

State of California

BEHAVIORAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date January 23, 2026
Time 9:00 a.m.
Location BHSOAC
1812 9th Street
Sacramento, California 95811

Members Participating:

Alfred Rowlett, M.B.A., M.S.W., Chair	Brandon Fernandez, M.P.H.
Rayshell Chambers, M.P.A., Vice Chair	David Gordon, Ed.M.
Mark Bontrager, J.D., M.S.W.*	Assemblymember John Harabedian by Rosielyn Pulmano
Sheriff Bill Brown, M.P.A.	Karen Larsen
Robert Callan, Jr.	Gladys Mitchell, M.S.W.
Christopher Contreras	Jay Robinson, Psy.D., M.B.A.
Senator Dave Cortese, J.D. by Marjorie Swartz	Marvin Southard, Ph.D., M.S.W.*
Makenzie Cross	Jay'Riah Thomas-Beckett, M.A.
Amy Fairweather, J.D.	Jevon Wilkes

*Participated remotely

Members Absent:

Mayra Alvarez, M.H.A., Immediate Past Chair	Steve Carnevale
Pamela Baer	Shuo Chen, J.D.
Michael Bernick, J.D.	Tumboura Hill
Keyondria Bunch, Ph.D.	Mara Madrigal-Weiss, M.Ed. Gary Tsai, M.D., DFAPA, FASAM

BHSOAC Meeting Staff Present:

Brenda Grealish, Executive Director	Lester Robancho, Health Program Specialist
Sandra Gallardo, Chief Counsel	Cody Scott, Meeting Logistics Technician
Amariani Martinez, Administrative Support	

Opening Business and Administrative Items

1: Call to Order and Roll Call – Information

Chair Alfred Rowlett reconvened the meeting of the Behavioral Health Services Oversight and Accountability Commission (BHSOAC, Commission, or Commission for Behavioral Health (CBH)) to order at 9:04 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.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending in Person: Chair Rowlett, Vice Chair Chambers, and Commissioners Brown, Callan, Contreras, Designee Swartz for Cortese (arrived at 9:16am), Cross, Fairweather, Fernandez, Gordon, Designee Pulmano for Harabedian, Larsen, Mitchell, Robinson, Thomas-Beckett, and Wilkes. Attending Remotely: Commissioners Bontrager and Southard.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements – Information

Chair Rowlett thanked Mayra Alvarez for her leadership during her term as Chair of the Commission for 2025. He shared a humorous story that demonstrated her impact on the state and the nation and stated she is a uniquely talented person with an understanding of the landscape of California and the nation in a way that is best for the people.

Commissioners and staff expressed their thanks, appreciation, and gratitude for her work and her service as Chair of the Commission for 2025.

3: General Public Comment – Information

Laurel Benhamida, Ph.D., (attended remotely via Zoom) stated: Good morning. This is Laurel Benhamida with Muslim American Society – Social Services Foundation in Sacramento, with a statewide reach, and REMHDCO. I would like to thank the Commissioners for maintaining the \$20 million for the IPF for next year in your vote yesterday, and suggest a training for staff and Commissioners and stakeholders on private-public partnerships – the risks, rewards, failures, successes, and options for structuring such a partnership. Thank you very much.

Stretch Break

The Commission took a 10-minute break.

Program Advisory Committee Updates and Recommendations

4: Population-Based Prevention Panel – Information

Chair Rowlett stated the Commission will hear a panel discussion of the impact of Behavioral Health Transformation and the Behavioral Health Services Act (BHSA) on prevention. He deferred to Executive Director Grealish to facilitate this agenda item.

Executive Director Grealish stated prevention means different things to different people. She stated today's diverse panel will share their perspectives on recent changes in the prevention landscape in behavioral health in California. She asked the members of the panel to introduce themselves and to define what prevention means from their organizations' viewpoint.

Introductions and Definition of Prevention

Trudy Raymundo, Public Health Consultant, California Department of Public Health (CDPH), introduced herself and her organization and stated she will be speaking of prevention from a statewide perspective. She stated the role of the CDPH with the new BHSA is taking a strong leadership stance from a statewide perspective to advance behavioral health services. The CDPH works to educate Californians about mental health illness and substance use disorders (SUDs) and encourages health-seeking behavior in communities from a population-based approach.

Ms. Raymundo stated prevention is defined within public health as delivering best practices in the behavioral health space. The CDPH strives to activate state and local subject matter experts because the collective expertise will create impact within communities. The CDPH strives to be well-coordinated and aligned to provide strong oversight with the right training and technical assistance resources to bring success.

