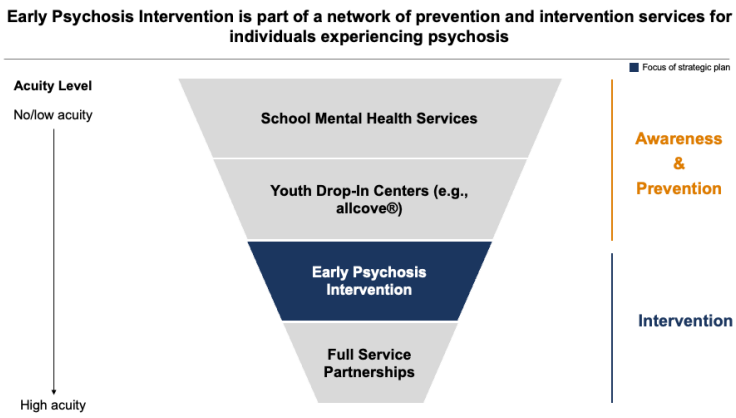


Exhibit 5: Intervention and prevention services for early psychosis

Source: Early Psychosis Intervention (EPI) Advisory Group

[57] MHSOAC publicly listed initiatives
[58] EPI Plus program
[59] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[60] Report to the Legislature on Full-Service Partnerships, MHSOAC, January 2023
[61] MHSOAC Report to the Legislature on Full Service Partnerships
[62] DHCS draft for public comment, The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH- CONNECT) Section 1115 Demonstration, August 2023

of FSPs, as indicated by fewer emergency department visits, a reduction in emergency mental health services, and decreased involvement with the criminal justice system.[63]

- The Commission has invested in strategies to support **school mental health services** for children and youth. **In 2024, DHCS partnered with MHSOAC** and awarded $67M to 99 organizations across 30 counties to expand early intervention programs for children, youth, and young adults, including coordinated specialty care.[64]
- The introduction of BH-CONNECT is expected to expand coverage for evidenced practices including Coordinated Specialty Care for First-Episode Psychosis.[65]

3.2 Expanded CSC model

CSC is a team-based, collaborative, multidimensional approach to treatment that emphasizes the use of evidence-based interventions, shared decision-making, voluntary participation, and program fidelity.

There are six core elements of care that are part of CSC[66]:

1. **Psychotherapy** can be individual- or group-based and is typically based on cognitive-behavioral treatment (CBT) principles and emphasizes resilience training, symptom management, and coping skills.
2. **Medication management** involves catering dosage and drug type to a client's specific needs and monitoring for psychopathology, side effects, and attitudes towards medication.
3. **Supported education and employment (SEE)** typically involves sessions with an SEE specialist who acts as a coach to help clients plan life goals and return to education or the workforce to achieve those goals.
4. **Family support and education** involves educating family about psychosis, alongside coping and communications skills to best engage with loved ones.

[63] Report to the Legislature on Full-Service Partnerships, MHSOAC, January 2023
[64] DHCS news release
[65] The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration
[66] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care

5. **Service coordination** includes collaborative communication between providers (e.g., using phone, videoconferencing, electronic health records; between team leads, physicians, nurses, SEE specialists) to discuss topics such as progression of care, medication needs, and the client's treatment/life goals; individual case management is also used to coordinate catered support and services.
6. **Peer support** provides CSC-FEP program participants with a sponsor with shared lived experiences related to FEP or other factors (e.g., demographics, substance abuse), who provides mentorship and healthy coping skill.

In addition to these core elements, the California CSC model focuses on the client and their family, caregivers, and/or other supporters at the center of the care team, incorporating an assertive case management approach. This approach includes peers and family partners, community outreach and education, and weekly team meetings to improve client outcomes.

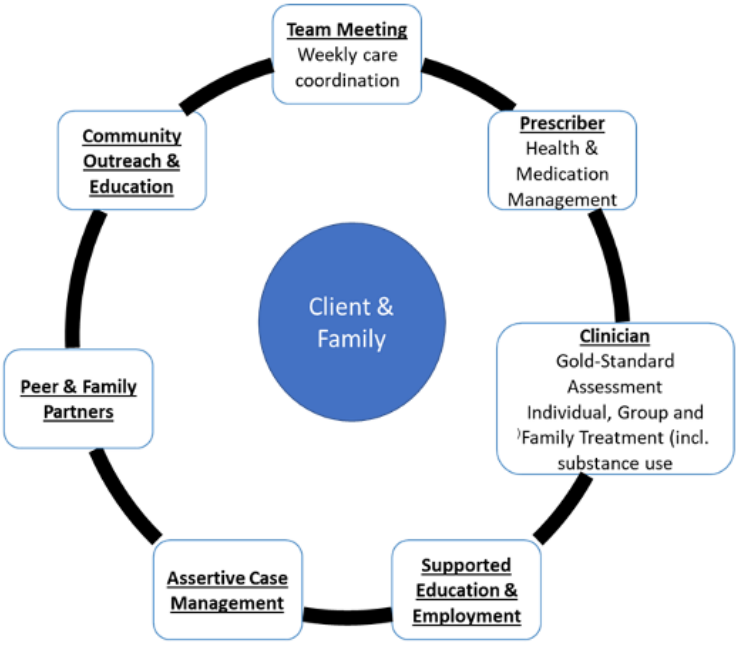


Exhibit 6: Expanded CSC model followed in California

Sources
EPI-CAL TTA CSC Model presented in collaboration with UC Davis, Stanford University and UCSF, MHSOAC

3.3 Funding for EPI programs

Financing for existing early psychosis programs in California comes from program-based sources at the national, state, and county levels (e.g., SAMHSA Mental Health Block Grant, CA Mental Health Services Act funding), and claims-based reimbursements. According to the California Early Psychosis Assessment Survey (CEPAS) of 28 CSC programs, state funding appears to be the most common source of nonclaims-based program funding, with 54% of programs reporting receipt of programmatic state funding. Around twice as many early psychosis programs receive reimbursement from Medicaid (Medi-Cal in California) compared to programs receiving reimbursement from commercial insurance plans (43% and 21%, respectively).[67]

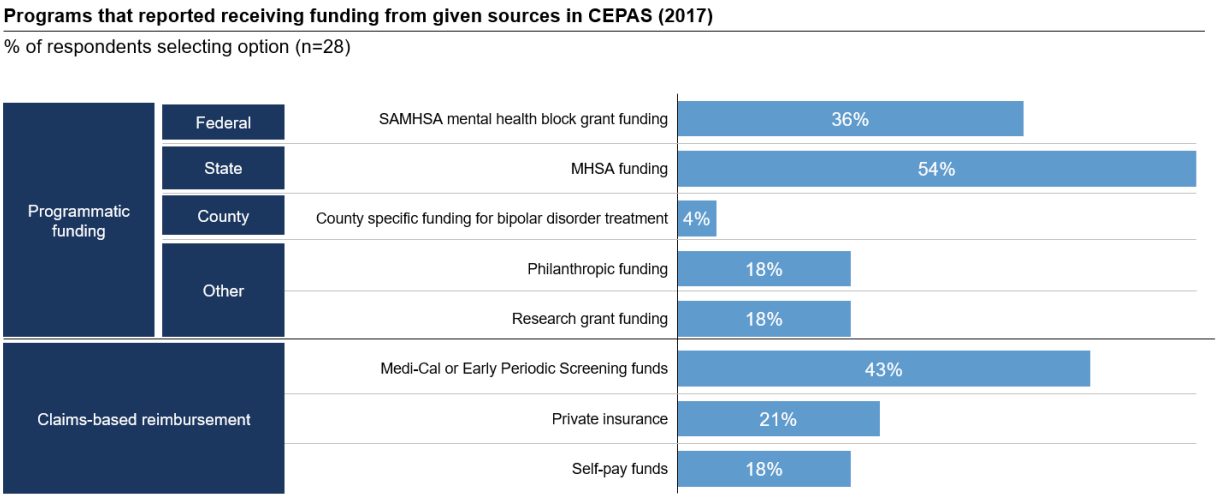


Exhibit 7: Programmatic funding and claim-based reimbursement sources for CSC programs

Sources
Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017, discussions with experts

3.4 Access to programs across geographies

California counties have developed a range of locally designed behavioral health programs to serve California's diverse population.[68, 69] The realignment of health and social services

[67] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[68] The California County Platform Chapter 6 Health Services, *March 2023*
[69] County Behavioral Health Director Association

programs in 1991 restructured California's public behavioral health system, allowing counties to become responsible for program design and delivery within statewide standards for eligibility and services.

There is a need for additional Early Psychosis Intervention (EPI) Programs. To serve all residents experiencing early psychosis in California each year, EPI-CAL estimates the state will need 277 facilities providing EPI services that have the capacity to support 75 clients each.[70] Currently, there are 43 EPI programs in California.[71]

As a result, the implementation of early psychosis intervention programs in California varies across counties. This variation is observed in performance against access metrics, with 13% of state residents living in counties without an Early Psychosis Intervention (EPI) program.[72] There are also differences between counties in treatment models and fidelity to CSC program components. In 2017, across the 58 California counties, 24 counties representing 76% of the state's population and 41% of counties reported having at least one active program for treatment of early psychosis. Only five counties reported having multiple programs active. Another 21% of counties had programs in development, while the remaining 38% reported no programs for early psychosis.[73]

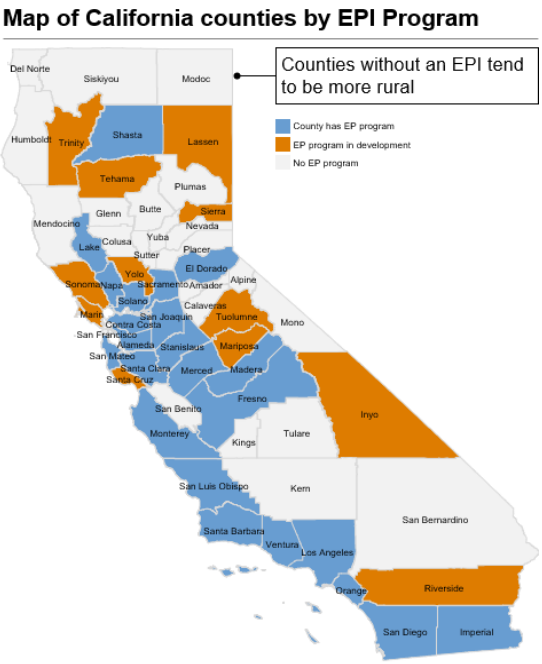


Exhibit 8: Map of California Countries by EPI Program

Sources
Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

Many counties are working to address workforce gaps to expand access. While all states are working towards building a sufficient CSC-trained workforce to meet population needs, California faces a critical lack of CSC-trained staff. The state would need an estimated

[70] EPI-CAL calculator estimating the number of EPI programs needed; the Incidence of early psychosis in California is 21,000 individuals. Assuming the average # of clients served by each EPI program is 75, the number of programs needed to serve 100% of annual incidence is 277

[71] Interview with Executive Director of EPI-CAL, April 17, 2024

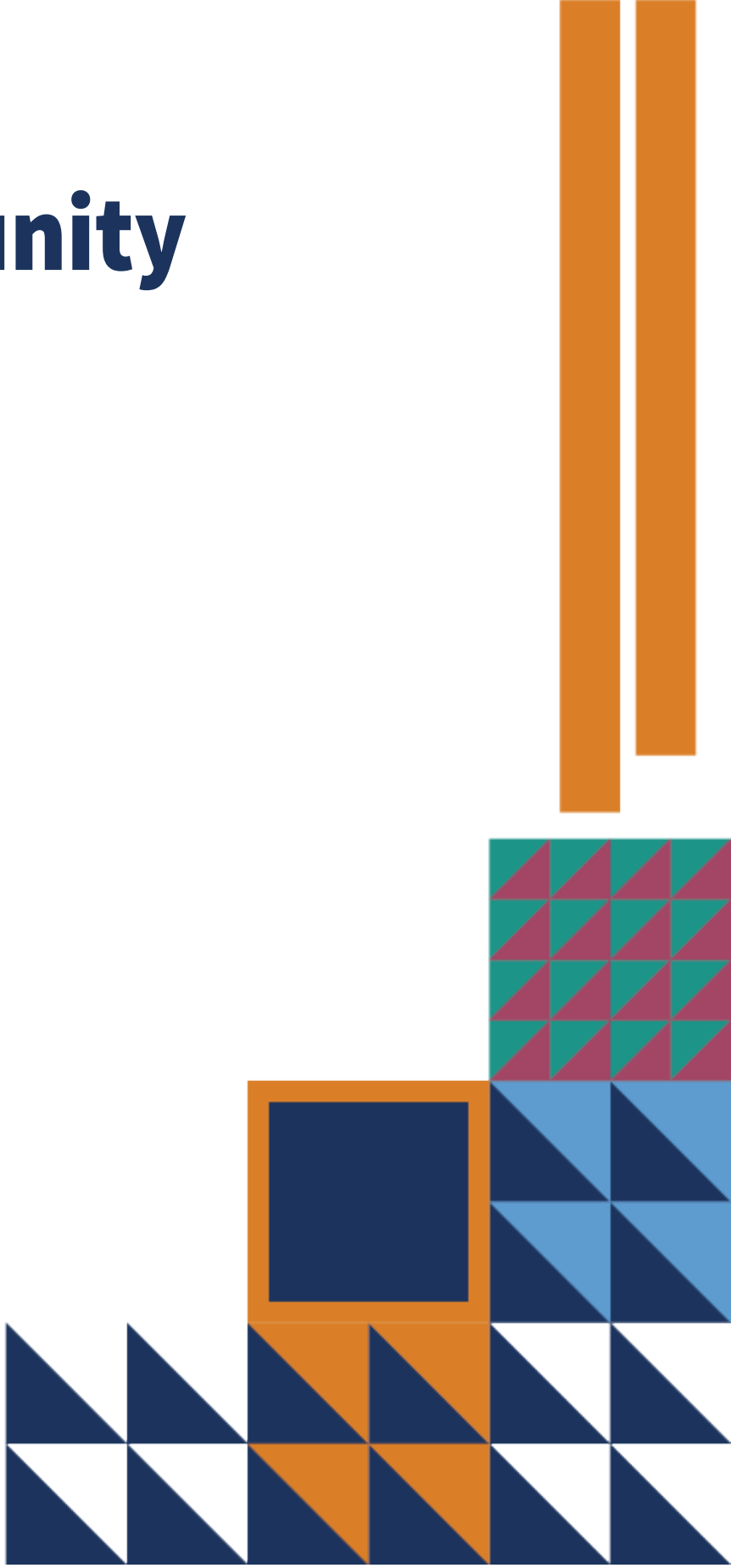
[72] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

[73] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

5,000 more CSC personnel to meet its needs.[74] Further, only 50% of CSC programs in California have staff training specifically in CSC, compared to 85% across the US.[75]

[74] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[75] California 2022 Uniform Reporting System Mental Health Data report SAMHSA

4. Opportunity



In early 2024, the MHSOAC partnered with the National Alliance on Mental Illness (NAMI), the National Association of State Mental Health Program Directors (NASMHPD), the National Council for Mental Wellbeing, and the McKinsey Health Institute (MHI) to develop a National Early Psychosis Intervention Impact Model to estimate the effect of expanding access to Coordinated Specialty Care (CSC). Through interviews with 19 psychosis and CSC subject matter experts[76], and review of dozens of academic research papers, articles, and policy briefs, the collaboration produced an analytic model. This model estimates the direct system cost savings and indirect productivity gains of expanding CSC access across several impact categories (i.e., healthcare, housing, employment and education, criminal and legal system involvement) and to caregiving family members, based on published research on the outcome evaluations of CSC[77]. The analyses have been further refined to detail the impact of expanded access to CSC in California.

Scaling access to EPI programs from the estimated 10% today to 90% would provide access to CSC for an additional 135,000 individuals in California experiencing psychosis. Further, 11,500 caregivers will be able to continue to pursue their careers and to spend time with their loved ones and friends in a non-caregiving capacity.

Moreover, preliminary estimates suggest that expanding access to CSC from addressing 10%[78] of estimated need (i.e., the current estimated level of access in California) to 90%[79] of estimated need will generate measurable cost savings for the system.

If a plan to expand access from 10% to 90% for individuals with needs is implemented in a strategic manner, the state is likely to generate $21B of overall value for the entire ecosystem, compared to a system addressing only 10% of the need over a 10-year period.

Increasing CSC access from 10% to 90% provides services to an additional ~17,000 individuals a year (from approximately 2,100 to 19,000). It also generates an estimated $1.7 billion in annual system cost savings and productivity gains by year 5.[80]

[76] Subject matter interviews conducted between January and February 2024. Additional information included in Chapter 6.1 Approach
[77] Detailed list of references can be found throughout this document and specifically in this chapter
[78] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics); Total programs in CA = ~43; Client per program – average 50-75
[79] The Kennedy Forum
[80] California Early Psychosis Intervention Impact Model

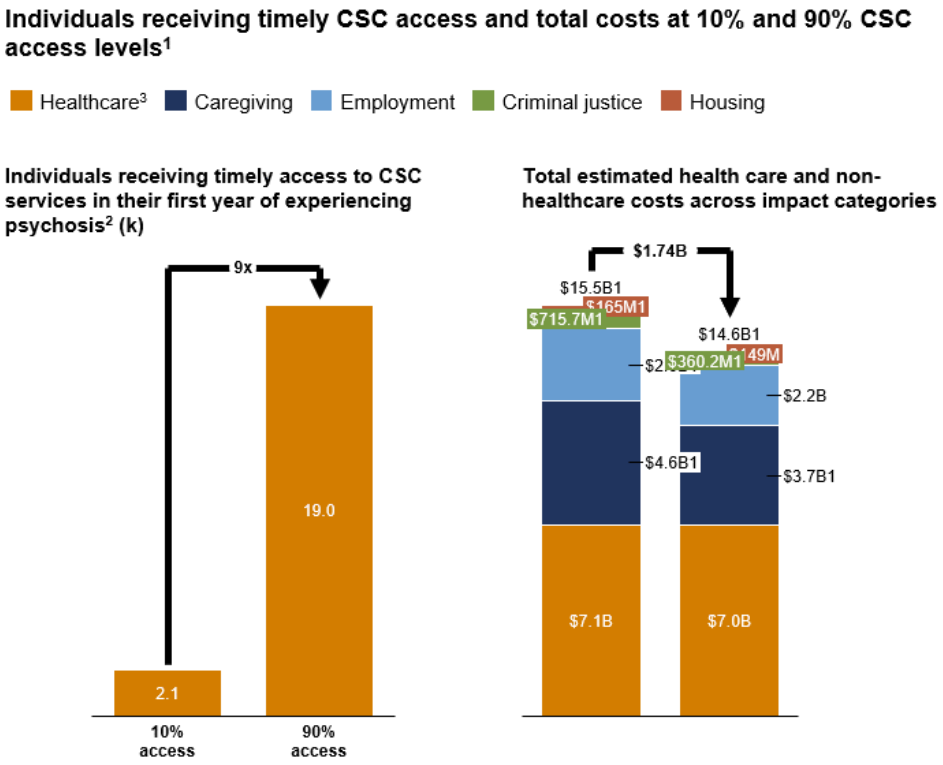


Exhibit 9: Preliminary high-level estimates of the impact of increasing access to CSC from 10% to 90% in California

Sources

1. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. (2019) for Medi-Cal and uninsured populations, and Simon et al. (2017) for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care for 5 years compared to receiving CSC for 2 years and ongoing care for 3 years.
2. Number of individuals receiving timely access in their first year and delayed access in their second year (6.7%) of experiencing psychosis per the 10% and 90% access rate. Incidence is calculated based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics). Age range from the Radigan paper has been expanded to assume the same incidence rate for individuals between 19 and 34 years with Medi-Cal and for the uninsured population.
3. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are assumed to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.

