

Public comment from Stacie Hiramoto

From: Stacie Hiramoto <shiramoto@remhdco.org>

Sent: Wednesday, October 22, 2025 12:24 PM

To: Brenda Grealish <brenda.grealish@bhsoac.ca.gov>; Mayra E. Alvarez
(malvarez@childrenspartnership.org) <malvarez@childrenspartnership.org>

Cc: Kendra Zoller <Kendra.Zoller@bhsoac.ca.gov>; Melissa Martin-Mollard
<Melissa.MMollard@bhsoac.ca.gov>

Subject: Letters Re: Tomorrow's CBH Meeting

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Hello Brenda –

I don't know if these letters are in time for the Hand out packet for tomorrow's meeting, but hoping that they are. Thank you so much.

Stacie Hiramoto, MSW

Director

She/her/kanojō

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California Reducing Disparities Project

October 22, 2025

Members of the Commission for Behavioral Health
Offices of the Behavioral Services Oversight and Accountability Commission
1812 9th Street
Sacramento, CA 95811

Re: Full Commission Meeting of October 23, 2025
Item 12 – Innovation Partnership Fund

Dear Chair Alvarez and Commissioners,

This letter outlines our specific content concerns regarding the Innovation Partnership Fund (IPF) Framework V3 document. We have provided our process concerns in a separate letter. We do want to thank the Commission for the opportunity to make these recommendations and appreciate the Commissioners as well as the Commission staff for the time spent thus far on this subject.

We have three primary concerns with the document and suggest these changes:

- 1. Community Defined Evidence Practices or CDEPs should be prioritized for funding.** CDEPs clearly fit under the Commission's short definition of Innovation: "A new or adapted approach to solving persistent problems in California's behavioral health system— especially those that relate to equity, access, workforce shortages, and service fragmentation." The Commission goes on to say that Innovation should: *Introduce or scale practical, **community defined evidence-based practices** that increase access to prevention, treatment, and recovery supports.*

In addition, as noted in a presentation by the Executive Director earlier this year, **CDEPs were the most frequently suggested priority by stakeholders.** (See attachment 1) A study of the CDEPs of the California Reducing Disparities Project (CRDP) conducted by the Psychology Applied Research Center of Loyola Marymount University found that CRDP programs utilizing CDEPs not only saved the taxpayers \$5 out of every \$1 spent but maintained or improved the mental health status of participants as well.

CDEPs are also proven to reduce mental health disparities for both the BIPOC and LGBTQ+ communities. Programs utilizing CDEPs are often what these communities prefer to be funded over mainstream medical model type approaches and services. Finally, CDEPs contribute to the diversification of the workforce, which can be leveraged to address the workforce shortages described in the innovations definition.

2. **The IPF should not be limited to only people with a diagnosis or who are “seriously mentally ill” (SMI).** The majority of funding under Proposition 1 will go to people with serious mental illness. We do not oppose this. But funding is also allowed to go towards people who have not been diagnosed (or that are “mild to moderate”) especially in the Innovation, Prevention, and Early Intervention components.

In the current Framework, it needs to be acknowledged that the IPF could be used for programs that might be considered “prevention” or programs that serve people that are *at risk* and do not yet have a diagnosis. The Act allows prevention programs to be provided at the county level, as well as the state. Please see the excerpts from the Department of Health Care Services document attached.

Further, in order to fund authentic community defined evidence practices or CDEPs, the IPF must not be limited to serving **only** those with SMI. CDEPs do not base or limit participation in a program based on a diagnosis, or lack of one.

3. **Projects aimed at BIPOC and LGBTQ+ communities should be specifically prioritized.** The actual language for Innovations in that section of statute prioritizes: *underserved communities; low-income communities; and communities experiencing other behavioral health disparities*. BIPOC and LGBTQ+ communities fit into all these categories, but if not called out, are still at risk of continuing to be overlooked using those generic terms. Decades of investment demonstrate that behavioral health disparities are not reduced when specific populations experiencing disparities are not prioritized and data is not collected to measure impact among priority populations.

As never before, BIPOC and LGBTQ+ communities have been explicitly targeted and have suffered disproportionately because of recent actions by the federal government. Even using the terms “*diversity*” or “*equity*” are banned or otherwise discredited within federal programs by Executive Order.

Proposition 1 includes a stated purpose to serve those with “the greatest needs and highest risk...” Those in BIPOC and LGBTQ+ communities carry a strong

argument that members of their communities are the ones with the greatest needs and highest risk. The MHSA under Proposition 63 was really only beginning to make some progress in reducing disparities for BIPOC and LGBTQ+ communities. Proposition 1 must ensure that its' prioritization of underserved communities and goal of reducing behavioral health disparities is realized. As a state, California must push this forward, not pretending that the need has been met or that equity once again, goes to the back of the line.

Again, thank you for the continued opportunity to provide input. We hope our recommendations can be incorporated into version 4 of the IPF Framework.

Sincerely,

A handwritten signature in black ink, appearing to read 'Josefina Alvarado Mena', with a long horizontal flourish extending to the right.