Ms. Raymundo stated the CDPH focuses on primary prevention. Intervening early is important. The CDPH takes a closely-monitored multi-sectoral approach in its work to hone in and leverage public health historical expertise in data evaluation with a focus on equity, accessibility to all, root causes, promoting protective factors, and reducing risk factors to help support the overall well-being of individuals well before the signs of illness start to occur. The CDPH takes a trauma-informed approach from a life course perspective for healing and resilience.

Carmen Katsarov, Executive Director, Behavioral Health Integration, CalOptima Health, introduced herself and her organization and stated she will be speaking of prevention from the Medi-Cal managed care perspective. She stated CalOptima Health has a dual-special-needs plan and a Program of All-inclusive Care for the Elderly (PACE) program. She stated CalOptima looks at prevention from a whole health perspective, and she noted that behavioral health and social health are part of whole health.

Le Ondra Clark Harvey, Ph.D., Chief Executive Officer, California Behavioral Health Association (CBHA), introduced herself and her organization and stated she will be speaking of prevention from a provider perspective. She stated CBHA members represent a diverse collective of behavioral health providers across the state. The CBHA represents those providers in the many different services that they provide. The CBHA works to align policy with the reality that members are seeing in the field as they provide services to some of the most disenfranchised individuals and communities in the state.

Dr. Harvey stated providers see prevention as approaches to address social drivers. She stated social drivers impact the work of these providers and the people they serve. Their work in addressing those social drivers early on defines what prevention is in terms of their work.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), introduced herself and her organization and stated she will be speaking of prevention from a policy and advocacy organization perspective. She stated she will share her organization's definition of prevention during her presentation.

Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association of California (CBHDA), introduced herself and her organization and stated she will be speaking of prevention from a county leadership and city mental health authority perspective. She stated the Mental Health Services Act's (MHSA's) definition of Prevention and Early Intervention (PEI) has been guiding the work of counties in the prevention space for almost 20 years. She stated counties build awareness, provide education and outreach, help to combat stigma and discrimination, and address disparities.

Adrienne Shilton, Senior Vice President, Public Policy and Strategy, California Alliance of Child and Family Services (CACFS), introduced herself and her organization and stated she will be speaking of prevention from a non-profit organization perspective. She stated CACFS takes a broad view of prevention. Prevention could look like housing support to a foster youth who is aging into adulthood and who might otherwise age out into either homelessness or housing insecurity, a community-based family resource center that connects families to public benefits that they might not otherwise have had access to, school-based behavioral health and providing services and care in a more non-stigmatizing environment and providing that support and care to students who may not otherwise have access to that care, preventing child welfare involvement altogether by providing more support and services in homes, and suicide prevention and crisis response.

Ms. Shilton stated CACFS members were involved in the advocacy to set aside PEI components that counties administer. This was not always the case. CACFS members advocated that the intent of the reform was not to continue a cycle of today's youth becoming tomorrow's homeless adults struggling with untreated mental illness and substance use.

Executive Director Grealish summarized that this panel is an amazing cross-section of the different systems and brings together their diverse perspectives on this challenging issue. She noted that the panel demonstrated that even defining prevention is complicated and complex. The different views make up the broader behavioral health prevention landscape. She noted that there are more players in the prevention space but the Commission invited these six key players today to help Commissioners better understand prevention as it transitions to the BHS.

Presentations

Executive Director Grealish asked a series of questions to the Panel. These questions are included below as bullet points throughout the presentations.

Trudy Raymundo provided the statewide perspective. She stated the BHS transformed the approach to prevention by shifting from county-administered prevention programming to a single leadership statewide approach. The CDPH has a strong

leadership role, has much to share in this space, and has expertise to leverage as part of the population-based prevention effort.

- What does population-based prevention work look like at the CDPH?

Ms. Raymundo stated there is currently a lot of confusion about the transition from the MHSA PEI component to the BHSA population-based prevention within the CDPH. The CDPH approach around population-based prevention is about the entire community. It hones in on how to support and strengthen protective factors and to reduce and mitigate all risk factors from the perspective of supporting overall health and well-being well before illness occurs. The CDPH considers root causes and root drivers from an upstream approach.

- What do the BHSA key changes look like within the CDPH?