In year 5, healthcare costs decrease from $7.1B to $7.0B as a result of expanding access to CSC from 10% to 90% and reduction in healthcare service utilization (e.g., inpatient, emergency, residential care)

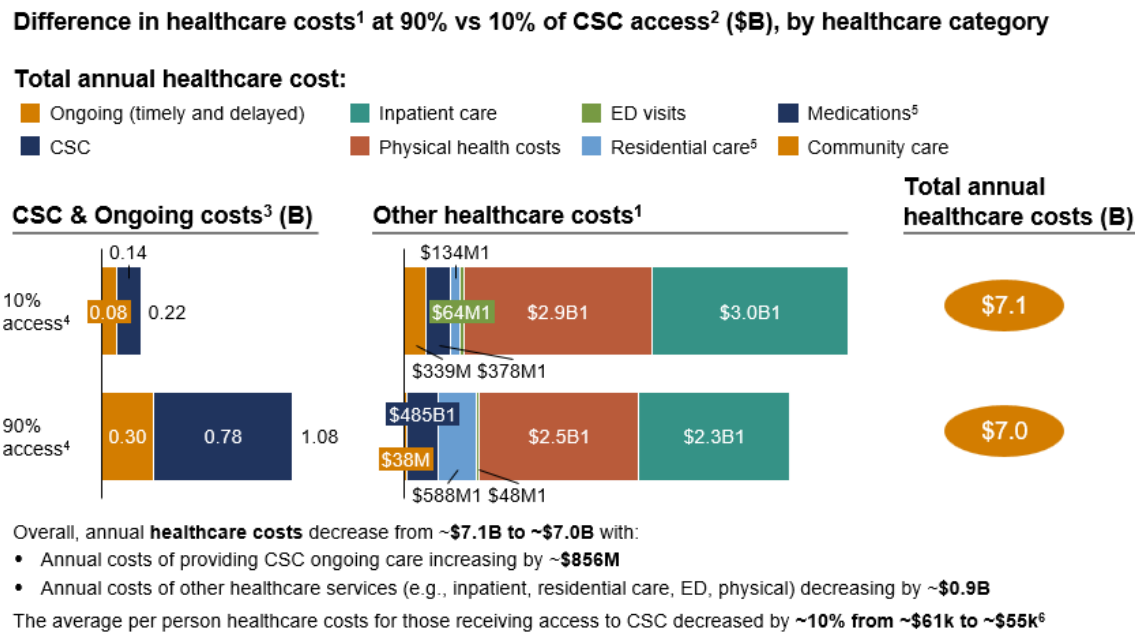


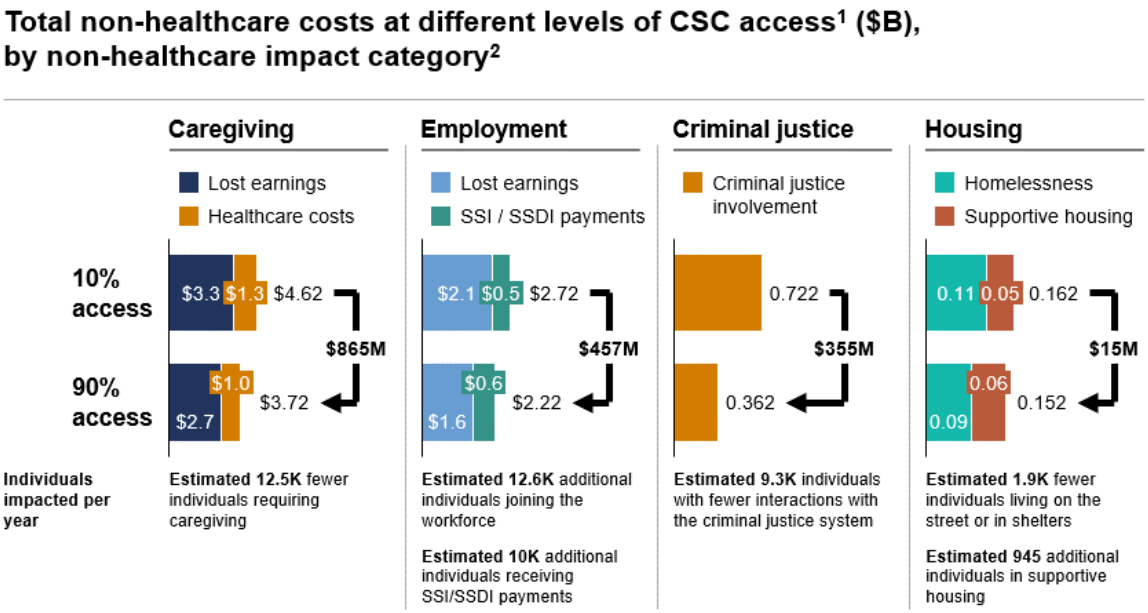
Exhibit 10: Preliminary estimates of impact on healthcare costs from expanding CSC access from 10% to 90% of estimated need

Sources

1. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.
2. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis.
3. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et al. (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.
4. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. for Medi-Cal and uninsured populations, and Simon et al. for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively.
5. Medication and residential care costs are indirect cost increases – annual cost increases because of increasing access.
6. Calculated by dividing the total healthcare cost of providing CSC by total people receiving CSC care for 10% and 90% access, respectively. Does not account for community care.

Increasing access to CSC is estimated to generate $1.7B in non-healthcare cost savings in year 5 (Exhibit 10). The net savings are estimated to be around $1.7B, with $0.5B in direct annual costs and $2.3B in direct and indirect savings across the full ecosystem.

Exhibit 11: Increasing timely access from 10% to 90% is estimated to generate $1.7B in potential non-healthcare cost savings per year



Sources

1. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study.
2. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. for Medi-Cal and uninsured populations, and Simon et al. for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively.

These non-healthcare savings include:

- An estimated $865M in net benefit generated by reducing lost earnings and healthcare costs for caregivers.
- Approximately $457M in net savings through the reduction of lost earnings for individuals accessing EPI and rightsizing SSI/SSDI payment.
- $355M in estimated savings driven by reduced criminal justice involvement.
- $15M in estimated savings within housing systems driven by a reduction in individuals experiencing homelessness and additional access to supportive housing.

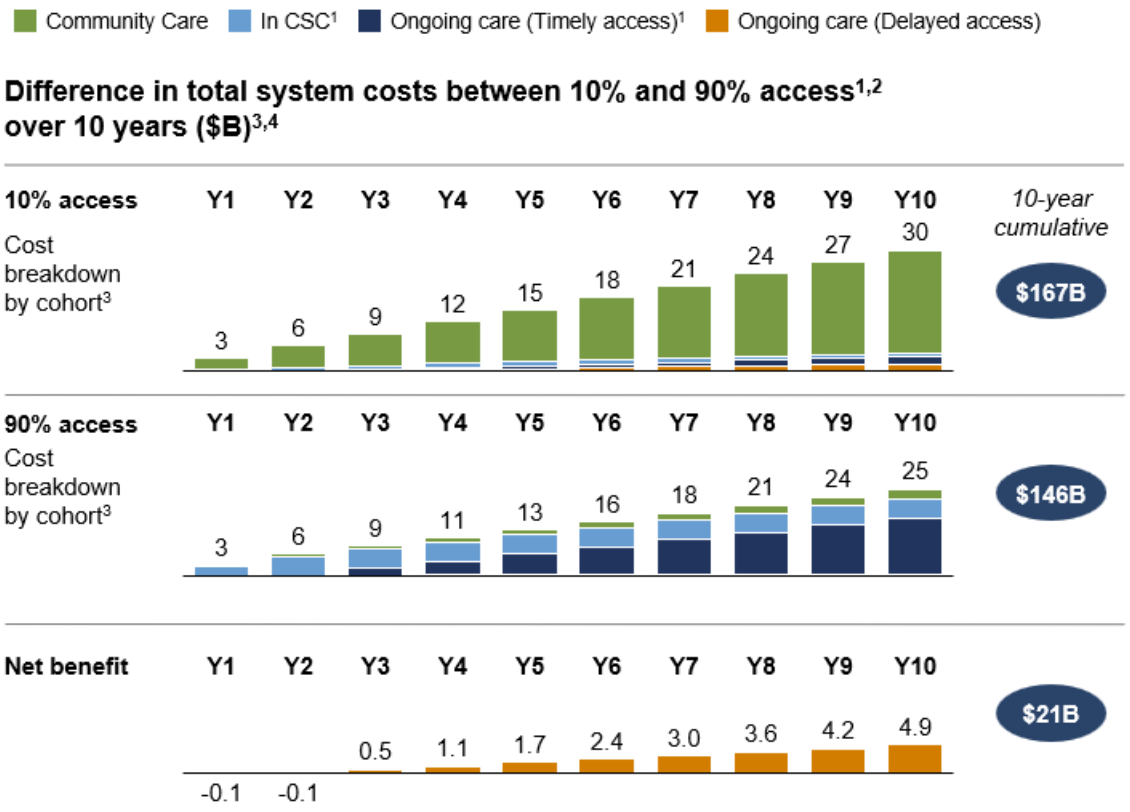


Exhibit 12: Over a 10-year span, a system that addresses 90% of need may generate an estimated $12B in savings for California compared to a system addressing only 10% of need

Sources

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis.
2. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study.
3. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et al. (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.
4. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. for Medi-Cal and uninsured population and Simon et al. for 19-34 aged population that has commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively.

This expansion would positively impact over 135,000 individuals experiencing psychosis and their families, demonstrating the substantial long-term benefits of investing in early psychosis care (Exhibit 13).

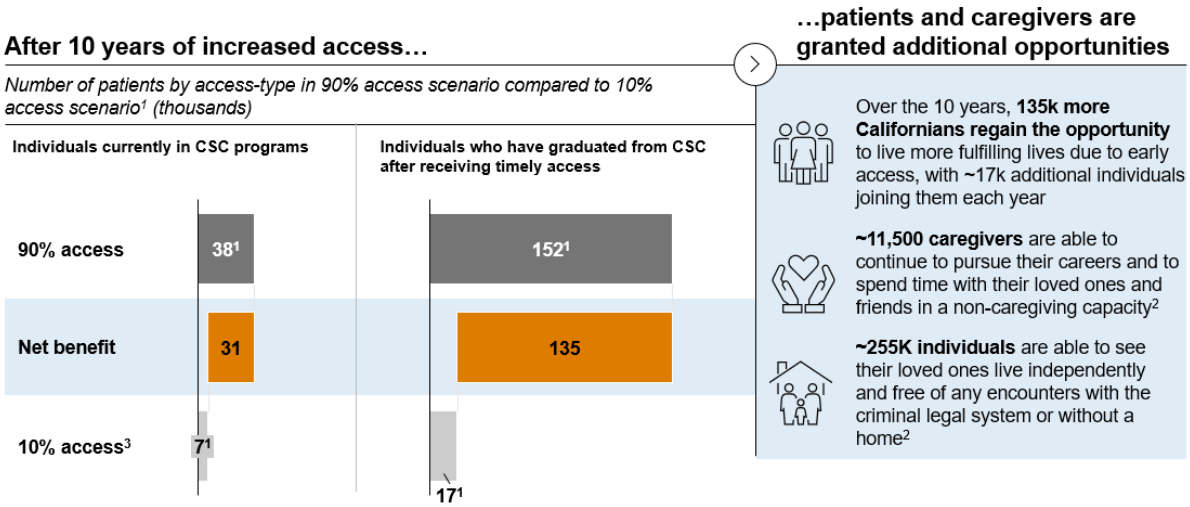


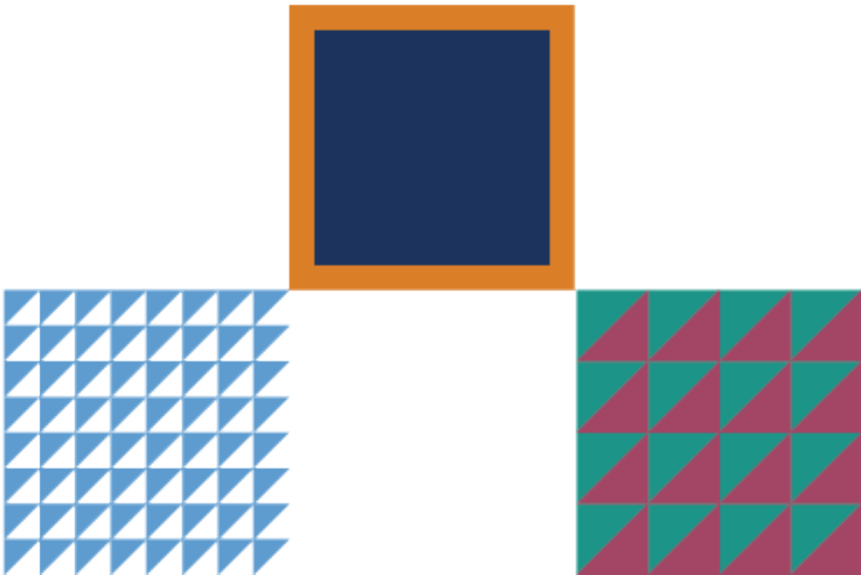
Exhibit 13: Expanded access in California reaches over 135k individuals experiencing psychosis and their families over a 10-year span

Sources

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
2. Based on a fixed assumption of 10% of individuals experiencing psychosis require caregivers
3. Based on the 2022 US Census estimate that the average persons per California household is 2.89; Assumes 1.89 persons per household are granted additional years with loved ones in a non-caregiving capacity. Note that timely and delayed access is based on when an individual is identified as having early psychosis. Individuals may have wide variability in DUP at the time of identification. However, based on available data in empirical research, a conservative approach to mapping outcomes was taken. Where DUP is provided, shorter DUP outcomes were mapped to the timely access group and long DUP outcomes were mapped to the delayed access group. For referenced studies that did not provide DUP, outcomes were assumed to align with the timely access group

All estimates are based on published research on CSC and its impact on early psychosis, using research published during 2013-24. Estimates of the potential system impact of expanding access to CSC may not include the impact of more recent care delivery innovations that may be deployed but were not captured in our research due to the availability of published research and data. There are components of the system impacted by the expansion of early intervention that are not included in the model due to a lack of published research, such as the impact on state hospitals, for which we might expect CSC to have downstream impacts. The real-world impact of scaling CSC in California will depend on model design and investment decisions, including those laid out in this strategic plan.

5. Potential path forward to scale early psychosis intervention



This Early Psychosis Intervention (EPI) strategic plan was formulated through an iterative process, seeking input from a broad range of experts to build consensus, encourage alignment across key partners, and engage California residents. MHSOAC sought technical inputs from subject matter experts, including people with lived experience, to inform key components of the strategic plan. These components will be shared with a broad range of ecosystem partners including individuals with lived experience, national leaders, state, and county administrations focused on health, education, housing, and criminal and legal systems, private sector health care providers and payers, CSC programs, researchers, community-based organizations, nonprofits and philanthropic organizations for input. We will ensure that all Californians have the opportunity to engage in and refine the strategic plan through a public hearing prior to the Commission's review and adoption of the plan.

Process for developing and refining the EPI strategic plan

Exhibit 14: Distribution process for the draft EPI strategic plan

This draft describes the **overall vision** for the early psychosis intervention and the **strategic objectives** required to realize this vision. These cover awareness, access, quality, and equity. The plan also discusses **foundational levers** that are critical enablers necessary to expand access to EPI successfully. These levers include sustainable funding, workforce and capabilities, accountability mechanisms, infrastructure, and ecosystem engagement.

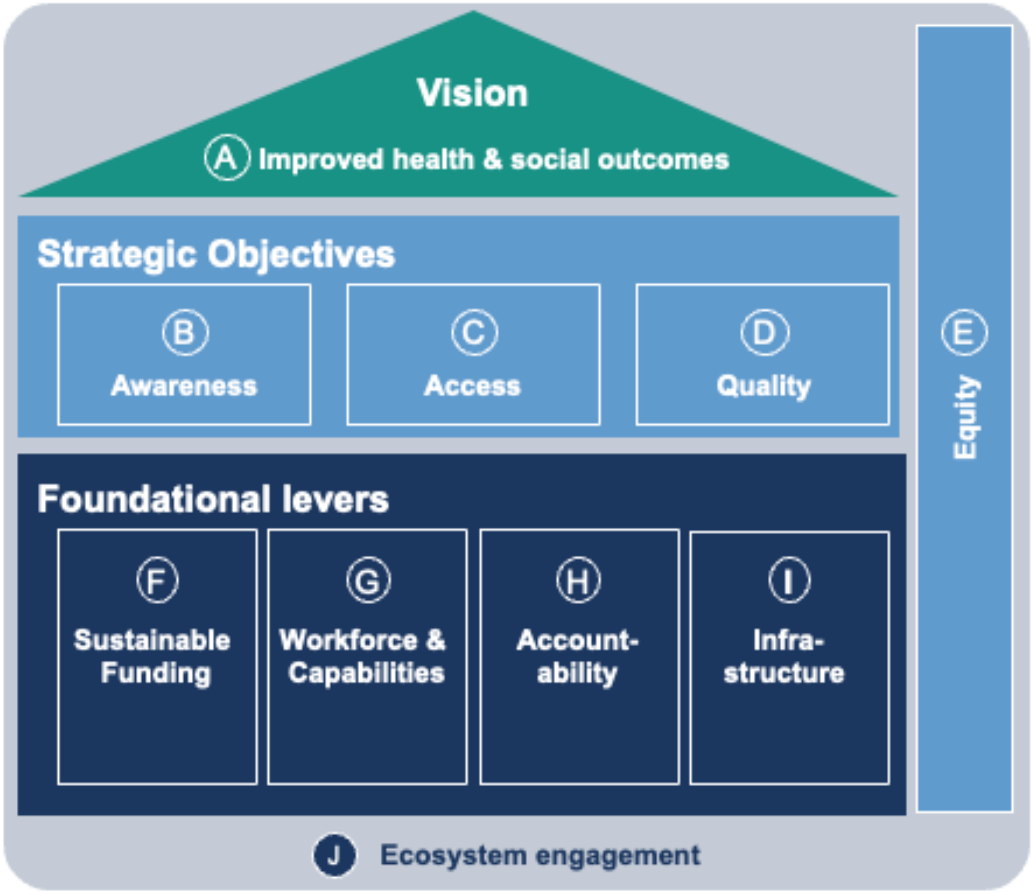


Exhibit 15: Overview of the strategic plan for early psychosis intervention in California

5.1 EPI Vision[81]

The primary goal is to ensure Californians experiencing early psychosis and their families have equitable access to high-quality, appropriate, holistic care.

[81] Discussions with MHSOAC

To this end, the State may consider:

- Building on its pioneering focus on behavioral health.[82]
- Creating alignment across public and private sectors to expand access.
- Promoting fidelity across formats of care using a comprehensive learning health agenda and training for providers.
- Bolstering a population-based approach for indicated adults and adolescents with needs.
- Using widespread public education to destigmatize, identify, and address psychosis early on.
- Engaging diverse perspectives and center community voices in learning, design, and implementation.

The plan targets measurable and specific goals over a three-year time horizon that could include elements such as:

- Increase access to timely, affordable, high-quality EPI services and reduce time to treatment
- Right-size the need for high-acuity and high-cost downstream resources (e.g., state hospital inpatient psychiatric beds)
- Address some drivers of social needs (e.g., housing, education, and employment);
- Enhance the State's capacity and capabilities to provide high-quality EPI services by expanding the behavioral health workforce.

Progress against the targeted goals should be evaluated through outcome measures such as access to coordinated specialty care, client experience and outcomes, improvements in stable housing, career attainment and retention, reduced involvement with criminal and legal systems.

[82] MHSOAC

EPI Focus - *Focus of the strategic plan*

Ensure equitable access to early intervention for all Californians experiencing early psychosis by scaling access to EPI for individuals and their families, with mindful attention to marginalized communities

Ecosystem goals

Build on the state's focus on prevention and early intervention including reduction of stigma, in the context of the behavioral health care continuum

State Aspirations

Support California in achieving its goals, including goals outside of EPI or behavioral health

Exhibit 16: The focus of the strategic plan for EPI is situated within broader ecosystem goals and state aspirations

Sources
Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

5.2 Strategic Objectives

To achieve the vision and scale impact, the State will need to elevate awareness and education about early symptoms of psychosis and available resources, tackle barriers to psychosis treatment access, and improve the quality of evidence-based care, all while maintaining a focus on equity.

In the following sections, the Plan will examine how California is performing against the strategic objectives in the current state, potential goals that the State may aspire towards, key milestones for achieving progress, and possible next steps to inform the solutions that California considers. To achieve the State's goal of 90% access and minimize the duration of untreated psychosis (DUP), each component will be essential.