Josefina Alvarado Mena
Chair
CRDP Cross Population Sustainability Steering Committee

cc: Brenda Grealish, Executive Director, Commission for Behavioral Health
Melissa Martin-Mollard, Staff to the CBH Program Committee



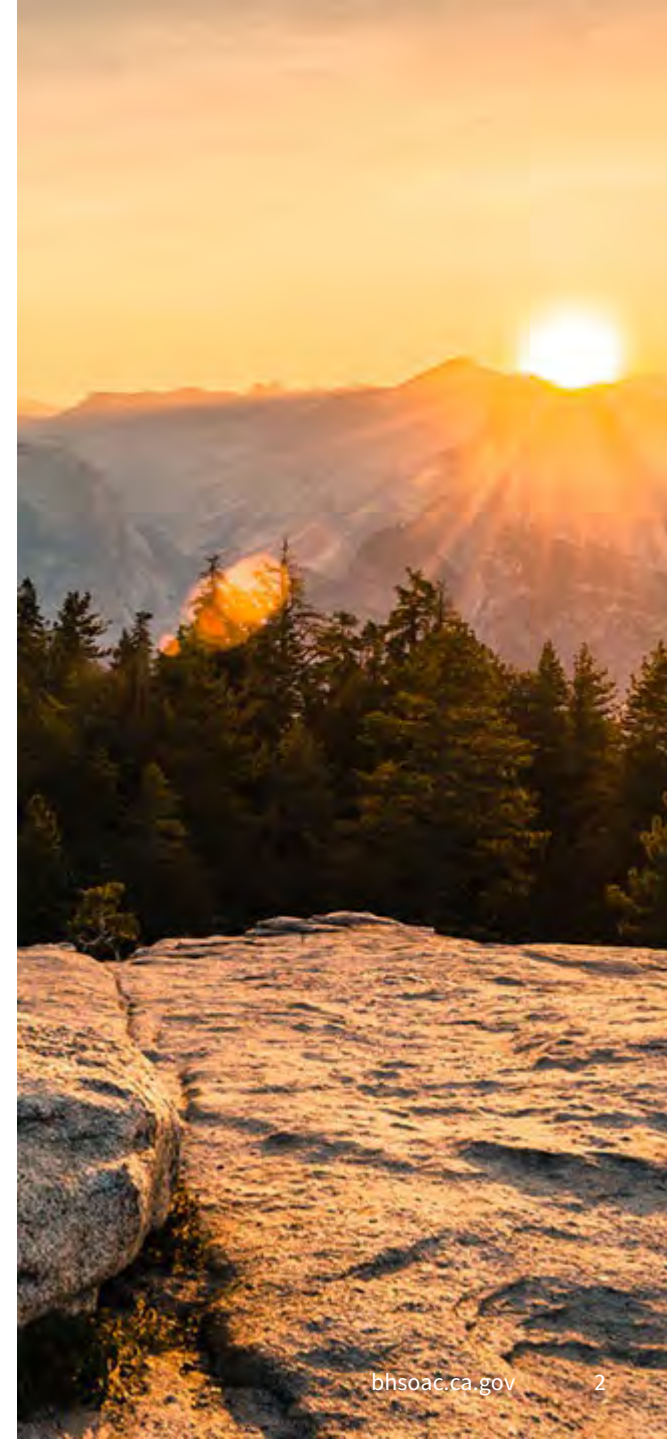
Innovation Partnership Fund Community & Stakeholder Concepts

Will Lightbourne, *Interim Executive Director*
April 24, 2025

Community Defined Evidence Practices

THE MOST FREQUENTLY SUGGESTED PRIORITY.

- Overall concept: Support development of runways for CDEPs to become established practice
- Focus CDEPs on the need of particular communities
- Technical assistance to help counties integrate CDEPs into service array



Excerpts from the DHCS Report

“Understanding The Behavioral Health Services Act: Myths vs. Reality”

DHCS: <https://www.dhcs.ca.gov/BHT/Pages/BHSA-Myths-Reality.aspx>

Myth: The BHSA will significantly shift county behavioral health funding toward housing and intensive treatment, reducing the resources available for upstream, preventive services such as peer-support centers, outpatient care, and mobile crisis response.

Reality: The BHSA requires counties to strategically allocate all county behavioral health funds **holistically** across the mental health and SUD care continuums, including investments in peer support services and mobile crisis response.

The BHSA’s goal is to create a more effective and integrated system, not to dismantle existing services. Counties need to conduct a thorough needs assessment and develop a three-year plan that balances **prevention**, early intervention, and intensive services across all county behavioral health funding sources, including SAMHSA and Opioid Settlement Fund funding, which may be used for prevention activities. **Counties must prioritize services based on local needs and informed by stakeholder engagement through their Community Planning Process.**

Myth: Unlike the MHSA, the BHSA does not prioritize prevention and instead focuses on downstream funding for those needing the most support.

Reality: The BHSA rebalances funding priorities without abandoning prevention efforts, including prevention and early intervention services for individuals at risk of a mental health or substance use disorder who do not have a diagnosis.

While there is a strong emphasis on housing and services for individuals living with the most significant behavioral health needs, prevention remains a crucial component of a comprehensive behavioral health system. The BHSA aims for a more integrated system where early intervention works in concert with intensive services, and prevention is coordinated and monitored effectively for statewide population health. To this end, BHSA prevention funding through the California Department of Public Health (CDPH) will support statewide population-based prevention strategies. Further, the BHSA maintains MHSA

Early Intervention funding under the Behavioral Health Services and Supports (BHSS) funding allocation, requiring counties to spend at least 51% of their BHSS funding allocation on Early Intervention.

County Early Intervention programs may fund indicated prevention programs and services for individuals who are at risk of, or experiencing, early signs of a mental health or substance use disorder. Individuals do not need a behavioral health diagnosis to receive prevention and early intervention services.

Additionally, other sources of funds that support prevention activities, such as the Community Mental Health Services Block Grant (MHBG), Substance Use Disorder Block Grant (SUBG), 1991 and 2011 Realignment, and Opioid Settlement Funds, are not impacted by BHSA and continue to support primary prevention activities.