Ms. Raymundo stated the CDPH is working closely with the Department of Health Care Services (DHCS), since the BHSA split PEI into population-based prevention and early intervention. The first three pieces of the pie – promotion, universal prevention, and selective prevention – are led by the CDPH. The rest of the pie is about early intervention, treatment, and recovery, which is led by the DHCS. To create a strong, aligned system, all these pieces must work in tandem; they cannot be separated. There is a need to ensure that resources are in place to meet individuals where they are throughout their life course.

Ms. Raymundo applauded the groundbreaking work of the California Reducing Disparities Project (CRDP), which has been foundational in terms of how it informs the work of the CDPH both now and in the future. The CDPH leverages existing expertise to think through how to activate other subject matter experts within this area.

- What is the CDPH's plan for implementing population-based prevention?

Ms. Raymundo stated the CDPH plans to implement behavioral health prevention through strong leadership and a statewide approach focused on ensuring that coordinated and effective systems are built across the spectrum. Being aligned and coordinated will help the CDPH advance the 14 statewide behavioral health goals. The CDPH aims for accountability, data transparency, shared metrics, leveraged resources, and community partnership. It is investing in statewide approaches along with community-driven and community-level work to ensure that the work is culturally informed, driven, and relevant.

- How will the CDPH fill in gaps due to changes at the county level?

Ms. Raymundo stated the shift from county-level programming to a statewide approach will reduce funding at the local level. Difficult decisions must be made. She suggested, rather than thinking about how to fill gaps, thinking about the need to take a different approach around prevention. It is important that the programs that are developed create impact, reach the whole community, and are sustainable. The CDPH is developing programs that are community-driven but from a statewide perspective and work at the policy level.

- Provide an update on the CDPH reorganization to include a behavioral health approach to prevention, which is new to the CDPH portfolio.

Ms. Raymundo stated the CDPH wants to ensure that it is well-coordinated and aligned internally as well as externally. Among other efforts, the CDPH has created the new Office of Social and Behavioral Health to centralize and coordinate behavioral health activities; ensure leadership, oversight, and alignment across various programs; and promote behavioral health as a public health priority.

- What happens in CalOptima's private and commercial side and the Medi-Cal managed care plan side is mostly unknown. Both sides have obligations and responsibilities. What are those obligations?

Carmen Katsarov provided the Medi-Cal managed care perspective. She stated prevention and services at the plan level with delegated health networks or Federally-Qualified Health Centers (FQHC) are more medical from a population standpoint. For Medi-Cal managed care plans, CalOptima annually submits a population health management program to the regulator for approval, which highlights medical health education and wellness, behavioral health, and substance use for members.

- How do CalOptima's plans fit into the prevention landscape?

Ms. Katsarov stated CalOptima is responsible for completing the initial health risk assessment and prioritizing individuals at higher risk. Individuals are then referred to services as part of CalOptima's case management services, based on tiering of risk and need. Case management services include disease management for chronic conditions, a new diagnosis, change in condition, and transitional care.

Ms. Katsarov stated managed care plans are guided by contracts. For the provider network, CalOptima contracts with health networks, FQHCs, and others to do prevention screenings throughout the lifespan.

Ms. Katsarov stated CalOptima must provide non-specialty mental health. She noted that Ms. Cabrera will discuss specialty mental health in SUDs in her presentation. Non-specialty mental health helps with mild to moderate conditions and individuals who have transitioned down from specialty mental health. CalOptima sees prevention as keeping individuals from needing additional levels of support.

- What other opportunities do CalOptima's plans have, such as the Community Reinvestment Fund?

This question was not addressed.

- How is the landscape changing for county behavioral health, including the new community planning processes and coordinating with managed care plans and local health jurisdictions?

Michelle Doty Cabrera provided the county leadership and city mental health authority perspective. She provided an overview of the MHSA and how the BHSA compares to it. She stated the transition from the 20-year-old MHSA to the newly-enacted BHSA is underway. Counties are currently working with their community partners on developing the first BHSA plans, and some counties are beginning to submit their plans to the state. The CBHDA is working closely with state partners at the DHCS and the CDPH to help shape implementation guidance.

Ms. Cabrera stated, when the MHSA was established 20 years ago, counties were directed by the state to use the Institute of Medicine's Continuum of Care model to help define how PEI funds under the MHSA differed from the other things that the MHSA funded. 19 percent of counties' MHSA funds needed to sit in the PEI bucket with at least 51 percent being used for individuals under the age of 25.