5.2.1 Awareness

This plan defines awareness as statewide **understanding and familiarity** with the symptoms and available resources and care for early onset of psychosis. Awareness may be built through educational approaches that **minimize stigma around psychosis and psychosis treatment** and **strengthen public expectation** of access to high-quality EPI services Awareness also includes ensuring that individuals experiencing psychosis have information on treatment effectiveness and potential impacts on their lives and well-being.[83]

Current state of awareness

Lack of awareness may result in high levels of stigmatization; studies have found that 55% of individuals on the schizophrenia spectrum experience stigma.[84] In California specifically, experts report that stigma and lack of awareness continue to be a challenge to providing the needed care.[85]

California has invested in improving awareness and reducing stigma associated with seeking mental health care through multiple initiatives spearheaded by MHSOAC, CDPH, DHCS, CYBHI, and other agencies; a few key initiatives include:

- **allcove®, an integrated mental health youth drop-in center**,[86] seeks to offer destigmatizing and accessible services for youth ages 12 to 25. Beyond treatment for moderate mental health challenges, allcove® provides linkages to services. Originally launched in 2018 by Santa Clara County, allcove® became a state-wide effort through the Budget Act of 2019**.**
- **The Workplace mental health project**,[87] launched in 2018 through Senate Bill 1113, enabled the development of five voluntary standards that employers may adopt to support mental health awareness. These include leadership and organizational commitment; positive workplace culture and climate; access to services; crisis preparation, response and recovery; and measurement, evaluation and continuous quality improvement.
- **CYBHI Public Education and Change Campaigns**[88] is a youth-co-designed statewide campaign to reduce mental health stigma and boost help-seeking behavior. Launched in 2022, the 100M effort will span four years and work towards culturally appropriate solutions that are grounded in community empowerment strategies. **The CYBHI ACEs**

[83] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[84] C. Simonsen et al, Perceived and experienced stigma in first-episode psychosis: A 1-year follow-up study, Comprehensive Psychiatry (2019)
[85] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[86] allcove®
[87] Workplace mental health
[88] CDPH Public education and change campaigns

and Toxic Stress Public Awareness and Healing-Centered Campaign,[89] spearheaded by CA-OSG with $24 million funding, is a dynamic statewide initiative spanning 2023 to 2024. By convening diverse partners, the campaign aims to enhance public understanding of Adverse Childhood Experiences (ACEs) and toxic stress, including how toxic stress is a treatable health condition.

Awareness of Early Psychosis

"First of all, **people don't really understand what's going on with you or your loved one experiencing psychosis. It's a language only you and those who have experienced this journey speak."**

"**There are so many ways in which you are misunderstood** and perceived in how you are contributing to society and what you are doing with your life when **you are really just trying to survive"**

"If you are born with diabetes, people don't judge you for it, unlike if you say I have psychosis. I look at it as something that is manageable. While you need treatment for it, **you can live and live to the best of your ability."**

"Being a part of someone's life in this way, yes, has its challenges, but it is also a privilege**. My brother is one of the most amazing people I've ever known and is incredibly intelligent and wise and has brought a lot more healing and awareness to my family than I could have ever imagined**."– Sister, Caregiver, Family Peer Support Specialist

Key objectives/goals[34]

The key goals of the plan regarding awareness are:

- **Improving awareness** of symptoms of early psychosis, particularly among individuals who may play a role in identifying these signs and connecting individuals to care (e.g., teachers and primary care physicians) through intentional and

[89] CYBHI ACEs and toxic stress public awareness campaigns

educational approaches informed by research and best practices including integrating screenings where appropriate.

  - **Enhance familiarity** with psychosis assessments and care resources for individuals and their loved ones.
  - **Destigmatize psychosis** and related conditions among the general population through education
  - **Destigmatize care-seeking behavior** with a particular focus on vulnerable population segments.
  - **Educate Californians on the effectiveness of EPI** for short- and long-term recovery.

- Establish and strengthen expectations of access to high-quality EPI services through publicized targets (e.g., 90-90-90 treatment targets set by UNAIDS)

Next steps

MHSOAC proposes the following next steps for consideration:

- Improve public awareness:
  - **Creating one-stop resource centers** for psychosis care seekers and families to access content on early psychosis symptoms and pathways to access care[90]
  - **Create educational materials** that feature **scientists and doctors** who can speak with authority on the effectiveness and impact of EPI
  - Build an EPI **champion/ambassador program** where individuals who have gone through EPI programs themselves share their lived experiences and knowledge with the community

Tailor communications to **specific population groups including channel usage and culturally relevant messaging,** leaning on community partners to help inform and implement population-specific communication approaches that address stigmatization and other barriers that limit care seeking.

  - **Build partnerships with existing behavioral health awareness campaigns** to create or enhance psychosis-specific programming (e.g., integrating psychosis education into other awareness programs such as ACE)[91]

[90] Interview with Lead Investigator of social and cultural determinants of psychosis risk, City College of New York, March 28, 2024
[91] Interview with Director, Stanford Center for Youth Mental Health and Wellbeing, 20 March 2024

- Ensure individuals working within crisis responses systems (e.g., 988 mobile crisis units, emergency room clinicians) are aware of early psychosis symptoms and treatment avenues

- Establish and strengthen public expectations:
  - **Enhance transparency and strengthen public engagement** by making current access, coverage, and equity measures for EPI publicly accessible; implement regular reporting and tracking of KPIs to strengthen and foster accountability.
  - Develop **a public communications strategy with awareness campaigns that facilitate a call to action by Californians** to catalyze engagement from key ecosystem partners in pursuit of the goal of achieving access to CSC for 90% of individuals within the 1st year of onset of psychosis.
  - **Enhance school mental health curriculum and public awareness campaigns** to explain the benefits of CSC and showcase its comparative advantage in terms of prevention and control outputs

Potential Milestones/Progress Measures

Prospective milestones towards achieving awareness objectives include the following:[92]

- Align with advisory group and partners on the timeline and sequencing for awareness building based on EPI system readiness
- Review landscape of behavioral health awareness programs in California and identify potential partnerships and/or learnings to support awareness building for early psychosis intervention.
- Convene a workgroup with a charter to design a public engagement strategy including target metrics for awareness (e.g., awareness and stigma as measured through annual surveys, average duration of untreated psychosis) and approaches to build awareness among vulnerable populations.
- Determine community organizations to potentially partner with on tailoring messaging for specific populations or engaging in awareness efforts directly within the community.

[92] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

– Engage a team of critical ecosystem partners to implement and refresh awareness strategies.

5.2.2 Access

Access is defined as the adequate supply of affordable, timely, and evidence-based care across geographies and subpopulations.[93] The implications of providing access may vary based on geography (e.g., urban vs. rural vs. suburban settings) and population-based factors (e.g., children and youth vs. adults).

Current state of access

An estimated 10% of Californians experiencing psychosis are currently able to access effective early intervention services.[94] This Plan evaluates the current state through four lenses of access: timeliness, convenience, coverage, and eligibility. Workforce and infrastructure, which are key access enablers, are discussed in later sections of the strategic plan (4.3.2 and 4.3.4, respectively).

Timeliness

The California Department of Managed Health Care (DMHC) requires health plans to provide timely access to care. In the context of nonurgent mental health appointments, including for early psychosis, health plan members have the right to appointments within 10-15 business days and within 48-96 hours for urgent care.[95] However, experts report that many clients do not receive an appointment within the target time frame, especially in cases where the initial point of care is for stabilizing services (e.g., emergency departments and crisis care centers).[96] Per the 2022 DMHC Timely Access Report, the mean wait time for urgent appointments with a psychiatrist was 109 hours, exceeding the 48-96 our threshold. [97]

Convenience of access

In California, convenient access to EPI programs varies across counties; as on 2017, 59% of counties did not have an active EPI program, and less than half of the counties without active

[93] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[94] EPI-CAL estimates; Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group)
[95] DMHC
[96] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[97] DMHC 2022 Timely Access Report

programs are in the process of developing a program. [98] Lack of convenient access may be particularly pronounced in vulnerable places within California.[99] Additionally, even in counties with EPI programs, there may be insufficient capacity and/or infrastructure to meet community needs.[100]

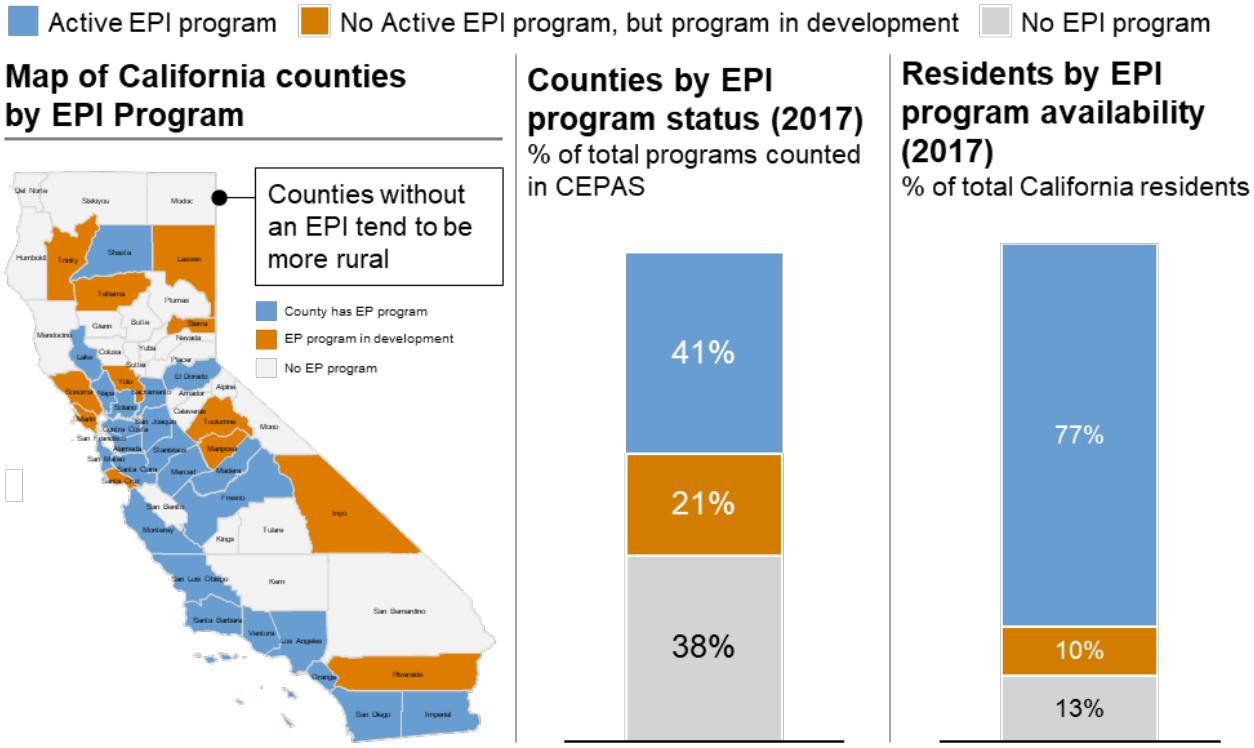


Exhibit 17: Landscape of active and developing EPI programs within California

Sources
California Early Psychosis Assessment Survey (CEPAS); U.S. Census Bureau Data: Annual estimates of Resident Population: April 1, 2010 to July, 2019
Note – This visual is not meant to assess sufficiency of EPI treatment offerings by county as needs vary based on population density and the CSC standard of care.

[98] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[99] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[100] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Coverage

In the current state, there are differences **between counties' CSC reimbursement model (Medi-Cal) and that of private health plans**. Medi-Cal often covers the suite of CSC services.[102] In contrast, private insurance usually only reimburses specific clinical services such as psychotherapy and medication management.[103] Private health plans rarely reimburse nonclinical components of CSC care (e.g., peer-support programs, supportive education, and employment) despite the robust evidence base demonstrating the effectiveness of these interventions in improving health and social outcomes for people with early psychosis.[104] In California, 53.9% of the population is covered by private insurance, 26.8% by Medi-Cal, 12.0% by Medicare, and 0.8% by the military; 6.5% of Californians are uninsured.[105]

"A robust international body of literature demonstrates the effectiveness of a multimodal, recovery-oriented, and team-based treatment model – referred to as coordinated specialty care (CSC) in the United States – for addressing the complex needs of individuals with early psychosis. However, CSC remains out of reach for many individuals who would benefit from it. One major barrier to access in the United States is financial restrictions: CSC programs often struggle to receive compensation for nonbillable but essential patient-specific services (such as occupational and educational guidance, peer support, and community outreach), and patients with commercial insurance may need to pay for some or all CSC services out of pocket." Hirschtritt et. al (2024) [101]

On the federal level, there have been efforts to ensure coverage for mental health services. In 2008, the Mental Health Parity and Addiction Act called for mental health benefits covered by insurance to be provided at the same level as physical health care benefits. Mental Health Parity has been strengthened by executive and legislative actions, most recently through an executive rule in 2023; however, many still struggle to afford the care they need.[106]

California is advancing mental health legislation that encourages more participation in the delivery of mental health services for plans and providers. The State enacted the Senate Bill (SB) 855[107] in 2020. SB 855 requires health insurance to cover medically necessary

[101] Hirschtritt et. al. Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis
[102] CMS approves payment for Coordinated Specialty Care of First-Episode Psychosis
[103] NAMI – Coverage of Coordinated Specialty Care for early of First-Episode Psychosis, SAMHSA, Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies
[104] Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis by Hirschtritt et. al. 2024
[105] KFF
[106] The White House: FACT SHEET: Biden-Harris Administration Takes Action to Make it Easier to Access In-Network Mental Health Care (July 25, 2023)
[107] Senate Bill 855

mental health and substance-use disorder care. All benefits that are medically necessary to prevent, diagnose, or treat mental health conditions and substance use disorders must be covered, including visits to a mental health care provider, **intensive outpatient treatment, residential treatment, hospital stays,** and prescription drugs if covered by policy.[108] An additional requirement is that networks include coverage for sufficient providers and facilities within a reasonable distance to provide timely care or arrange care from out-of-network providers or facilities.[109]

While Medi-Cal has historically covered many CSC components, it has not defined CSC as a distinct benefit or provided bundled reimbursement. California's Department of Healthcare Services (DHCS) proposed **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH- CONNECT)** may change this. One of the goals of BH-Connect is "improved availability in Medi-Cal of high-quality community-based behavioral health services, evidenced-based practices (EBPs_, and community-defined evidence practices, including CSC for first-episode psychosis". By defining CSC as a county-optional Medi-Cal benefit and offering bundled payments to county BH plans, California aims to support delivery of the comprehensive Early Psychosis Intervention.[110]

Eligibility and Intake

California currently does not have a consistent standard for CSC eligibility and intake, in part reflecting the complexity of consistently and accurately diagnosing early psychosis. Studies have shown that the diagnostic stability (the degree to which a diagnosis remains the same during subsequent assessments) of psychotic disorders is 47.7%.[111] This is indicative of both the complexity of accurate psychosis assessment and potential opportunities to improve consistency in screening and diagnosis for psychosis. Experts also suggest expansion of eligibility criteria for accessing EPI programs like CSC.[112] In California, eligibility criteria vary across EPI programs. Most EPI programs under the stewardship of EPI-Cal extend treatment to a broader continuum of psychotic disorders, including individuals at Clinically High Risk (CHR) for psychosis and individuals affected by mood disorders.[113] However, as of 2017, 17% of EPI programs in California do not serve individuals at CHR and 7% of programs do not treat people whose primary diagnosis is a mood disorder.[114]

[108] California Department of Insurance
[109] California Department of Insurance
[110] The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT) Section 1115 Demonstration
[111] Peralta et al, Long-term diagnostic stability, predictors of diagnostic change, and time until diagnostic change of first-episode psychosis: a 21-year follow-up study, November 2021
[112] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[113] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[114] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

Impact of access to Early Psychosis Intervention on caregivers

"[Before access to EPI] **You're in survival mode for so long.** You cannot think of any other way of how things can be. You expect that your lack of sleep will be constant. Everything, your well-being, social life, relationships, comes crashing down. You're not living your best life, and **you can't give a lot to the people that you love, especially those experiencing psychosis that you support as a caregiver.** That changes in CSC programs.

Getting used to the fact that someone is actually going to be there is hard. **Realizing that there are people supporting you, listening to you, and taking on some of the tasks of caregiving that you have been providing to your loved one is a shell shock in a good way.** It's it takes a while for people to get used to that." – Sister, Caregiver, Family Peer Support Specialist

In California, our model is much more youth-focused, family-focused, we are more open in who we serve, and we are really trying to further expand the criteria used for program eligibility. So just really trying to get programs to take time to actually understand community's needs and build programs within the context of CSC to meet those needs." – Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics)

Key objectives/goals

The goal for access is to ensure that 90% of individuals within the 1st year of onset of psychosis have **timely, affordable, appropriate,** and **convenient** access to CSC programs that are designed to inspire trust. [115] In the long term, the State may seek to ensure access within a shorter time frame, recognizing that the World Health Organization (WHO) recommends specialized treatment no more than 90 days after the start of psychosis symptoms.[116]

[115] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

[116] J Bertolote et al, Early intervention and recovery for young people with early psychosis: consensus statement

Next steps[117]

MHSOAC proposes the following next steps for consideration:

- **Timeliness:** To improve the timeliness of access, California could establish a workgroup to collect data to identify root causes for access barriers and establish incremental and long-term targets related to the average duration of untreated psychosis (DUP), average wait times for enrollment into CSC programs, and other metrics of timely access
- **Coverage:** To work towards ensuring all individuals experiencing early psychosis have access to CSC, regardless of their insurance coverage, California could consider exploring strategic optimization of service-based reimbursements and programmatic funding sources, explored in some more detail in Chapter 4.3.1.
- **Convenience:** California could explore the following steps to improve convenience:
    - Survey care seekers, their families, and community members to understand care experiences, timelines, and convenience challenges and identify solution to address access barriers outside of the health system (e.g., transportation for treatment)
    - Establish county-level archetypes and corresponding care models for convenient access based on factors such as population density, existing infrastructure, and the presence of vulnerable places and communities.[118] Develop criteria for determining when to deploy a given model (e.g., hub and spoke, regional models, virtual care elaborated in chapter 4.3.4)
    - Explore and build out telehealth offerings related to EPI.
    - Build partnerships with trusted community-based organizations to enable more culturally competent programs that create an environment of safety and accessibility (described further in chapter 4.2.4. Equity.)
- **Eligibility and intake:**
    - Standardize psychosis diagnosis and intake processes (e.g., refining clinical guidelines, providing enhanced clinician and provider training for individuals who may screen or identify psychosis, such as primary care providers, school mental health providers, and healthcare providers in correctional settings).

[117] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[118] CDPH definitions of vulnerable communities and vulnerable places

- Improve access to screening for individuals in child welfare homes and youth involved with the criminal/ legal systems due to the strong linkage between trauma exposure and psychosis.[119]
- Strengthen care referral networks through partnerships with health systems, health plans, criminal/legal system facilities, housing services providers, and community- and faith-based organizations to connect patients with EPI screening and treatment services.
- Explore universal screening for select settings (e.g., within the criminal justice and behavioral health systems)
- Develop protocols and training for individuals without a healthcare background who may play a role in the identification of psychosis symptoms.
- Strengthen linkages between EPI and the crisis care continuum system (e.g., 988) to ensure individuals in crisis experiencing psychosis receive the proper care and referrals include mobile supports when needed
- Establish Centers of Excellence to offer training and technical assistance EPI program to ensure model fidelity, improve outcomes for clients, disseminate community-defined care practices and strengthen culturally-sensitive care[120].

Potential milestones/progress Measures[121]

- Establish access standards in the context of urban, suburban, and rural communities.
- Establish community-led working groups to
  - Evaluate EPI access barriers across counties and population groups within California (e.g., capacity, coverage, infrastructure)
  - Build out an iterative timeline for addressing access barriers and meeting goals.
  - Identify and implement solutions with relevant partners in private, public and social sectors.
- Refine and reinforce guidelines for psychosis diagnosis and referral built in conjunction and partnership with DHCS proposed guidelines to Medi-Cal
- Track and report on impact. Potential metrics could include:

[119] Morrison et al, Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors, September 2005
[120] BH-CONNECT 2023
[121] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Timeliness:** average duration of untreated psychosis (DUP), average wait time for the first appointment, % of individuals within the first year of onset of psychosis receiving CSC
- **Coverage:** the # of individuals with private insurance with fully covered CSC treatment, out-of-pocket expense for clients using self-pay funding
- **Convenience:** # of community partners engaged in EPI program design, self-reported ease of access for EPI programs for clients through surveys
- **Eligibility and intake:** % of diagnosed individuals referred to EPI, % of clinicians reporting using the same clinical guidelines for early psychosis diagnosis.

5.2.3 Quality[122]

Quality is defined as the approach for ensuring that Early Psychosis Intervention (EPI) services increase the likelihood of desired outcomes, foster a positive client experience, and are consistent with learnings and individual community needs.[123]

Current state of quality

The American Psychiatric Association (APA) proposes Coordinated Specialty Care (CSC) as the **established standard of care** for early psychosis intervention.[124]

However, nationally and within California, the interpretation of Coordinated Specialty Care varies with multiple treatment models deployed.[125] Within California, **different treatment models are in use for EPI** including the Portland Identification and Early Referral (PIER) model, the Felton Institute Prevention and Recovery in Early Psychosis (Felton) model, the Early Diagnosis and Preventative Treatment (EDAPT) model, the Early Assessment and Support Alliance (EASA) model, and the Recovery After an Initial Schizophrenia Episode (RAISE) model. The California Early Psychosis Assessment identified the PIER model as the most commonly used approach for CSC (20% of programs that responded to the survey cited

[122] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[123] Institute of Medicine definition cited in Dimensions of Quality in Mental Health Care
[124] Keepers et al, The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia, September 2020
[125] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

using this model), followed by Felton and EDAPT models (17% of programs). Approximately 27% of programs reported utilizing other models that incorporated different components of CSC with modifications. [126]

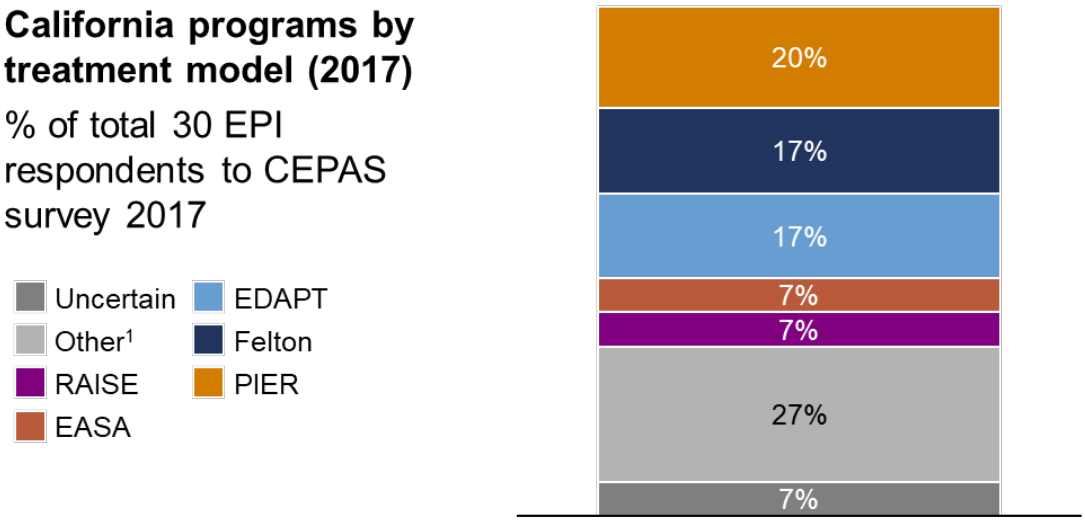


Exhibit 18: California CSC programs vary in the specific type of CSC they offer

Sources
The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al,
1 Other model that include various CSC components. For example, Los Angeles reported using the University of California, Los Angeles, Center for the Assessment and Prevention of Prodromal States model; Contra Costa County reported using the PIER model with adaptations; and Madera County reported using a "peer supportive service" within a full-service partnership to support linkage to medications and therapy.

Across CSC models, fidelity is a critical component of quality. The First Episode Psychosis Services Fidelity Scale (FEPS-FS) is based on a list of 35 essential components identified by systematic reviews and an international consensus process. It has been used in California as part of EPI-CAL fidelity assessments. In California, CSC **programs have varied in fidelity** to the 35-point FEPS-FS scale across models, indicating differences in adherence to evidence-based practices.[127]

[126] The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al,
[127] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

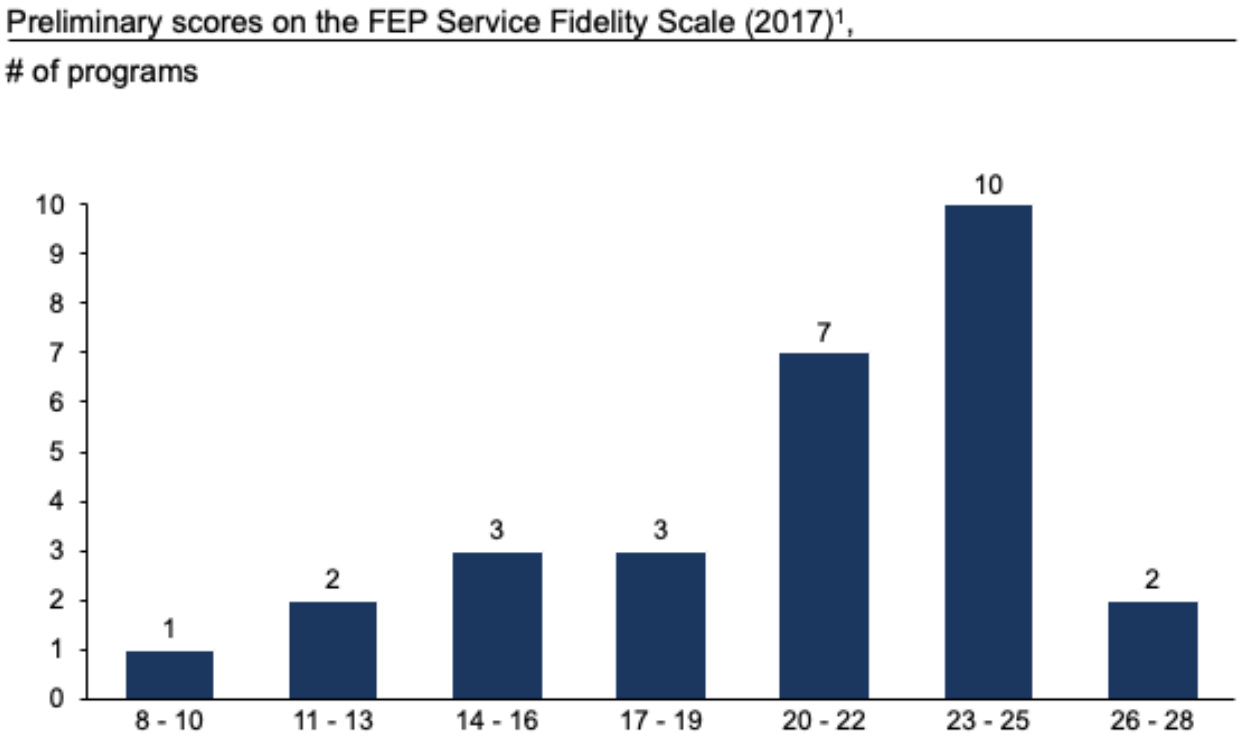


Exhibit 19: California CSC programs vary in fidelity

Sources
The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al, 2017

Furthermore, **programs also have varied design dimensions,** such as the duration of the care plan, eligibility criteria for care seeking, and data collection and maintenance practices.[128]

Despite variations in care delivery, **a slightly higher percentage of participants in California CSC programs reported general satisfaction** regarding the quality and appropriateness of their programs compared to the national average. According to a SAMHSA survey, 90.4 % of participants in California CSC programs reported general satisfaction with care, while the national average was 87.8% .[129]

However, most Californians do not have access to CSC care currently, and other treatment programs may not be meeting the same level of care. Moreover, as CSC programs scale, there will be questions on how to maintain program quality and ensure fidelity.[130]

[128] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[129] SAMHSA, 2022 Unified reporting summary
[130] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

To monitor and improve quality, the National Institute of Mental Health (NIMH) established the EPINET National Data Coordinating Center (ENDCC), with **EPI-CAL serving as California's regional hub for EPINET.**[131] EPI-CAL aims to improve the quality of services and measure the impact of treatment through initiatives such as the Learning Healthcare Network (LHCN), which supports the standardization of practices and knowledge sharing between programs.[132] Additionally, EPI-CAL Training and Technical Assistance (TTA) provides training to support the implementation and sustainability of county-led EPI programs.[133]

Quality of Early Psychosis Intervention

"We had a resident on the team (at SacEDAPT) and he was just so collaborative. It was the first time I felt empowered to say, 'This isn't working out what else can we do', as opposed to being a recipient of 'I am a doctor so listen to me'. Now I offer this empowerment to families I work with – **you have the right to say what is or is not working. It is not about them being well according to a doctor and being asymptomatic, but that they have the ability to have a livelihood - are they able to live their life"** – Sister, Caregiver, Family Peer Support Specialist

"I think what has been really impactful are these individuals who come in at one of the most challenging times of their lives – often having come from the hospital or having been to jail. Getting to work with them and their families to find a path forward, walk with them on that path, and then be able to celebrate their amazing successes has been a real highlight**. I think when most folks hear the diagnosis of psychosis, they think everything is over.** Unfortunately, we as providers often reinforce that notion. Our own stigma creates a bleak outlook for the folks that we're intending to serve. **And I believe that when CSC is done well, we are partners in supporting people towards their dreams. I've had the privilege of seeing folks go to college, go to grad school, get married, have kids, and live their lives – just as they should. And that's the dream I want to be possible for all folks in California who have psychosis and their families.** – Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics)

[131] EPINET National data coordinating center
[132] EPI-CAL
[133] EPI-CAL TTA Orientation

Key objectives/goals[134]

The key goals of the plan with regard to quality are to:

- Promote a clearly defined CSC model as the **standard of care for treatment of early psychosis** developed in alignment to the proposed Medi-Cal standards**.**
- **Improve fidelity to the CSC model** for EPI programs in California. Set clear standards with tailored approaches integrated, that evolves over time to address culture, age, and geographic needs.
- Continuously improve the CSC model and care delivery to **enhance experience and outcomes** for individuals with early psychosis.

Next steps[135]

MHSOAC proposes the following next steps for consideration:

- Promote a **standard of care for treatment of early psychosis**.
    - **Consider aligning on a single CSC program model** for California and promote **the implementation of all CSC components for EPI,** including nonclinical components (e.g., Supportive Education and Employment)
- Research and pilot standards of care for **step-down services** (e.g., community-based services) to be provided after receiving care from CSC as well **as coordination between CSC programs, primary care providers and other parts of the care continuum for psychosis** (e.g., Full-Service Partnerships) to ensure integrated mental health and physical health care for clients to ensure integrated mental health and physical health care for clients
- **Improve fidelity to the CSC model**
    - **Align on approach and tools for measuring fidelity**: Identify metrics to measure both fidelity and establish defined targets.
    - **Review EPI programs against fidelity scores**: Review EPI programs against fidelity scores to facilitate targeted interventions for improving adherence to modalities such as Early Diagnosis and Preventative Treatment (EDAPT), PIER, and FELTON; tailor assessments to promote and ensure cultural and contextual appropriateness.
- Continuously improve the CSC model and care delivery to **enhance experience and outcomes** for individuals with early psychosis.

[134] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[135] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Identify service-user-driven quality metrics** that can assess outcomes (e.g., patient experience, clinical outcomes, and broader ecosystem impact) and establish goals for each metric in collaboration with clients and ecosystem partners. These goals may need to account for various deployment models (e.g., peer-led or virtual) of EPI while promoting shared ownership and accountability.
- **Consider incentive mechanisms for EPI linked** to fidelity goals, outcome goals, and client experience goals (e.g., align reimbursements to quality outcomes or establish shared savings program to incentivize quality outcomes).
- **Ensure technical assistance and training programs** to consider the needs of vulnerable places (e.g., hyper-rural, hyper-urban settings) and provide additional resourcing where needed to meet quality standards. Training programs could be connected or established through a **Center of Excellence.**
- **Examine models of data infrastructure management implemented** in other states (e.g., Massachusetts, Georgia, Nebraska, Tennessee, Oklahoma) to inform metrics and mechanisms that may form the basis of a robust data system for EPI programs in California.
- **Establish a Center of Excellence** that could help enable collaboration with higher education institutions, enhanced technical assistance provider capacity, and upskilling of the workforce faster through an enhanced training curriculum. These could be in partnership with the proposed BH-CONNECT demonstration plan as well as BH-Transformation initiatives.

Potential milestones/progress measures[136]

A few prospective milestones in the process of working toward the quality goals are:

- Establish an evidence-based standard of care and continuous quality improvement strategy through a workgroup of relevant ecosystem partners.
- Collect and review evidence on quality outcomes.
- Identify metrics across dimensions of quality. The Institute of Medicine outlines six dimensions of quality[137] that may be used to inform metrics:

[136] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[137] Institute of Medicine definition cited in Dimensions of Quality in Mental Health Care

  - Effectiveness: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit
  - Client-centeredness: providing care that is respectful of and responsive to individual client preferences and needs. Ensuring that client values guide all clinical decisions.
  - Timeliness: reducing waits and sometimes harmful delays for both those who receive and those who give care
  - Safety: avoiding injuries to patients from the care that is intended to help them
  - Efficiency: avoiding waste, including waste of equipment, supplies, ideas, energy, and human resources
  - Equity: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
- Build a mechanism to manage, measure, monitor, and improve quality, including:
  - EPI program reporting requirements.
  - Data validation mechanisms.
  - Centralized monitoring capacity (establish quality metric working group).
  - Launch impact tracking with potential metrics such as:
    - Improvements in quality outcomes.
    - Increases in fidelity scores for EPI programs.

5.2.4 Equity

The plan defines equity as ensuring full and equitable access to high-quality early psychosis care resources focusing on vulnerable communities.[138]

Current state of equity for EPI in California

California has established **key definitions and operating bodies** within the health equity space that can serve as the foundation for this plan's equity approach. The California

[138] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Department of Public Health (CDPH) defines **health equity** as efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.[139] CDPH established the Office of Health Equity (OHE) to lead efforts focused on reducing health and mental health disparities experienced by **vulnerable communities** in California. According to CDPH, vulnerable communities include but are not limited to racial or ethnic groups; low-income individuals and families; individuals who are incarcerated or have been incarcerated; individuals with disabilities; children, youth, and young adults; seniors; women; immigrants and refugees; individuals who are limited English proficient; and LGBTQ+ communities; or combinations of these populations.[140]

Workforce diversity is also critical for ensuring culturally competent and equitable care. According to the 2021 California Behavioral Health Workforce Assessment, there is cultural and racial diversity in the California behavioral health workforce on aggregate: ~60% of behavioral health workers are people of color, which reflects the diversity of California's population. However, the highest-paid professions in behavioral health – counselors, psychologists, physicians, and psychiatrists – are disproportionately white. Additionally, while approximately one-third of physicians in the state speak Spanish, that statistic does not necessarily indicate that client language needs are being met.[141]

Within behavioral health care, California has driven efforts aimed at **identifying and addressing health disparities.** In 2015, CDPH published the "California Statewide Plan to Promote Health and Mental Health Equity" which included demographic analyses of mental health disparities and a discussion on the root causes and consequences of state health inequities.[142] In 2017, Assembly Bill 470 led the Department of Health Care Services (DHCS) to improve reporting for specialty mental health services at the county and statewide levels.[143] As a result, DHCS now provides publicly available data on disparities in mental health utilization, access, and outcomes.[144]

Several **initiatives are underway to advance equity** in mental health care access and delivery. The Community Mental Health Equity Project (CMHEP) is a cross-departmental effort focused on reducing disparities in behavioral health care through allocating grants to community organizations.[145] Another effort is the California Reducing Disparities Project, which CDPH founded in 2009 to address mental health equity for key population groups.[146]

[139] California Department of Public Health Office of Health Equity
[140] California Department of Public Health Office of Health Equity
[141] CDPH Demographic Report on Health and Mental Health Equity in California
[142] CDPH Portrait of Promise: the California Statewide Plan to Promote Health and Mental Health Equity
[143] CPEHN, Existing Disparities in California's system of specialty mental health care, May 2019
[144] DHCS Adults Age 21 and Over Mental Health Services Demographic Dashboards (AB470)
[145] DHCS, Community mental health equity project
[146] The California Reducing Disparities Project

From a **regulatory and oversight standpoint,** AB 133 authorized the Department of Managed Health Care (DMHC) to establish health equity and quality measures for behavioral health plans to address long-standing health inequities and ensure the equitable delivery of high-quality healthcare services.[147] On the county level, DHCS has oversight and monitoring responsibilities of county Mental Health Plans' cultural competence and quality improvement programs.[148]

There is limited historical data on equity in EPI programs, however, experts report similar equity trends to what is seen in California's Behavioral Health system more broadly. In terms of access, experts note specific populations that are accessing EPI services less frequently, potentially due to cultural or language barriers. Additionally, many California leaders have stressed the importance of improving cultural competency and workforce diversity to better meet the needs of vulnerable populations.[149]

Equity in Coordinated Specialty Care

"**We have worked hard to incorporate and elevate lived experiences. This is an area of active work.** We really want to make sure that the voices of folks with lived experiences are part of our clinical team – and are respected as members of our clinical team." – Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics)

Key objectives/goals[150]

To fulfill the vision of this plan with regard to equity, key goals of the plan are:

- **Reduce barriers** to receiving appropriate and timely care for vulnerable populations by **co-designing EPI programs with communities** to ensure culturally competent, contextually appropriate, and holistic solutions for individuals with early psychosis and their families.
- **Improve tracking and establish measurable goals around equity metrics.**
- Address the needs of California's diverse population by **developing a more diverse healthcare** workforce.

[147] 2022 Health equity and quality committee recommendations report
[148] CDPH Community Mental Health Project
[149] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[150] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Next steps[151]

MHSOAC proposes the following next steps for consideration:

- **Reduce barriers to access:**
    - Assess key barriers to access for vulnerable communities (e.g., trust in institutions, concerns of confidentiality) through direct engagement and partnership.
    - Identify trusted community partners to cocreate solutions to access barriers (e.g., churches, schools, community colleges)[152]
    - Invest additional funding for awareness efforts designed for vulnerable populations in partnership with community organizations.
    - Build out specialized care options for individual population groups as needed (e.g., children and youth)
    - Address realized or perceived gaps in funding for EPI services, particularly among those who are low-income and/or uninsured
    - Partner with community organizations to ensure cultural competency is central to CSC model design and delivery.
    - Explore public-private partnerships that facilitate equitable access (e.g., working with private healthcare providers to deliver coordinated specialty care, partnering with ride-sharing organization to transport individuals to relevant CSC services)
- **Track and set measurable goals around equity metrics:**
    - Collaborate with communities to set measurable equity goals (e.g., parity in access and outcome metrics, increases in the percentage of vulnerable communities with access)
    - Establish data collection and analysis approaches that can inform decision-making in partnerships with community coalitions.

Potential milestones/progress measures[153]

Prospective milestones in the State's process of working towards EPI equity goals could include:

[151] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

[152] Program for residency, community engagement and peer support training (PRECEPT) Connecting Psychiatrists to Community Resources in Harlem, NYC

[153] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- Align on a definition for equity in the context of scaling early psychosis care in California.
- Form a working group to identify priority populations and assess the key barriers (e.g., linguistic barriers, lack of trust).
- Review and evaluate community partnership models.
- Determine community organizations for potential partnerships.
- Establish platforms and processes to strategically partner with diverse and traditionally underserved population groups.
- Set up structures to continuously assess and iterate on equity strategies.

5.3 Foundational Levers

To achieve the strategic objectives of improved awareness and access to high-quality early psychosis care with a focus on equity the following building blocks need to be in place.

5.3.1 Sustainable Funding

The plan defines sustainable funding as the 'scaling strategy' and fiscal model to ensure high-quality, timely access to early psychosis care regardless of insurance type[154].

Current state of funding

Government funds are the most common source of CSC-FEP funding, with each source typically funding specific components of care. Some of the key funding sources in California

[154] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

are listed below:

	Funding sources	Current State
Programmatic funding	Federal	• **MHBG** Grant and 10% set aside funding for FEP[1]
	State and county	• Assembly Bill 1315 established the EPI Plus program[3] • The Budget Act of 2019 provided MHSOAC with $19.5M in one time MHSA funds to support expansion of programs[4] • Prop 1 authorized $6.38 billion in bonds to build mental health treatment facilities for those with mental health and substance use challenges and for providing housing for the homeless[5] • In Feb 2020 MHSOAC approved allocation of $15.6M to support existing programs and $3.9M to contract UC Davis to provide training and technical assistance to grantees; awarded 5 EPI Plus program grants totaling $10M, $1M for public awareness and increasing workforce development and retention, $600K for research on early barriers to accessing care[4] • **DHCS** in partnership with MHSOAC awarded $67M to 99 organizations across 30 counties to expand EPI programs funded through CYBHI in March 2024[6]
	Other sources (e.g., foundations)	18% programs receive philanthropic funding[7]
Service-based reimbursement	Medicaid	• Centers for Medicare and Medicaid Services approved new billing codes enabling Medicaid to cover previously non-reimbursable CSC components such as peer support • 43% of programs accepts Medi-Cal[7] • Experts estimate receiving only 30-40% compensation for CSC service costs[8]
	Private insurance	• Only 21% program accept private insurance coverage[8] • Pilot program with small cohorts of commercially insured populations are underway with Kaiser Permanente Northern California patients[8]

Exhibit 20: Programmatic funding and service-based reimbursement sources for CSC

Sources

1. SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," August 2023, 2. EPINET, 3. EPI Plus, 4. MHSOAC 5. Proposition 1, 6. DHCS, 7 CEPAS, 8. Hirschtritt et al mention commercially insured population is excluded from coverage though Medical and eligibility criteria could have more room for evolution.

A few barriers regarding funding for early psychosis care are:

- Design challenges across the healthcare system billing processes that may be focused on covering services by clinical providers and not the other components of EPI interventions such as education and housing supports[155]
- Most **commercial health plans do not provide coverage for several CSC components,** for example Supported Education and Employment or case management and peer support, only reimbursing direct clinical care[156]
- **Perceived lack of incentives** for commercial plans to invest in early intervention as individuals may not remain on the same plan for several years[157].
- **Opportunity for improving the authorization process** to EPI programs to increase claims approval rates: Since CSC programs are often out of network for commercial health plans, there may be instances where patients with commercial insurance seek care from programs not contracted with plans without authorization from plans, leading to claims denials.[158]
- **County-led CSC programs** face challenges in navigating the funding system.
    - Many county-led EPI programs may have challenges navigating complex **billing processes** to receive appropriate payment for reimbursable services from payers with insufficient technical assistance to address these challenges[159]
    - **Competing priorities and budget constraints among counties** that are trying to navigate budget challenges, build residential facilities, and plan for upcoming changes related to SB43[160].

These funding challenges have an impact on care delivery:

- **Discontinuity of care** for individuals on commercial plans – in addition to challenges getting authorization for the CSC programs, when individuals change or lose insurance coverage, there is a disruption in care delivery that may impact patient outcomes[161.]

[155] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[156] Powell et. al. Implementing Coordinated Specialty Care for First Episode Psychosis: A Review of Barriers and Solutions (2020)
[157] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[158] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[159] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[160] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[161] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Inability to access all components of CSC:** Reportedly, seven county-run programs in California have not adopted the peer-support service component in their treatment. Experts believe that challenges in successfully billing for these services is a potential reason why the adoption and provision of this CSC component are not uniform for all counties. [163]

Key objectives/goals[164]

To address financial barriers in accessing CSC care, the Centers for Medicare and Medicaid Services (CMS) introduced two billing codes specifically for CSC in 2023. These codes aim to streamline billing processes and ensure reimbursement for a broader range of CSC services. By allowing programs to bill for team-based care rather than individual services, the new codes will enhance financial viability, improve service coverage, and encourage innovation within CSC programs.
However, while the introduction of team-based billing codes represents a significant step forward for CSC funding, further actions are needed to address remaining barriers and ensure equitable access to high-quality early psychosis care. [162]

This plan outlines the following goals with regard to sustainable funding:

- Coverage for EPI services: Refine reimbursement models and rates to fully cover the cost of EPI for Californians with early psychosis regardless of insurance coverage.
- Funding for scaling to 90% access: Quantify and secure funding required to scale high-quality and equitable access to EPI.
- Innovative funding models to address future demand: Incentivize public and private investments in setting up and delivering EPI to meet future demand.

Next steps[165]

MHSOAC proposes the following next steps for consideration:

- **Establish approaches for covering the cost of care:**

[162] Reimbursement for a broader array of services in CSC for early Psychosis (Matthew et. Al.)
[163] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[164] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[165] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - Examine the barriers to accepting Med-Cal reimbursement by EPI service providers[166]
  - Explore implications of state paying the nonfederal match for enabling EPI care for Medi-Cal enrollees
  - Identify the key billing challenges like the multiplicity of HCPCS billing codes and draft the steps needed to transition from a fee-for-service payment model[167]
    - Develop an approach for providing information to commercial plans about individuals seeking treatment for early psychosis to validate insurance status sooner and fast-tracking authorization, where appropriate.
  - Explore partnerships with agencies like CalPERS to support pilots for commercial coverage of EPI care services
  - Design and deploy additional training to support EPI program administrators in navigating billing and reimbursements.

- **Secure funding for scaling to 90% access:**
  - Conduct landscape analysis of reliable funding streams in partnerships with departments/agencies with an interest in expanded access to EPI.
  - Explore using a regional fund allocation while piloting the hub and spoke and regional care models (described in Chapter 4.3.4) to better resource areas with low population density.
  - Consider allocating EPI funding at the state level instead of the county level, similar to the California Children's Services Program[168] to explore the impact of improved participation in CSC model of care.
  - Explore learnings from other states, including Illinois, which required coverage of some components of CSC by all insurers[169].
  - Collaborate with other programs with aligned objectives (e.g., CalAIM[170] Care Court[171], BH-CONNECT[172], BHSA[173]) to design and fund key initiatives to enhance coordination and optimize funding allocated to each program.

[166] DHCS
[167] Hirschitritt et al, Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, March 2024
[168] California's Children Services Program
[169] SAMHSA Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies
[170] California Health Care Foundation: CalAIM in Focus
[171] Fact Sheet: CARE Court
[172] BH-CONNECT
[173] BHSA

- **Identify innovative funding models:**
    - Investigate incentive models to encourage private investment in programmatic funding for EPI programs such as bundled rates for team-based care and collaboration with private insurance providers to improve the commercial viability of private investment in CSC care.
    - Explore enhancing network adequacy standards for EPI to better address network needs to deliver high-quality EPI services and incentivize improved coverage from commercial health plans.
    - Identify and evaluate the impact of initiatives (e.g., patient assistance programs/drug costs, co-pay assistance to reduce out-of-pocket expenses) on the total affordability of EPI service.

Potential milestones/progress measures[174]

To achieve 100% coverage for all components of CSC through service-based reimbursement and improve the proportion of programmatic funds used for enhancing infrastructure, therefore reducing the proportion used for subsidizing service delivery, California may need to **develop workgroups** to identify critical barriers and develop consensus amongst key funding partners on potential next steps in addressing them to achieve the following milestones:

- **Align on needs and sources:**
    - Estimate funding needs for programmatic and service-based reimbursement.
    - Identify funding sources across federal, state, county, and philanthropic entities.
    - Convene key funding partners to align on funding allocations for EPI.
- **Identify challenges in service-based reimbursements:**
    - Identify key challenges to the reimbursement model.
    - Establish workgroups to refine the reimbursement model and address challenges.
- **Implement solutions:**
    - Secure and disperse programmatic funding.
    - Design and implement initiatives to improve the reimbursement model.

[174] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Track impact:** Potential metrics include:
  - % of programs that accept Medi-Cal and commercial insurance
  - % of CSC care delivery cost covered by claims-based reimbursement

5.3.2 Workforce Supply and Capabilities

Achieving the objectives outlined in the EPI strategic plan requires sufficient capacity of staff trained in evidence-based care for individuals experiencing early psychosis. MHSOAC believes it is critical to approach workforce considerations through the lens of reducing disparities in access across populations and regions.[175]

Current state of Workforce Supply and Capabilities in California

Throughout California, there are workforce shortages across behavioral health roles (e.g., case managers, physicians, psychiatrists, psychologists, nurses, community workers, and peer and family support members). For EPI specifically, experts report gaps in the availability of trained clinicians and prescribers, particularly child psychiatrists.[176] Workforce deficits vary by region. For example, while the California-wide average is 11.0 psychiatrists, the Greater Bay area has 16.7 psychiatrists per 100k population compared to San Joaquin Valley, which has 5.2 per 100k population. There are also workforce disparities based on race: Black and Latino Californians are underrepresented among psychiatrists and psychologists relative to the general population, and Latinos are also underrepresented among counselors and clinical social workers (discussed in more detail in section 4.2.4 on Equity).[177]

Workforce deficits in behavioral health are projected to continue. According to research from UCSF, if current trends persist, in 2028, California will have **50% fewer psychiatrists and 28% fewer psychologists, LMFTs, LPCCs, and LCSWs combined** than will be needed to meet population needs.[178]

Growing workforce constraints and disparities within EPI and behavioral healthcare more broadly may be attributed to several potential drivers.

[175] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[176] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics)
[177] Healthcare Center at UCSF: An Overview of California's Behavioral Health Workforce Presentation (2022)
[178] Coffman et al, Research Report on California's Current and Future Behavioral Health Workforce (2018)

One such driver within the behavioral health field is the age distribution of providers: ~40% of psychiatrists and psychologists in the state are **over 60 years old and are likely to retire or reduce working hours in the next decade**.[179]

Additionally, California may not be realizing the full potential of **peer specialists and team leads within the state.**[180] Centers for Medicare & Medicaid Services (CMS) instructs that "peer support providers must complete training and certification as defined by the State" without dictating any further guidance or stipulations regarding peer certification.[181] SAMHSA's National Model Standards for Peer Support Certification recommend that "in lieu of any formal educational requirements, prospective certified peer workers should be able to demonstrate literacy and fluency in the language in which they will be providing services, either through required examinations or other application requirements."[182] However, in California, Medi-Cal Peer Support Specialists must have a high school diploma, GED, or equivalent degree for certification.[183] This may limit the pool of individuals who are eligible to apply for peer support provider certifications and may impose additional recruitment barriers for some individuals, including those from marginalized communities.[184]

An additional recruitment challenge for expanding the peer workforce is **funding constraints** from both public and private insurance to reimburse peer-led support services (discussed in detail in Chapter 4.3.1).[185]

Outside of recruiting difficulties, there are also challenges with workforce retention. Behavioral health professionals may experience burnout and high turnover rates due to the demanding nature of the work and limited resources.[186] In the case of CSC, experts report that challenges retaining the workforce are exacerbated by few clinicians trained to deliver CSC care, which results in high case volumes for those trained. These workforce constraints may have an impact on care delivery. Many EPI programs utilize **telehealth or rely more heavily on nurses or physician assistants** for elements of care delivery. Additionally, to serve diverse communities in their preferred languages, some providers may rely on **interpreting services** to enable care for individuals in languages other than English.[187]

CSC programs are largely funded and run by the public sector and face further challenges in addition to those impacting the broader behavioral health landscape:

[179] Healthcare Center at UCSF: California's Current and Future Behavioral Health Workforce (2018)
[180] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[181] CMS Center for Medicaid and State Operations SMDL#07-011, August 15, 2007
[182] SAMHSA's National Model Standards for Peer Support Certification, 2023
[183] California Department of Health Services "Medi-Cal Peer Support Services Specialist Program - Frequently Asked Questions"
[184] SAMHSA's National Model Standards for Peer Support Certification, 2023
[185] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[186] SAMSHA: Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies
[187] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- Funding models have historically not reimbursed for some components of the CSC model (e.g., community outreach and education) or only partially reimbursed.[188] This may lead to limitations for CSC providers in reliably retaining their workforce.[189]
- In the **public sector for behavioral health services**, wages may not be competitive with private sector alternatives, which can impact the number of available workers at all skill levels including **master's and PhD-level practitioners**.[190]

Another aspect of the workforce is **training and skill development.** The number of EPI programs in California with staff trained specifically in CSC components is 35% lower than the national average (CA: 50%, US: 85%).[191] Additionally, there are an insufficient number of mental health providers that have the combined specialized competencies needed for CSC, creating a significant training burden on CSC program leaders.[192] Moreover, specialized education in EPI is often less accessible within counseling and social work disciplines.[193]

California is making significant investments to bridge behavioral health workforce supply gaps and build capabilities.[194] In 2019, the Office of Statewide Health Planning and Development launched a five-year plan for growing and training the behavioral health workforce.[195] Building on its progress, in 2023, California announced it is investing $5.1B and proposing an additional $2.4B investment through reforms to the Mental Health Services Act to train and support 65,000 healthcare workers over the next five years.[196] **Specifically for EPI programs**, MHSOAC invested $1M in 2020-21 in workforce development and retention efforts. In 2020, MHSOAC also awarded $3.9M to the University of California, Davis, the leaders of EPI-CAL, to provide training and technical assistance to CSC programs across four years.[197]

Key objectives/goals

The workforce objectives[198] of the EPI strategic plan are:

- **Increase interest in and prestige of early psychosis intervention careers** to expand workforce timeline

[188] Powell et. al. Implementing Coordinated Specialty Care for First Episode Psychosis: A Review of Barriers and Solutions (2020);
[189] Meadows Mental Health Policy Institute, 2020; Powell et al, 2021
[190] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[191] California 2022 Uniform Reporting System Mental Health Data Report SAMHSA
[192] Pollard, J. M., & Hoge, M. A. (2017). Workforce development in coordinated specialty care programs. National Association of State Mental Health Program Directors, Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023
[193] Kourgiantakis, T., Sewell, K. M., McNeil, S., Lee, E., Logan, J., Kuehl, D., McCormick, M., Adamson, K., & Kirvan, A. (2022). Social work education and training in mental health, addictions, and suicide: A scoping review; Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023
[194] Workforce for a Healthy California
[195] OSHPD 2020-2025 Mental Health Services Act Workforce Education and Training Five-Year Plan
[196] CA MH Movement
[197] MHSOAC Investments
[198] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Increase supply:** Recruit new individuals into the EPI workforce to achieve 90% access to CSC services for all Californians and align incentives to reduce attrition of clinicians (for all specialists and nonspecialists) in CSC programs.
- **Enable more efficient use of existing workforce:** Efficiently deploy existing workforce to ensure optimized use of their capacity to ensure deployment of all components of CSC.
- **Improve capabilities across the workforce:** Ensure availability of CSC-specific state-wide training programs to meet or exceed the national average level of 85% of staff trained specifically in CSC components (as compared to the current 50% for California)
- **Optimize use of available funding sources** (e.g., Proposition 1) for workforce education and recruitment
- **Measure and monitor workforce supply and demand** to identify and address critical capacity constraints

Next steps[199]

MHSOAC proposes the following next steps for consideration:

Supply of diverse workforce:

- **Conduct landscape assessment** of demand for EPI workforce capacity and potential supply sources from educational institutions; identify where additional support to expand supply is needed. Identify programs and schools for expanding recruitment efforts and roles to extend the capacity of the current workforce.
- **Increase recruitment efforts to attract** the needed workforce based on capacity and capability requirements (e.g., explore new recruitment channels, revamp compensation and benefits, set up job fairs and other career events to promote EPI program opportunities, establish deeper partnerships with training programs and academic institutions, recruit from nontraditional sources, provide incentives for working in EPI).
- **Identify solutions to optimize the efficiency of the current workforce** and enhance their capacity to provide CSC (e.g., implement flexible staffing models to allow for redistribution of resources based on fluctuating demand; expand the use of mobile outreach teams to provide EPI services to different locations; implement task-shifting models to help with detection, referral, and providing basic services).

[199] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- Develop incentives for graduate programs and other learning institutions to **partner with CSC programs** to pair students with job opportunities.
- **Expand peer-led workforce:**
    - **Consider** broadening **eligibility criteria for peer support specialist certifications** to expand the pipeline of potential providers.
    - **Recruit CSC graduates** to train as peer support specialists.
    - **Consider** broadening **eligibility criteria for peer support specialist certifications** to expand the pipeline of potential providers.
    - **Provide additional training on CSC model delivery** for individuals with lived experience and their communities.
- **Grow pipeline of diverse future workforce:**
    - Increase funding for stipends and scholarships for students in behavioral health professions, social services, education or other related fields.
    - Increase funding for stipends and scholarships for students in behavioral health professions, social services, education or other related fields.
    - Increase funding for postbaccalaureate programs that focus on medical school reapplicants from underserved communities.
    - Increase psychiatry resident positions.
    - Recruit and train students from underserved areas to practice in community health centers in their home regions.
    - Expand rotations for social work, education degrees in organizations engaged in EPI services
- **Develop a more diverse workforce:**
    - Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)
    - Identify programming for EPI workforce development, retention, and promotion to increase diversity.
    - Develop strategies to engage peers in the EPI workforce (e.g., engaging CSC graduates as peer specialists)[200]

Explore options to improve total compensation to address pay parity gaps and retain providers (e.g., funding to support EPI workforce costs, loan repayment benefits, improved

[200] Oluwoye et al, Study protocol for a multi-level cross-sectional study on the equitable reach and implementation of coordinated specialty care for early psychosis, August 2023

healthcare coverage for employees and their families, programs to support burnout prevention, continuing education stipends).

Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)

Capabilities/training and development:

- **Explore options to improve total compensation to address pay parity gaps** and retain providers (e.g., funding to support EPI workforce costs, loan repayment benefits, improved healthcare coverage for employees and their families, programs to support burnout prevention, continuing education stipends).
- **Partner with professional schools** to enhance curriculums for specialist and non-specialist providers in recognizing early psychosis and referring individuals to appropriate care.
- **Create a central repository for CSC curricula**, including on-the-job training and essential competencies for health professionals as well as other service providers such as social workers, employment specialists.[201]
- **Increase and promote opportunities for future clinicians to engage in behavioral health, specifically CSC programs** (e.g., psychiatric rotations, clinical psychology internships, externships to enhance training (e.g., through grant funding, scholarships).
    - Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)

Highlight career pathways within EPI for nonclinical roles (e.g., education specialists, social workers, peer counsellors) during education and trainings for these professions

Potential milestones/progress measures[202]

- Establish a workforce and capabilities workgroup to conduct analysis, develop and roll out a recruitment strategy based on the findings.
- Conduct a current state demand and supply assessment of EPI workforce, including analysis by region and expertise/role.
- Identify key drivers of attrition and develop a plan to address prioritized drivers.
- Identify workforce diversity needs and integrate findings into a recruiting strategy.

[201] Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023

[202] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- Design and implement the recruitment strategy and rollout plan.
- Develop training programs for upskilling the existing workforce and training new professionals.
- Establish KPIs to measure progress on workforce supply and capabilities and the efficiency of training programs (e.g., workforce supply and demand by region, by role, and through the lens of workforce diversity; number of appointments via telehealth vs. in person; number of family and peer partners for each region/community; performance, morale, and satisfaction before and after training programs; performance against benchmarks of standard of care).
- Implement continuous monitoring mechanisms to improve workforce supply and capabilities.

5.3.3 Accountability

This plan defines accountability as the approach to establishing or utilizing governance structures to enable responsibility and ownership, measure progress for access, cost, quality, and other related outcomes, and establish ongoing improvement processes through research initiatives.[203]

Current state of Accountability for EPI in California

Accountability structures for CSC programs are closely tied to funding sources for the various county and commercial EPI programs. County-run EPI programs are established using funds received from both state, federal and grant sources and commercial EPI programs are primarily supported through research grants, as described in Chapter 5.3.1 Sustainable Funding.

Counties generally have some discretion in the allocation of funds for mental health services[204]. Counties do not have to establish an EPI program with funding received but may utilize it for other needs[205]. As of 2017, 38% of counties do not have an EPI program.[206] Additionally, there are **challenges exist in coordinating among different couties regarding delivering and funding EPI.** EPI Programs of a county serve its individuals utilizing funding

[203] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[204] Example sources: Funding for Medi-Cal Mental Health Services, Mental Health Block Grant
[205] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[206] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

dispersed via County Department of Behavioral Health (DBH). While some counties may have reciprocity systems in place to serve individuals across counties, many individuals who seek county care differ from when they enroll in Medi-Cal due to challenges in accessing EPI. This could act as a barrier to access care for those who move across counties (e.g., for education), are housed in a state child welfare system, or are in a juvenile system in a different county[207].

The counties that have EPI programs **may have different contractual obligations that may impact their approach to deploying EPI**. There are variations in contractual requirements for EPI providers contracted with DBH. For example, some programs are required to measure and track the fidelity of the program, while others may not be.[208] There are limited mandatory contract components which may pose challenges to ensuring EPI programs are accountable to delivering care aligned to set standards.[209]

Both county and commercial EPI programs lack robust data-gathering mechanisms, limiting the ability to identify improvement opportunities.[210] This is further elaborated in Infrastructure, Chapter 5.3.4.

MHSOAC's strategic plan (2024-27)[211] includes a goal to develop a behavioral health index that will track and promote key indicators of behavioral health by county, with benchmarks from peer counties, peer states, and nations to compare with California and its counties. Additionally, California launched the **Learning Healthcare Network initiative,** for which one of the goals is to utilize a collaborative statewide evaluation to examine the impact of LHCN[212] on EPI care network and evaluate the effect of EPI programs on the consumer- and program-level outcomes.

The **Behavioral Health Services Act (BHSA),** which replaced the 2004 Mental Health Services Act, enhances oversight, transparency, and accountability at both state and local levels. The Act also creates pathways to ensure equitable access to care, advancing equity and reducing disparities for those with behavioral health needs.[213] BHSA requires that counties "establish and administer an early intervention program that is designed to prevent mental illnesses and substance abuse disorders from becoming severe and disabling and to reduce disparities in behavioral health." The early intervention programs should include, among other criteria, "access and linkage to care includes the scaling of, and referral to the Early Psychosis Intervention (EPI) Plus Program […] Coordinated Specialty Care, or other similar evidence-

[207] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[208] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[209] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[210] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[211] MHSOAC Strategic Plan
[212] https://mhsoac.ca.gov/sites/default/files/documents/2018-12/Multi County_INN Plan_Statewide Early Psychosis LHCN_2018.pdf \hLearning Healthcare Network
[213] Behavioral Health Services Act - DHCS

based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs."[214]

Key objectives/goals[215]

- **Establish governance structure and mechanism** to define roles and responsibilities in expanding access to EPI and develop accountability mechanism for all ecosystem partners.
- **Develop a monitoring and evaluation framework** to track progress against goals with KPIs that provide insight into client experience and impact across various ecosystem partners and develop reporting mechanisms to communicate progress to all ecosystem partners.
- **Establish an ongoing improvement process** that utilizes learnings to identify development opportunities in EPI program design and delivery.

Next steps[216]

MHSOAC proposes the following next steps for consideration:

Governance structure and mechanism

- Align on which organization(s) will be responsible for refining and implementing the EPI strategic plan.
- Establish the purview of the leadership team(s) and their authority to design and implement the strategic plan with key partners.
- Identify existing efforts in California aligned with the strategic plan and align on partnership approaches where feasible.
- Convene ecosystem partners to determine which groups will lead each of the initiatives.
- Design incentive models and accountability structures for each implementation partner and implement infrastructure or legislative changes to ensure accountability.
- Develop mechanisms to incentivize all counties to establish or partner with existing EPI programs.
- Identify and develop mechanisms to ensure care across counties for those who need care (e.g., additional reciprocity relationships between counties)

[214] Cal. Welf. and Inst. Code § 5840
[215] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[216] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Monitoring and evaluation framework

- Develop a process for gathering and reporting on metrics to assess implementation progress, building on the learning healthcare network [217]
- Establish KPIs to measure the impact of expanded EPI access for clients and ecosystem partners.

Ongoing improvement

- Develop a process to gather learnings (including insights from people with lived experience, academic research, and data) and refine program design and implementation.

Potential milestones/progress measures[218]

To ensure accountability goals are met, the potential milestones may include:

- Identify existing accountability, monitoring and evaluation, and process improvement initiatives for EPI.
- Identify the leadership team to implement the EPI strategic plan.
- Implement accountability initiatives.
- Establish monitoring, evaluation, and reporting framework to assess implementation progress.
- Develop and implement a process for gathering and reporting on progress metrics.

5.3.4 Infrastructure

Infrastructure is defined as the availability of facilities and technology to provide care that is accessible, equitable, and effective, including the use of telehealth, where appropriate.[219]

Current state of infrastructure

California has invested in both physical and digital infrastructure for EPI.

[217] Learning Healthcare Network
[218] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[219] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

The **physical infrastructure** includes the facilities and resources necessary for the provision of EPI services (e.g., physical clinics for providing CSC components and screening services). Currently, the availability of EPI **programs per capita** in California is trailing the national average (1 program for every **907k** Californians compared to 1 program for every **879k** residents in the US).[220] The availability of EPI facilities **varies across the counties:** 41% of counties having an active EPI program, 21% of counties are in the process of developing an EPI program, and 38% have no EPI programs[221] (described further in Chapter 4.2.2). Some of the rural and low-density counties cite challenges relating to low incidence rates and finding qualified local service providers as barriers to setting up their own EPI programs.[222]

Additional physical infrastructure considerations beyond EPI programs across different levels of care exist. California has invested in infrastructure to support **care across the continuum of psychosis**, ranging from drop-in facilities for youth (e.g., allcove®)[223] to a build-out of crisis infrastructure through the Behavioral Health Continuum Infrastructure Program (BHCIP).[224]

Digital infrastructure is the technical foundation and systems that support the delivery of services. Digital infrastructure also involves the management of data, including the hardware, software, networks, and protocols, to enable the secure and efficient exchange of information among care providers, clients, payers, and other ecosystem partners. Examples of digital infrastructure include technology that enables the delivery of CSC service components like case management, technology that enhances access using telehealth, electronic health record (EHR) platforms, and centralized data systems and tools for measuring key metrics for scaling EPI programs.[225]

One key aspect of digital infrastructure is the health information and billing system. There is currently no unified approach across counties to managing **medical records and billing.** Additionally, there is limited interoperability between county programs and health plans that limits the ability of some programs to bill for CSC services and consequently limits reimbursement.[226]

Digital infrastructure may also be used to inform individual- and provider-level decision-making. Currently, EPI-CAL uses an EPI-focused **technology platform (mHealth)** to collect core client outcomes and data use metrics. Data insights from this platform are available to clients and their physicians across 30 programs to support care decisions; the platform is also

[220] Programs per capita is derived by dividing the CA population as per census, by number of programs as per EPICAL. CA has ~43 programs for a population of 38.9M; United States has 381 programs for a population of 334.9M
[221] Tara Niendam et al., The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[222] Interview with Executive Director of EPICAL, 2nd May 2024
[223] MHSOAC: allcove® Youth Drop-In Centers
[224] DCHS: Behavioral Health Continuum Infrastructure Program
[225] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[226] Interview with Executive Director of EPI-CAL, April 17, 2024

available in 13 languages.[227] EPI-CAL also utilizes **Beehive**, a data collection and visualization software platform that incorporates information about a client's recovery and wellness into their mental health care.[228]

On a systems level, there are opportunities to strengthen **data infrastructure in support of scaling EPI.** There is currently no centralized method for tracking system capacity (e.g., open workforce positions, number of programs, number of clients) or metrics to assess network strength and integrity (e.g., wait times for clinic availability, the average duration of untreated psychosis). Related systems are currently managed through individual recordkeeping such as excel spreadsheets.[229]

There are also opportunities to improve the digital infrastructure to facilitate **care coordination**. While there is a national database for locating care for serious mental illness,[230] the state may consider creating a publicly available statewide EPI coordination system for accessing CSC programs and other resources.[231]

Experts point out that select vulnerable places and communities may require improved digital ecosystem readiness as a foundation for specialized EPI digital infrastructure. This includes reliable broadband, population-level digital literacy, access to suitable devices for engaging with telehealth, and digital support accessing information management systems. Challenges may exist in building capabilities for new technology adoption.[232]

Draft key objectives/goals[233]

Design and build the infrastructure needed for **delivering affordable, appropriate care to 90%** of individuals who need it with a focus on ensuring equity and a high standard of care.

Next steps[234]

MHSOAC proposes the following next steps for consideration:

- **Explore and scale multiple archetypes of care deployment models** to improve access to care in alignment with workforce improvement strategies (Chapter 5.3.2):
    - **Increase the number of EPI programs:** EPI-CAL estimates the need for 277 EPI care centers to cater to the annual incidence of early psychosis in California. A few potential steps towards achieving this target may be:

[227] EPI-CAL
[228] EPI-CAL Beehive
[229] Interview with Executive Director of EPI-CAL, April 17, 2024
[230] SAMHSA SMI care program locator
[231] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[232] Interview with Director Mental Health Strategic Impact Initiative, April 30, 2024
[233] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[234] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

        - Identifying areas with the greatest gaps in the supply of EPI services based on community demand and prioritizing a list of locations for establishing EPI programs.
        - Designing a phased plan to develop facilities and provide resourcing in the form of equipment and service providers.
    - **Explore new formats of extending EPI:** Collaborate with partners to understand local strengths and needs to meet demand in the context of the CSC approach; explore innovative partnerships for CSC (e.g., Hub and spoke model, multicounty collaborative or regional mobile care delivery models).
    - Identify **digital capabilities** required for expanding telehealth, omnichannel care delivery, tailored mobile applications, and remote monitoring.
    - Estimate resource needs at the program and provider level relating to digital and physical infrastructure.
- **Identify resources for infrastructure development:**
    - **Establish partnerships** with other healthcare providers, supportive housing providers, community organizations, or academic institutions to accelerate infrastructure development and deployment.
    - **Explore solutions for improving interoperability of medical records and billing modules** for EPI programs specifically and mental health services broadly; this could involve building on national efforts such as the SAMHSA Behavioral Health Information Technology (BHIT) Initiative that is investing more than $20M over the next three years to advance interoperable exchange of behavioral health data across the care continuum.[235]
    - **Identify technical support** and funding to transition EPI programs to the same medical records and billing systems.
- **Improve care coordination and access:**
    - Develop a publicly available resource that identifies EPI programming across the state to help individuals select potential programs in their area.
- **Launch training programs for effective use of technology and digital infrastructure:**

[235] SAMHSA Behavioral Health Information Technology Initiative, February 2024

- Conduct needs assessments to identify training gaps in technology and digital infrastructure.
- Collaborate with technology experts to design tailored training programs.
- Ensure accessibility of training programs for all ecosystem partners.
- Provide digital literacy training in underserved communities.
- Establish monitoring and evaluation mechanisms for progress tracking and refinement.

Draft milestones/progress measures[236]

- Establish working groups to design and implement infrastructure initiatives.
- Identify digital and physical infrastructure gaps for the state and each county.
- Create an infrastructure development plan and identify resource requirements.
- Identify and contact infrastructure partners.
- Deploy infrastructure development plan.
- Complete need assessment of technical training
- Establish cadence and mechanism to refresh and reestimate infrastructure needs.

5.3.5 Ecosystem Engagement

Ecosystem engagement focuses on establishing a more integrated care delivery model for people experiencing early psychosis and their families by encouraging incentive alignment and coordination among key partners. The key ecosystem partners considered in this chapter include people with lived experience, families, community-based organizations, public and private payers and providers, state and county agencies focused on housing, education actors, and the criminal and legal systems.[237]

[236] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[237] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

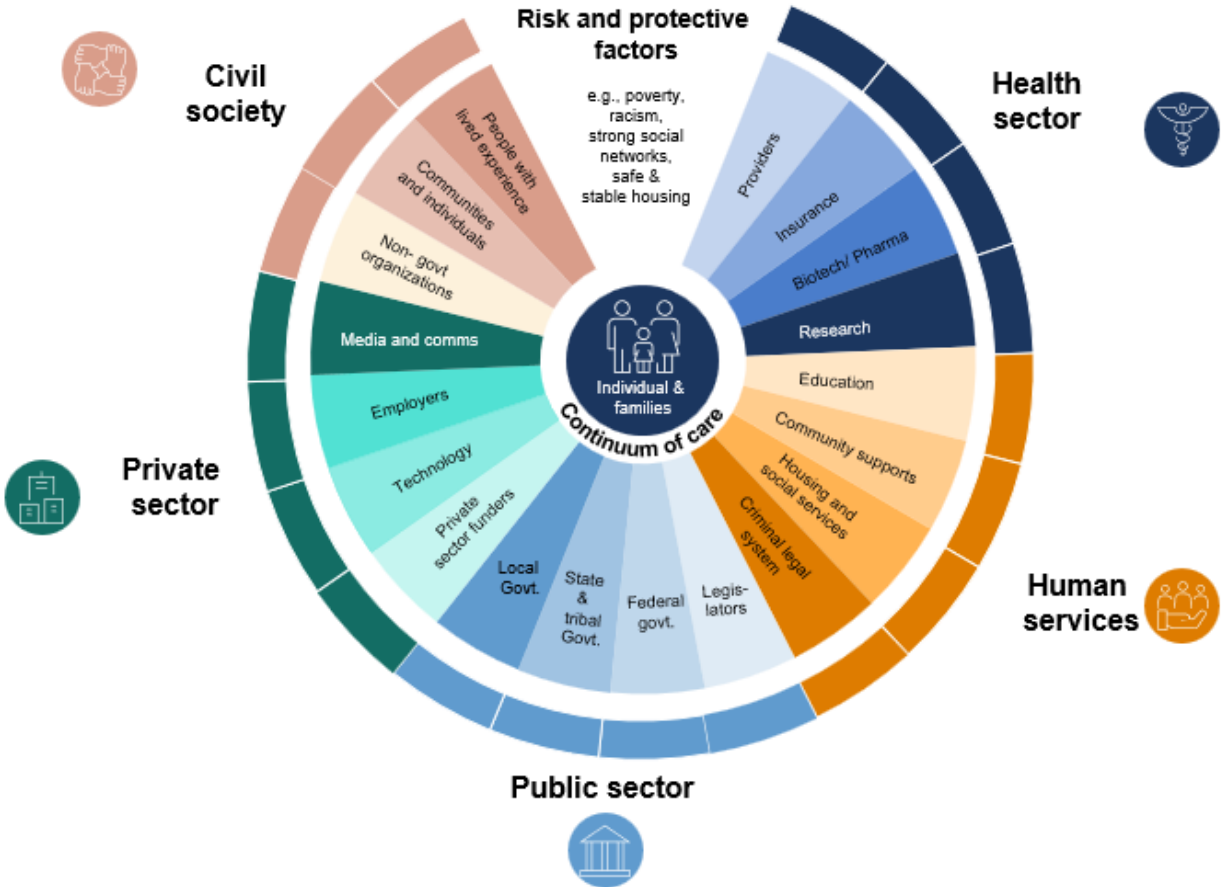


Exhibit 21: Overview of sectors and ecosystem partners

Sources
The Kennedy Forum System Mapping Tool

Current state of ecosystem engagement in California

Ecosystem partners play a crucial part in EPI. Roles include developing human capital, funding system elements, collecting and sharing relevant information, providing products /services, and developing policy.

For example, ecosystem partners may play a crucial role in identifying symptoms for individuals experiencing psychosis. However, key challenges exist the ecosystem **in symptom identification, referral, and diagnosis.** These include **limited knowledge of the symptoms of psychosis for workers in education, criminal and legal, and housing systems** and limited knowledge of referral pathways for individuals experiencing a psychotic episode.[238] This may lead to delays in referral to appropriate screening and care. **Even within healthcare, there may be a need for additional training on psychosis** diagnoses and

[238] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

treatment for early psychosis, as individuals may be incorrectly diagnosed and treated for other conditions.[239] This occurrence is not unique to California. A retroactive chart review of 78 patients referred to a specialty early psychosis consultation clinic found that of the 43 cases that had a primary diagnosis at referral of a schizophrenia spectrum disorder, the primary diagnosis in the consultation clinic was different in 22 (51%) of these 43 cases.[240]

Ecosystem partners' **contributions extend beyond the identification of symptoms; they are also often engaged in care delivery.** Both county and commercial EPI programs collaborate with state and local programs, national organizations, and community partners to coordinate services such as supportive education and employment.[241] These services are typically coordinated by individual EPI programs through relationships with county and community organizations. Such relationships are **often not established as formal partnerships and vary by program.**[242]

[239] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[240] Specialized Consultation for Suspected Recent-onset Schizophrenia: Diagnostic Clarity and the Distorting Impact of Anxiety and Reported Auditory Hallucinations, Coulter et. al
[241] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[242] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

NON-EXHAUSTIVE

✓ Partner plays a primary role ✓ Partner plays a secondary role

Roles of select ecosystem partners		People Developing the human capital needed to support progress	Funding Funding or enabling funding specific system elements	Data & information Collecting and sharing data and/or information	Products & services Developing and/or deploying products and services	Policy Developing and shifting policies
Health Sector	Insurance		✓	✓	✓	✓
	Providers	✓		✓	✓	✓
	Research			✓	✓	✓
Human Services	Education	✓		✓	✓	
	Community supports	✓		✓	✓	
	Criminal legal system			✓	✓	✓
	Housing and social services			✓	✓	
Civil Society	People with lived experience	✓	✓	✓	✓	✓
	Non-govt. organizations	✓			✓	✓
Public Sector	Local Govt.	✓	✓	✓	✓	✓
	State & tribal Govt.	✓	✓	✓	✓	✓
Private Sector	Employers	✓	✓		✓	
	Technology			✓	✓	
	Private sector funders		✓			

Exhibit 22: Illustrative roles of ecosystem partners along the care journey

An opportunity exists to enhance coordination among key ecosystem partners to expand EPI access. While there is collaboration across ecosystem partners, limitations in processes and data sharing restrict the ability to gather important information about treatment history and coordinate care delivery across provider types (i.e., crisis care, inpatient care, and CSC programs) and between systems (e.g., housing and criminal and legal systems). Effective coordination and collaboration could help ensure individuals are referred to appropriate sites of care.[243]

In California, programs such as the Mental Health Court Linkage Program (CLP) provide examples of ecosystem collaboration to support individuals with mental illnesses, including psychosis. The CLP is a joint effort between the Los Angeles County Department of

[243] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Mental Health (LACDMH) and the Los Angeles County Superior Court. It is run by a team of 15 mental health clinicians who are stationed at 22 courts throughout the county. This program is designed to assist adults who have a mental illness or a co-occurring mental health and substance abuse disorder and are involved with the criminal and legal system. It is part of LACDMH's system of support and services that are available throughout the criminal justice process, from arrest to release. The program follows the "no wrong door" philosophy by using the courtroom as a point of entry for services. The program's goals are to improve coordination and collaboration between the criminal and legal systems and mental health systems, increase access to mental health services and support, and improve continuity of care.[244] Services provided include individual needs assessments; information to individuals and the Court on available treatment options; development of diversion, alternative sentencing, and post-release plans that take into account best-fit treatment alternatives and Court stipulations; linkage of individuals to treatment programs; and expedition of mental health referrals. [245]

Expanded access to CSC will have an impact on partners in healthcare, education, criminal and legal systems, child welfare, and housing systems. In healthcare, CSC reduces average inpatient days by 33% and the average number of ED visits per year by 36%.[246] Outside of direct health impacts, CSC reduces the likelihood of being unemployed by approximately 42%[247]. The CSC model also reduces the need for homelessness services amongst the FEP population by 48% and reduces the average cost per person of providing supportive housing to program participants.[248]

In the criminal and legal system, participation in CSC programs for EPI reduces involvement in the criminal justice system. Participants experience a 76% reduction in the risk of committing a first crime and are significantly less likely to be convicted of any crime when enrolled in CSC.[249]

[244] Los Angeles Department of Mental Health – Mental Health Court Linkage Program

[245] Los Angeles Department of Mental Health – Mental Health Court Linkage Program

[183] Cost Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program, Rosenheck et al.

[247] Predictors of occupational status six months after hospitalization in persons with a recent onset of psychosis, Dickerson et. al.

[248] Tsiachristas et al. "Economic impact of early intervention in psychosis services: results from a longitudinal retrospective controlled study in England"

[249] Pollard, Jessica M et al. "Analysis of Early Intervention Services on Adult Judicial Outcomes." JAMA psychiatry vol. 77,8 (2020). Based on the difference between the percent of individuals with convictions for any offense after enrolling in the STEP program (5%) and the percent of individuals with convictions for any offense receiving usual treatment (19%)

Key objectives/goals[250]

Potential objectives/goals to be considered for ecosystem engagement are as follows:

Enhanced integrated care delivery network: ensure coordination among ecosystem partners to enable timely and seamless access to all components of the CSC model for clients and their families.

Next steps[251]

MHSOAC proposes the following next steps for consideration:

- Improve **awareness, education, and training for early psychosis**
  - Communicate the impact of early identification and treatment of early psychosis for ecosystem partners to align incentives.
  - Provide training on symptom identification and referral pathways for state, county, and community ecosystem partners (e.g., law enforcement, K-12 educators, supportive housing workforce)
  - Provide additional training for medical students and residents on psychosis diagnosis and treatment.
- Enable **improved information sharing for care coordination**
  - Expand the use of psychiatric advanced directives to provide information on the care needs and preferences of individuals with psychosis and coordinate care delivery across partners (i.e., crisis care, Full-Service Partnerships, CSC programs, and inpatient care)
  - Explore resources for enabling interoperability of EHR systems and other data-sharing platforms across health systems, health plans, criminal and legal systems, and other partners to enable data sharing.
  - Establish coordination mechanisms to refer patients for diagnosis and treatment (e.g., centralized referral portals)
- **Establish stronger alliances among ecosystem partners for CSC care delivery**
  - Expand the use of programs deploying the "no wrong door" philosophy[252] to screen and refer individuals for psychosis in partnership with criminal and legal, housing, and other supportive services.

[250] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[251] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[252] No Wrong Door

- Consider establishing statewide or countywide partnerships for housing, education, employment, and other client needs where appropriate.

Potential milestones/ progress measures[253]

- To drive alignment among ecosystem partners and ensure the development of a more integrated care delivery network, the following milestones may guide execution:
    - Convene key ecosystem partners to highlight shared benefits of expanded access to EPI.
    - Identify initiatives to deploy better care delivery and size additional resourcing needs.
    - Identify and deploy digital resources and operating model changes.
    - Initiate impact tracking.

[253] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

6. Implementation plan

MHSOAC has prepared an initial draft of a high-level implementation approach for the rollout of the strategic plan. The implementation plan **will undergo further enhancement as the strategic plan is refined through input from ecosystem partners, public engagement, and additional guidance from the Governor, Legislature, and other stakeholders. The approach will also need to be tailored based on the entity responsible for spearheading implementation** if the plan is adopted.

To support the successful execution of milestones across the Strategic Objectives and Foundational Levers, **four Implementation Support workstreams have been identified.** These workstreams will focus on coordinating across key partners to implement initiatives, identifying and tracking key metrics to monitor the performance of the overall plan, developing and implementing a robust communication plan, and overseeing change management efforts to drive transformational change in the ecosystem.

- **Integrated coordination:** This workstream will establish a dedicated central team to coordinate among ecosystem partners and across initiatives to ensure successful and timely implementation of the plan.
- **Performance management:** To promote accountability during the implementation of the strategic plan, this workstream will identify metrics and track progress. The dedicated central team will be responsible for developing an integrated process for collecting and reporting on implementation progress across initiatives and partners and measuring impact.
- **Communication plan:** This workstream will develop and roll out coordinated communication and engagement strategies to ensure clarity, consistency, and alignment in messaging with California agencies, ecosystem partners, and other interested parties. Additionally, it will provide regular updates on progress.
- **Change management:** This workstream will support identifying change champions and sponsors across ecosystem partners to promote adoption and implementation of the strategic plan.

This chapter outlines key themes and milestones over a 3-year time horizon, with an initial perspective on where additional funding may be required to ensure the timely execution of our key goals across each element of the strategic plan as outlined in Chapters 4.2 and 4.3[254]. The multiyear time horizon allows for appropriate sequencing of milestones to account for interdependencies across teams and milestones. It also ensures sustainable impact over time, with each milestone achieved serving as a building block for subsequent successful milestones. By the end of Year 3, the expectation is that 90% of Californians with needs will have access to equitable, high-quality, and appropriate early psychosis care.[255]

[254] Objectives and milestones developed based on input from the Early Psychosis Intervention (EPI) Advisory Group
[255] Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

Over the course of **Year 1**, implementation begins with establishing workgroups, conducting landscape analyses and opportunity identification, and developing initial strategies and partnerships:

- **Workgroups:** Convene workgroup(s) to define goals and design innovative strategies across Strategic Objectives and Foundational Levers, as well as align on roles and responsibilities.
- **Landscape analyses:** Review behavioral health landscape, including identifying gaps, estimating infrastructure, funding, and other requirements to fill those gaps, and outlining barriers to impact.
- **Strategies and partnerships:** Develop strategies for working with populations identified as focus areas by MHSOAC and source partnerships across public, private, and social sector organizations.

Within **Year 2**, work progresses to establishing and rolling out pilots, prioritized by estimated level of impact, followed by aligning on performance indicators to ultimately begin tracking success:

- **Pilots:** Act on planned initiatives and pilot approaches, from engagement to funding, based on prioritization. Appropriately utilize embedded community partnerships and facilitate necessary training.
- **Performance indicators:** Define and implement measurements of success while simultaneously gathering pilot participant and partnership feedback to determine adjustments needed to pilots.

By **Year 3**, as pilots are well underway, the emphasis of work is on continued data analytics and consequent effort refinement for maximum impact:

- **Data analytics:** Continuously collect performance data to improve awareness, access, quality, and equity of care.
- **Effort refinements:** Based on analytics, redirect resourcing and refine goals to ensure adherence to the priority needs of target populations.

For specific milestones by year, see exhibits below.

May require additional funding

	Year 1	Year 2	Year 3
Awareness	• Convene a workgroup to **design awareness goals** and **public engagement strategy** • **Review landscape** of behavioral health awareness programs in CA and opportunities of psychosis specific partnerships • Develop **engagement strategies for populations** MHSOAC has deemed as areas of focus and **partner with key** Behavioral health **campaigns** • Develop a public **communications strategy** that facilitates a call to action by Californians for key ecosystem partners necessary to meet 90% access goals	Establish **one stop resource center** for care-seekers and family to access content on EP symptoms and ways to access care • Prioritize **channels** and **culturally competent** narratives for reduction of stigma Roll out planned initiatives in **partnership with key community partners**	• Identify **mechanisms to measure awareness** and continuously monitor metrics like engagement of priority population in programs, reduction in DUP etc. • Periodically **review effectiveness** of public narrative and establish process of refreshing it
Access	• Establish a workgroup to **identify barriers** and define progressive **goals** across dimensions of access: timeliness, affordability, convenience, standardization of intake • Establish approach for measuring **client satisfaction** with access	**Start pilots** of approaches on improving timeliness, affordability and convenience of access • Develop an approach towards **standardization** of psychosis diagnosis and **intake** into the EPI programs **Roll out mechanism** (e.g., surveys) to measure client's satisfaction with ease of access	**Continuously measure** access across the dimensions of timeliness, affordability, convenience and standardization of intake with established mechanism of initiating steps for improvement on metrics like average duration of untreated psychosis, average wait time for intake, client satisfaction with ease of access

Exhibit 23: Milestones related to improving Awareness and Access

Sources
Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

May require additional funding

	Year 1	Year 2	Year 3
Quality	• Establish alignment among stakeholder partners on the **standard of care** across 7 dimensions of quality • **Identify gaps in fidelity** to expanded CSC model and prioritize mechanisms for improving fidelity • **Estimate infrastructure requirement** for reporting and analyzing quality metrics • Define **mechanisms of self reporting**, cadence of assessments and technical assistance to support improvement	Set up a **center of excellence and** working team and technical assistance team to track quality across the state **Evaluate EPI programs** against fidelity scale **Commission in research** to assess and improve quality	**Automate mechanism to track quality** of care with transparent visibility for all ecosystem partners and the public • Continuously **re-evaluate goals and plan** for improving quality
Equity	• Align with experts the definition of equity in the context of scaling early psychosis care and **specific goals for reducing barriers to access** • Define approach to **integrating diverse cultural, linguistic and developmental needs** into the EPI program design and delivery • **Identify** diverse or marginalized populations and **communities to brainstorm solutions**	• Align on approach for establishing a **diverse skilled workforce** equipped to meet the diverse needs of vulnerable communities	Establish **data collection and analytics strategy** that can help decision making in partnerships with community

Exhibit 24: Milestones for enhancing Quality and Equity

Sources
Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

	Year 1	Year 2	Year 3
Sustainable funding	• **Identify key challenges to existing service-based reimbursement** models • **Estimate and align on funding needs** for programmatic and service-based reimbursement • **Identify funding sources** across federal, state, county and philanthropic entities • Convene key funding partners to **align on funding allocations** for EPI program	• **Secure and disperse programmatic funding** • **Design and implement initiatives** to improve reimbursement model • **Track funding progress and impact** across initiatives	• Disseminate **additional programmatic funding** • **Enforce billing** using refined reimbursement models decided across payors • Continue tracking and reporting progress
Workforce & capabilities	• Conduct **demand and supply assessment** of BH workforce; identify workforce need by region, expertise / role, and diversity Identify and prioritize **key drivers of attrition** • Develop and roll-out **recruitment strategy for key roles based on need by county** (e.g., psychiatrists and clinicians that includes expanding recruitment efforts and optimizing efficiency of current workforce)	**Roll out recruitment strategy for remaining roles -** expand recruitment efforts and optimize efficiency of current workforce **Develop and deploy training and onboarding** programs • **Establish KPIs** to track progress	Continue deploying recruitment and training initiatives Set up **continuous monitoring mechanisms** to track demand and supply and measure progress across other key metrics

May require additional funding

Exhibit 25: Milestones related to Sustainable Funding and Workforce and Capabilities

Sources Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

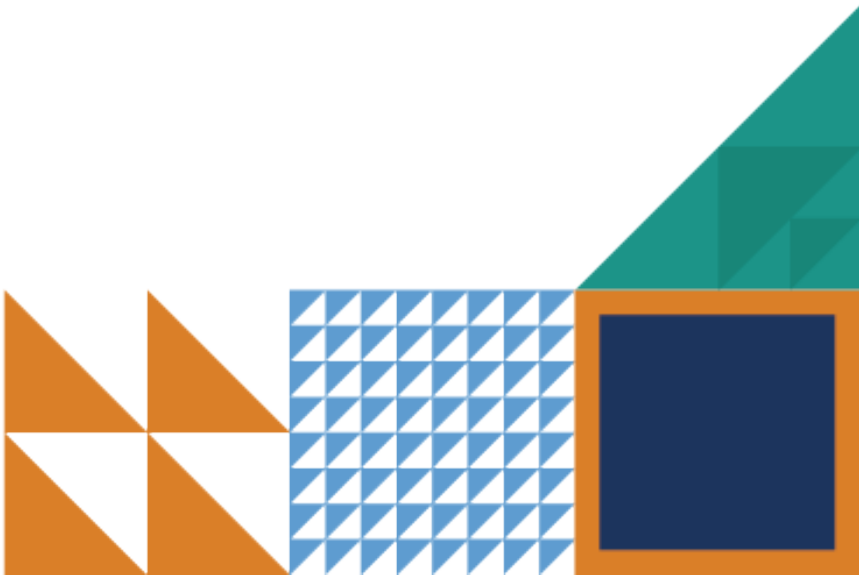
	Year 1	Year 2	Year 3
Accountability	• Establish **governance structure and mechanism and** identify the leadership team • Get appropriate advice to guide decisions on **legal and administrative scope** • Design **incentive models and accountability structures for key partners / entities** Develop and deploy **monitoring and evaluation and reporting framework** to measure progress across initiatives • Establish **process to commission and utilize research to improve EPI programs**	Track progress and **evaluate effectiveness** of current governance structure, adjust as needed **Deploy incentive models** and refine as needed **Solicit feedback from EPI programs** and incorporate changes into CSC programs	Monitor **effectiveness of the accountability measures** on ongoing basis and adjust strategy as needed • Continue to solicit feedback from EPI programs to measure improvement
Infrastructure	• Identify key **digital and physical infrastructure gaps** by county • Create **infrastructure development plan**, identify resource requirement Identify **infrastructure partners and establish contracts** • Assess the **need for technical training** and develop or contract out training programs	Deploy **infrastructure development plan** and begin setting up digital and physical infrastructure Begin **technical training** where needed Run pilots and set up expansion plans	• Track supply and demand and establish cadence and mechanism to **re-estimate infrastructure needs** **Continue deploying infrastructure** as per the plan
Ecosystem Engagement	• Convene **key ecosystem partners and define roles and responsibilities** • Develop **mechanisms or incentive models** to deploy better care delivery and improve payment systems • Evaluate and align on **potential reimbursement models** • **Evaluate and align on possible operating model** solutions • Develop **communication strategy and influential engagement plan** to engage private health plans	• **Convene key partners to make decisions** on reimbursement models and operating models Continue to deploy incentive models to **deploy better care delivery** • Work closely with all ecosystem partners to **establish the new reimbursement model and operating model**	Continue **deployment and roll-out of the reimbursement** model and operating model • Refine models based on feedback

May require additional funding

Exhibit 26: Milestones related to Accountability, Infrastructure, and Ecosystem Engagement

Sources Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

7. Appendix



7.1 Approach

The approach to drafting this strategic plan for expanding early psychosis care in California involved the following:

7.1.1 Syndicating quantitative estimates based on perspectives from national leaders and experts.

Through interviews and synthesis of existing research, a model was developed to demonstrate the potential impact of scaling CSC, looking at both the potential economic savings as well as the impact on quality of life. The impact was estimated across a near-term and a lifespan view.

A National Impact Model on Early Psychosis was developed, incorporating expert opinions, partnerships with leading organizations, and a thorough review of academic literature. The process involved interviews of over 19 subject-matter experts from various organizations, including national, state government agencies, and universities. Partnerships were established with leaders of the National Council of Mental Wellbeing, the National Association of State Mental Health Program Directors (NAMHPD), the National Alliance on Mental Illness (NAMI), and the McKinsey Health Institute (MHI). Additionally, dozens of academic research papers and articles, as well as more than ten policy briefs, were reviewed to gather relevant information.

Expert	Organization and roles	Interview date
Richard Frank	*Director, Center on Health Policy,* Brookings Institution	Jan 21
Steve Adelsheim	*Director,* Stanford Center for Youth Mental Health and Wellbeing	Jan 22
Lisa Dixon	*Director, Division Behavioral Health Services and Policy Research*, Columbia University	Jan 23
Robert Heinssen	*Senior Advisor*, NIMH, RAISE, EPINET	Jan 23
Tamara Sale	*Director EASA Center for Excellence,* OHSU	Jan 26
Vinod Srihari	*Director of STEP Program,* STEP program Yale University	Jan 29
David Shern	*Senior Public Health Advisor,* NASMHPD; *Moderator* PEPPNET Financing Workgroup	Jan 31
Patrick McGorry	*Director Orygen Youth Health, Chair Youth Mental Health,* University of Melbourne	Feb 1
Robert Rosenheck	*Director Division of Mental Health Services and Outcomes Research,* Yale, NIMH RAISE	Feb 1
Tara Niendam	*Executive Director* UC Davis, SacEDAPT Clinics; *Principal Investigator,* EPI-CAL	Feb 8
Keris Myrick	*Co-Director Mental Health Strategic Impact Initiative*, Mental Health America; Inseparable	Feb 8
Carolyn Dewa	*Director Behavioural Health Center of Excellence,* UC Davis	Feb 14
Brandon Staglin	*President, One* Mind	Feb 14
Debra Pinals	*Medical Director Behaviorial Health and Forensic Programs,* University of Michigan	Feb 16
Oladunni Oluwoye	*Co-director Washington State Center for Excellence in Early Psychosis*, Washington State University	Feb 22
Iruma Bello	*Director of OnTrackNY*, Behavioral Health Services and Policy Research, Columbia University	Feb 22
Ken Duckworth	*Chief Medical Officer*, NAMI	Mar 4
Jessica Banthin	*Senior Fellow & CBO expert*, Urban Institute	Mar 8
Deidre Anglin	*Lead Investigator of social and cultural determinants of psychosis risk*, City College of New York	Mar 28

Exhibit 27: Interviews with subject-matter experts

In developing the model, the first step involved estimating the early psychosis incidence rate among the population by age and insurance type (e.g., Medicaid, commercial, uninsured). The second step was to determine the level of access and estimate the proportion of individuals experiencing psychosis who receive access to Coordinated Specialty Care (CSC) either in a timely manner, in a delayed manner, or do not receive CSC and rely on community care for support. The third step was to estimate the costs of scaling CSC and the benefits of receiving CSC across various dimensions of an individual's life, such as healthcare, education and employment, housing, criminal justice, and caregivers and family members.

It is important to note that the initial model accounts for impact areas and estimates that have been empirically studied and reported in published literature. However, there are other known areas of CSC's impact that are not included in the model, such as productivity loss due to premature mortality. This comprehensive approach to building the economic model provides a robust business case for investing in upstream care for psychosis, demonstrating its potential cost effectiveness compared to more expensive downstream care like the need for more psychiatric beds.

Preliminary insights from the national impact model

Increasing the availability of CSC has the potential to improve the lives and livelihoods of individuals experiencing first-episode psychosis and to generate system impact. As access to CSC increases, more individuals receive services early in their psychosis journey, and overall

system costs decrease. For example, increasing access across the nation to CSC from 25% to 90% of individuals in need could generate $21k per year in healthcare and social impact per individual who receives CSC early in their psychosis journey, translating to $5.7 billion per year in national system impact.

The California-specific impact model was built using the same methodology but with California-specific estimates to help articulate the economic case for investment in upstream care for psychosis.

7.1.2 Series of consultative meetings and discussions with subject-matter experts

An Advisory Group of Subject-Matter Experts (SMEs) was formed to facilitate the discussion and development of the Early Psychosis Incidence (EPI) Strategic Plan. This group comprised a diverse range of stakeholders, such as state leaders, MHSOAC commissioners, healthcare partners, DHCS, DMH, DSH, local implementers, county leaders, public safety, EPI programs, ecosystem partners, commercial healthcare payers, healthcare providers, employers, communities and individuals, individuals with lived experience, family members, justice-involved individuals, tribal communities, children and youth, and national leaders. The group worked together to review the findings of the impact model, develop a landscape analysis of California, and share inputs for a strategic roadmap for the expansion of early psychosis care outlined in this plan.

Advisory group members

NOT EXHAUSTIVE

Category	Group	Name
Communities and Individuals	Individuals with lived experience	Brandon Staglin
	Individuals with lived experience	Claire Conway
	Individuals with lived experience	Keris Myrick
	Family members	Gladys Mitchell
	Children and Youth	Radha
	Tribal communities	Virgil Moorehead
Ecosystem Stakeholders	Payors - CalPERs	Julia Logan
	CHA	Paul Rains
Local Implementors	County Leaders	Supervisor Ellenberg
	Rural	Phebe Bell
	Public Safety	Sheriff Bill Brown
	EPI Programs	Ann Boynton
	EPI Programs	Steve Adelsheim
	EPI Programs	Kerry Ahern
	EPI Programs	Tara Niendam

Category	Group	Name
National Leaders	National Council for Wellbeing	Chuck Ingoglia
	NAMI	Daniel H. Gillison, Jr.
	NAMI	Darcy Gruttadaro
	NASMHPD	Brian Hepburn
	NIMH	Robert Heinssen
	Brookings Institute	Richard Frank
State Leaders	Healthcare - Dept Managed Care	Amanda Levy
	Healthcare - DSH	Ambarin Faizi
	Healthcare- Cal HSS	Stephanie Welch
	MHSOAC Commissioners	Jay Robinson
	MHSOAC Commissioners	Mark Bontrager
	Healthcare - CBHA	Le Ondra Clark Harvey
	Healthcare - DHCS	Paula Wilhelm
	Healthcare - Cal HSS	Sohil Sud

Exhibit 28: Early Psychosis Intervention Advisory Group members

Additionally, we extended an invitation to Individuals with Lived Experience and CSC providers to share their experiences of early psychosis and the impact of intervention models. These requests were sent via two advisory group members. Dr. Tara Niendam engaged the EPI-CAL network) and Brandon Staglin reached out to affiliates at 365Strong, the Accelerating Medicines Partnership® Schizophrenia (AMP® SCZ) program, and the National Association of State Mental Health Program Directors (NASMHPD). Two individuals agreed to be interviewed. One key barrier to identifying individuals with lived experience to share their experiences with CSC may be ongoing stigma related to psychosis and related diagnoses.

7.2 State Insurance Mandates

As noted in the body of this Plan, the **State of Illinois** law (Second Substitute Senate Bill 5903) that mandates commercial insurance coverage for Coordinated Specialty Care is described in SAMHSA Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies. The FIRST.IL program offers evidence-based CSC services to individuals aged 14 to 40 experiencing FEP. According to SAMHSA:

> "Illinois enacted the Child and Young Adult Mental Health Crisis Act (PA 101-0461, Sec. 30) in 2019, which mandates commercial insurance coverage of CSC, Assertive Community Treatment, and Community Support Team treatment for people under the age of 26 through a bundled payment. The law requires that most components of the CSC model be reimbursable through a bundled rate, including treatment planning, medication management and monitoring, crisis intervention services, peer support, case management, family psychoeducation, resiliency training, substance use treatment support, care coordination, public outreach and education, and individual and group psychotherapy. Commercial insurers are not required to cover treatment-integrated services to promote educational or vocational success, although these services are necessary for model fidelity. They will be financed through other sources."
>
> In addition, "[Illinois Department of Mental Health] provides additional [Mental Health Block Grant] funds of up to $17,500 for FIRST.IL services that are not covered through Medicaid, commercial insurance, or Vocational Rehabilitation billing, such as outreach and otherwise uncovered employment supports."

It is notable that, as of 2023, the State's major CSC provider (Thresholds) was reported as having entered a contract with one commercial insurance carrier. Our research did not reveal any published cost-effectiveness or economic impact data regarding this arrangement.

In the **State of Massachusetts**, the State's strategic plan for early psychosis included a recommendation for ensuring access to coordinated specialty care regardless of type of insurance, and the bill requiring commercial health insurers to cover comprehensive treatment programs, specifically Coordinated Specialty Care (CSC) and Assertive Community Treatment (ACT), has passed both chambers and has been referred to the MA Senate Ways and Means Committee.

While data demonstrating the impact of a state mandate for commercial insurance coverage in Massachusetts are not available, Kline et al (2021) found that CSC programs in Massachusetts (all of which accepted both commercial insurance and Medicaid) demonstrated overall patient improvement in functioning, with a 20% increase in employment, a 54% decrease in emergency department visits, and a 67% decrease in

hospitalizations. Patients saw significant improvements in delusions, negative symptoms, social functioning and self-reported quality of life at 6 months, while hallucinations and depression did not show significant changes over time; thus, illustrating that CSC programs are likely effective across publicly and privately insured populations.

In 2022, the **State of Washington** Health Care Authority partnered with stakeholders, as directed by legislation in Second Senate Substitute Bill 5903, to develop and implement a Team Based Rate for Medicaid. With respect to cost implications, the Statewide Implementation Plan includes the following analysis regarding coverage by commercial insurance:

> "Many critical components of the evidence-based CSC model are not supported by current third-party reimbursement structures, including the team-based care and coordination structure, supported employment and education services, case management, and peer support. HCA [developed] a comprehensive Medicaid case rate for the New Journeys [coordinated specialty care] program model… Using the preliminary Medicaid case rate estimate, if adopted it is anticipated that teams could generate approximately $415,584 annually based on a full caseload, which would cover 76% of the average annual New Journeys team cost. If a commercial parity mandate were enacted, a best practice pursued by other states in supporting CSC models, it is anticipated that teams could generate approximately $79,920 in additional annual revenue, which along with Medicaid reimbursement, could support up to 90% of annual New Journeys team cost."

7.3 Review of S.B.1337

This review of the California Health Benefits Review Program's (CHBRP) analysis of Senate Bill (S.B.) 1337, does not comprise a commentary on specific legislation, but rather a fact-based comparison of the MHSOAC EPI Strategic Plan with the analysis described in the CHBRP document. In its review of the potential financial impact of S.B. 1337, CHBRP concluded the benefit of CSC is no greater than outpatient treatment-as-usual.

As noted in the MHSOAC EPI Strategic Plan, the research literature (including most of the research cited by CHBRP) finds substantial, empirically-demonstrated benefits of CSC for individuals with early psychosis. In its cost analysis, CHBRP based most of its clinical assumptions on randomized controlled trials conducted outside of the United States and limited its impact analysis to ~30% of individuals with early psychosis. CHBRP assumed SB 1337 (expanded coverage for CSC) was a singular intervention and no other changes in workforce, public education, diagnostic accuracy, or early detection would occur. Also, CHBRP did not take into consideration the difference between timely and delayed access to CSC, which has substantial cost implications. A high-level analysis of the differences between the CHBRP and MHSOAC analyses follows:

Key differences

Research base
The conclusions of the CHBRP review are largely based on a single meta-analysis (Puntis et al, 2020) which does include data from the NIMH-funded RAISE study, and also includes data from randomized controlled trials conducted in Denmark, England, Hong Kong, and Norway where the availability and quality of community-based mental health and social services may differ substantially from the standard of care in the United States and, specifically, the State of California. Puntis et al. and the CHBRP paper did not include Dickerson et al., 2008; Nossel et al., 2018; Tsiachristis et al., 2016; Pollard et al., 2020; McDonnell, 2004 upon which the National Impact Model and MHSOAC CSC impact model draw their estimates of the impact of CSC across the dimensions of emergency department and inpatient hospital utilization, education, employment, criminal justice involvement, housing, and caregiver burden.

Cost
CHBRP and MHSOAC CSC impact model both draw cost assumptions from Humensky et al., 2013 so team cost estimates are comparable; however, the models were developed at different times and so the CHBRP model for team cost is based on dollar values in 2022 and MHSOAC's model was developed in 2024.

Context
The CHBRP assumes increased insurance coverage of CSC would be an isolated intervention,

without accompanying efforts to increase provider supply, improve accuracy of diagnoses, and provider and public education to encourage early detection and access to care. As such, it estimates limited short-term impact of SB 1337 due to persistent provider supply limitations, stigma, and low detection rates resulting in only 5,000 individuals with FEP accessing CSC in Year 1.

MHSOAC's EPI Strategic Plan identifies the foundational levers necessary not only to achieve sustainable funding but also to build the necessary clinical workforce and capabilities, accountability structures, infrastructure, and ecosystem engagement (including public education and awareness) in order to ensure 90 percent of Californians will have timely access to CSC (~19,000 per year).

Timing of Intervention
The CHBRP model does not differentiate between cost of care for individuals with delayed access (>12 months) versus timely access (<12 months) to CSC, which the literature indicates can be substantial.

The MHSOAC CSC impact model assumes scale up occurs prior to Year 1 representing full run rate of expanded CSC programming at with nearly 38,000 individuals with early psychosis accessing care in Year 1, nearly half of whom would be getting delayed access to care (>12 months post onset). Given the higher costs of care and reduced benefit of CSC for individuals with delayed access (with estimated per year ongoing cost of $117K for timely access vs $168K for delayed access), the cost of the 90% CSC access scenario is higher than the 10% CSC scenario in Years 1-3. Only when a substantial proportion of the population experiencing psychosis has timely access to CSC does the cost of care for the Early Psychosis population achieve net benefit (in Years 4-10).

Impact Period
The CHBRP model is limited to a 12-month impact period, so it does not realize the impact of savings as more individuals with FEP obtain timely access to CSC and fewer individuals have delayed or no access to CSC.

Caregiver Impact
The CHBRP model does not incorporate the economic value of reduced caregiver burden via increased employment or reduced healthcare utilization.

MISCELLANEOUS ENCLOSURES

May 22nd, 2025 Commission Meeting

Enclosures (3):

(1) Evaluation Dashboard

(2) Innovation Dashboard

(3) Department of Health Care Services Revenue and Expenditure Reports Status Update

BHSOAC Evaluation Dashboard May 2025
(Updated May 19, 2025)

Commission for Behavioral Health

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 3

Funds Spent Since the April 2025 Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 0.00
22MHSOAC025	$ 0.00
23MHSOAC057	$ 0.00
TOTAL	**$ 0.00**

Commission for Behavioral Health

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

BHSOAC Staff: Melissa Martin-Mallard
Active Dates: 07/01/21 - 06/30/27
Total Contract Amount: $7,544,350.00
Total Spent: $4,244,350

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	No
Quarterly Progress Reports	Complete	03/31/2024	No
Quarterly Progress Reports	Complete	06/1/2024	No
Quarterly Progress Reports	Complete	9/30/2024	No
Quarterly Progress Reports	Complete	12/31/2024	No
Quarterly Progress Reports	Complete	3/21/2025	Yes
Quarterly Progress Reports	In Progress	6/30/2025	Yes

Quarterly Progress Reports	Not Started	9/30/205	No
Quarterly Progress Reports	Not Started	12/31/2025	No
Quarterly Progress Reports	Not Started	3/31/2026	No
Quarterly Progress Reports	Not Started	6/30/2026	No
Quarterly Progress Reports	Not Started	9/20/2026	No
Quarterly Progress Reports	Not Started	12/31/2026	No
Quarterly Progress Reports	Not Started	3/31/2027	No
Quarterly Progress Reports	Not Started	6/1/2027	No

Commission for Behavioral Health

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

BHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 6/30/25
Total Contract Amount: $1,500,000.00
Total Spent: $1,500,000.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA. This contract is currently being amended to include implementation of the evaluation plan.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete Complete Complete	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	Complete	December 15, 2023	No
School Mental Health Metrics	Complete	June 15, 2024	No
Evaluation Plan (draft and final)	Complete Complete	September 1, 2024 January 15, 2025	No
Consultation on Report to the California Legislature	Complete	March 1, 2024	No
Progress Reports (a, b, and c)	Complete Complete Complete	September 15, 2023 January 15, 2024 June 15, 2024	No

Third Sector Capital Partners: FSP Toolkit (23MHSOAC057)

BHSOAC Staff: Kallie Clark
Active Dates: 06/05/42 - 06/30/25
Total Contract Amount: $250,000
Total Spent: $60,000

Third Sector will engage with MHP Full Service Partnerships (FSP), providers, state entities, and other subject matter experts to develop a best-practice toolkit for FSP programs across CA.

Deliverable	Status	Due Date	Change
Draft Plan for FSP Toolkit Working Group	Complete	August 31, 2024	No
Final Plan for FSP Toolkit Working Group	Complete	September 30, 2024	No
FSP Toolkit Working Group	In Progress	April 30,2025	No
Draft FSP Working Group Toolkit	In Progress	April 30, 2025	No
Final FSP Working Group Toolkit	Complete	May 30, 2025	No

DHCS Status Chart of County RERs Received
May 22, 2025, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated May 16, 2025. This Status Report covers FY 2022 -2023 through FY 2023-2024. All RERs prior to these fiscal years have been submitted by all counties.

The Department provides BHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the BHSOAC. Counties also are required to submit RERs directly to the BHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2023-2024 on the data reporting page at: https://bhsoac.ca.gov/county-plans/

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2023-24 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion	FY 23-24 Electronic Copy Submission	FY 23-24 Return to County	FY 23-24 Final Review Completion
Alameda	1/30/2024	1/31/2024	2/14/2024	1/29/2025	2/5/2025	2/18/2025
Alpine	7/30/2024	8/6/2024	8/8/2024	3/19/2025	3/20/2025	4/7/2025
Amador	2/8/2024	2/14/24	2/16/2024	1/23/2025	1/24/2025	2/12/2025
Berkeley City	1/31/2024	2/2/2023	2/6/2024	1/29/2025	2/4/2025	2/6/2025
Butte	5/5/2025	5/6/2025	5/8/2025			
Calaveras	1/31/2024	2/2/2024	2/5/2024			
Colusa	3/15/2024	3/20/2024	4/2/2024	1/29/2025	2/5/2025	2/19/2025
Contra Costa	2/13/2024	2/14/2024	2/15/2024	1/30/2025	2/6/2025	2/10/2025
Del Norte	1/30/2024	2/1/24	2/5/2024	1/30/2025	2/5/2025	2/11/2025
El Dorado	1/30/2024	1/30/2024	1/30/2024	1/31/2025	2/10/2025	2/12/20225
Fresno	1/29/2024	1/30/2024	2/1/2024	1/29/2025	2/5/2025	2/18/2025
Glenn						
Humboldt	1/30/2024	1/31/2024	2/2/2024	1/31/2025	2/7/2025	2/7/2025
Imperial	1/19/2024	1/30/24	2/7/2024	1/17/2025	2/10/2025	2/14/2025
Inyo	5/28/2024	5/29/2024	9/4/2024	5/2/2025		
Kern	2/2/2024	2/9/2024	2/23/2024	1/31/2025	2/10/2025	2/19/2025
Kings	2/8/2024	2/14/2024	2/16/2024	1/31/2025	2/7/2025	2/19/2025
Lake	5/8/2024	5/8/2024	5/9/2024	2/13/2025	2/14/2025	2/18/2025
Lassen	2/29/2024	2/29/2024	3/5/2024	4/29/2025	4/29/2025	5/1/2025
Los Angeles	2/5/2024	2/6/2024	2/16/2024	1/30/2025	2/6/2025	2/24/2025
Madera	3/22/2024		3/29/2024			
Marin	1/31/2024	2/2/2024	2/5/2024	1/31/2025	2/7/2025	2/13/2025

DHCS Status Chart of County RERs Received
May 22, 2025, Commission Meeting

County	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion	FY 23-24 Electronic Copy Submission	FY 23-24 Return to County	FY 23-24 Final Review Completion
Mariposa	2/7/2024	2/15/2024	2/15/2024	1/31/2025	2/7/2025	2/12/2025
Mendocino	1/31/2024	2/5/2024	2/15/2024	1/31/2025	2/6/2025	2/19/2025
Merced	1/18/2024	1/19/2024	1/23/2024	1/10/2025	1/14/2025	1/15/2025
Modoc	5/6/2024	5/8/2024	5/13/2024	1/31/2025	2/6/2025	2/11/2025
Mono	1/31/2024	2/5/2024	2/16/2024	1/31/2025	2/7/2025	2/14/2025
Monterey	1/31/2024	2/1/2024	2/20/2024	1/30/2025	2/6/2025	2/11/2025
Napa	2/6/2024	2/20/2024	3/11/2024	1/31/2025	2/3/2025	2/18/2025
Nevada	1/31/2024	2/9/2024	2/14/2024	1/30/2025	2/3/2025	2/3/2025
Orange	1/31/2024	2/7/2024	2/15/2024	1/31/2025	2/3/2025	2/5/2025
Placer	1/31/2024	n/a	2/7/2024	1/31/2025	2/4/2025	2/4/2025
Plumas	2/9/2024	2/9/2024	2/15/2024	2/4/2025	2/4/2025	2/10/2025
Riverside	2/1/2024	2/15/2024	2/21/2024	1/31/2025	2/3/2025	2/28/2025
Sacramento	1/31/2024	2/22/2024	2/23/2024	1/28/2025	1/28/2025	2/19/2025
San Benito	3/18/2024	3/18/2024	3/22/2024	3/10/2025	3/25/2025	4/10/2025
San Bernardino	1/31/2024	2/21/2024	2/21/2024	1/31/2025	2/4/2025	2/12/2025
San Diego	1/30/2024	2/5/2024	2/14/2024	1/31/2025	2/4/2025	2/13/2025
San Francisco	1/31/2024	3/18/2024	3/22/2024	2/13/2025	2/18/2025	3/12/2025
San Joaquin	2/22/2024	3/7/2024	3/27/2024	2/26/2025	2/27/2025	3/11/2025
San Luis Obispo	1/25/2025	2/8/2024	2/14/2024	1/31/2025	2/3/2025	2/18/2025
San Mateo	2/16/2024	4/9/2024	4/9/2024	1/31/2025	2/3/2025	2/5/2025
Santa Barbara	1/30/2024	2/9/2024	2/12/2024	2/3/2025	2/3/2025	2/12/2025
Santa Clara	2/1/2024	2/15/2024	2/22/2024	1/31/2025	2/3/2025	2/12/2025
Santa Cruz	8/16/2024	8/21/2024	10/11/2024			
Shasta	1/30/2023	2/15/2024	2/21/2024	1/30/2025	2/3/2025	2/4/2025
Sierra	12/18/2023	12/27/2023	1/15/2024	1/29/2025	1/29/2025	2/19/2025
Siskiyou	2/2/2024	2/15/2024	2/15/2024			

DHCS Status Chart of County RERs Received
May 22, 2025, Commission Meeting

County	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion	FY 23-24 Electronic Copy Submission	FY 23-24 Return to County	FY 23-24 Final Review Completion
Solano	1/31/2024	2/15/2024	2/20/2024	1/29/2025	2/3/2025	2/4/2025
Sonoma	1/31/2024	2/7/2024	2/14/2024	1/31/2025	2/3/2025	2/20/2025
Stanislaus	1/31/2024	2/6/2024	2/9/2024	1/31/2025	2/3/2025	2/3/2025
Sutter-Yuba	3/29/2024		4/2/2024	1/28/2025	1/28/2025	2/3/2025
Tehama	3/10/2025	3/10/2025	4/3/2025	3/14/2025		
Tri-City	1/31/2024	2/6/2024	2/9/2024	1/31/2025		2/3/2025
Trinity	5/21/2024	5/29/2024	6/10/2024	1/29/2025	1/30/2025	2/6/2025
Tulare	1/30/2024	2/20/2024	5/1/2024	1/31/2025	2/3/2025	2/19/2025
Tuolumne	3/1/2024	3/4/2024	3/7/2024	314/2025		
Ventura	1/31/2024	2/15/2024	2/15/2024	1/31/2025	2/3/2025	2/24/2025
Yolo	4/4/2024	4/5/2024	4/19/2024	1/30/2025	2/3/2025	2/3/2025
Total	**58**	**55**	**58**	**53**	**50**	**51**

INNOVATION DASHBOARD

May 2025

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	2	2	**4**
Participating Counties (unduplicated)	2	2	**4**
Dollars Requested	$5,557,686.00	$12,736,799	**$18,294,485**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2018-2019	54	54	$303,143,420	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)
FY 2022-2023	31	31	$354,562,909	26 (44%)
FY 2023-2024	15	15	$197,481,034	13 (22%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2024-2025	20	20	$74,628,439	13

INNOVATION PROJECT DETAILS

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Yolo	Semi-Statewide Enterprise Health Record	$5,234,306	3 Years	3/21/2025	4/21/2025
Under Final Review	Napa	PIVOT: Progressive Improvements for Valued Outpatient Treatment	$290,380	3 Years	N/A	3/11/2025

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Contra Costa	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$1,000,000	4 Years	3/10/2025	Pending
Under Review	Contra Costa	PIVOT: Progressive Improvements for Valued Outpatient Treatment	$11,736,799	5 Years	4/1/2025	Pending

APPROVED PROJECTS (FY 24-25)			
County		Funding Amount	Approval Date
Sierra	Semi-Statewide Enterprise Health Record Multi County Collaborative	$910,906	7/25/2024
Orange	Community Program Planning – Extension Request	$1,000,000	8/22/2024
Orange	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$4,980,470	8/22/2024
Shasta	Level Up Norcal: Supporting Community Driven Practices for Health Equity	$999,978	11/21/2024
Alameda	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$3,070,005	11/21/2024
Tri-City	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$1,500,000	11/21/2024
Nevada	BHSA Implementation Planning	$1,365,000	11/21/2024
Orange	Program Improvements for Valued Outpatient Treatment (PIVOT) Multi-County Collaborative	$34,950,000	11/21/2024
San Mateo	Peer Support for Peer Workers	$580,000	3/27/2025
San Mateo	Progressive Improvements for Valued Outpatient Treatment (PIVOT) – Medi-Cal Billing	$5,650,000	3/27/2025

San Mateo	Animal Care for Housing Stability & Wellness	$990,000	3/27/2025
San Mateo	allcove Half Moon Bay	$1,600,000	3/27/2025
Ventura	Veteran Mentor Project	$2,587,377	3/27/2025
San Luis Obispo	Medi-Cal Maximizing & Training Initiative (MMTI)	$600,000	3/27/2025
Monterey	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$3,000,000	4/24/2025
Mariposa	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$160,740.55	4/24/2025
Orange	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative - EXTENSION	$2,739,601	4/24/2025
Fresno	The Lodge 2	$4,200,000	4/24/2025
Ventura	Collaborative Care for Youth: Integrating Collaborative and Behavioral Health Models	$2,874,361	4/24/2025
Marin	Student Wellness Ambassador Program (SWAP) – EXTENSION	$870,000	4/24/2025