Ms. Cabrera stated counties were required to have at least one prevention program, one early intervention program, and one stigma and discrimination reduction program with their PEI initiatives. All PEI programs were required to include community outreach on the early signs of severe mental health conditions, as well as access and linkage to care, stigma, and discrimination reduction.

Ms. Cabrera stated, initially, counties had a mandate to develop statewide mental health awareness prevention campaigns, as well. They formed a joint powers authority, the California Mental Health Services Authority (CalMHSA), in 2010 to help them manage those statewide prevention campaign initiatives. That effort funded big statewide suicide prevention campaigns, such as Each Mind Matters and Know the Signs, rooted in population health approaches. Counties also funded evaluation of these efforts with the RAND Corporation to independently assess the impact of their work.

Ms. Cabrera stated the BHSA represents a significant change in that counties will have a new funding requirement for housing. The housing set-aside under Proposition 1 is approximately \$1 billion. Counties will also be expected to redirect funding to support a new priority for SUD treatment services, which historically county behavioral health directors were supportive of. Effectively, approximately \$1.15 billion in local mental health services funding was either redirected to the state under the CDPH or to this new housing priority.

Ms. Cabrera stated the state also changed the definition of prevention and early intervention under the BHSA to just early intervention. Under the BHSA, early intervention now must be designed to prevent a mental illness or a SUD from becoming severe and disabling and reduce disparities in behavioral health. This must include robust outreach and investments in other evidence-based practices and Community-Defined Evidence Practices (CDEPs). The final BHSA module to guidance from the DHCS, released in April 2025, narrowed the potential uses from selective prevention to indicated prevention and case identification. Although this was not what was in statute, it was the secondary implementing guidance from the state.

Ms. Cabrera stated this was in contrast to the CDPH's scope, which includes promotion, universal, and selective prevention campaigns that either target the whole state, like the original MHSA campaigns, or specific target populations. She stated the guidance to counties includes a strict prohibition on funding for "stigma and discrimination reduction activities," as those are intended to align with the population-based prevention activities funded by the state. This restriction is especially difficult for counties, given the long-standing commitment to equity and cultural competence. Anti-stigma and discrimination work will continue, but not with the same level of investment that was made historically under the MHSA.

Ms. Cabrera stated the final guidance on evidence-based practices and CDEPs that county behavioral health can fund came out in December 2025. She noted that, without

an alternative source of funding, counties will need to end some of their grants. This work has historically been not just community-informed, but community-driven. There has been a process of grieving for the losses in funding and direction that were part of the MHSA with its mandate to closely partner with communities to drive unique outreach initiatives that were rooted in community and culture.

Ms. Cabrera stated it is not just about losing funding; it is about changing the rulebook and shifting funding that has forced counties to dismantle good impactful work, cancel contracts, and tell community partners in this already chaotic moment that counties can no longer make these critical investments in stigma reduction, community awareness campaigns, suicide prevention, wellness centers, and peer support programs targeting marginalized communities. This direction to focus on those dealing with the most severe conditions, along with a prohibition on funding upstream population health and anti-discrimination work and the loss of programs and services funding, will have a profound effect on what counties fund, as well as how they interact with local and state partners.

- How have policy and advocacy organizations been planning and working through the changes in equity-focused prevention services brought on by the Proposition 1 transformation?

Stacie Hiramoto provided the policy and advocacy organization perspective. She stated, when Proposition 63 was passed, there were not many leaders of racial, ethnic, Black, Indigenous, and People of Color (BIPOC), or LGBTQ communities at the decision-making tables during the community planning process, and it showed. However, a few good programs came out of it, such as the CRDP, a statewide initiative aimed at reducing mental health disparities among underserved populations in California, focusing on culturally responsive and community-driven solutions. She noted that the CRDP was initially funded by the Commission.

Ms. Hiramoto stated the CRDP provides the best example of CDEPs, although there are many others around the state. PEI is ideal for CDEPs because it is not clinical, but the BHSA split prevention and early intervention. This is a travesty for CDEPs because CDEPs do not require a medical model diagnosis to participate; they are based on wellness and the culture of the people being served.

- How are communities reacting to the split between prevention and early intervention?

Ms. Hiramoto stated communities are trying to affect the rollout of the BHSA by advocating at venues such as this Commission meeting, listening sessions, the CDPH, and the DHCS.

- How are communities trying to affect the split between prevention and early intervention?

Ms. Hiramoto stated communities do not yet know what to do. They may apply for funding from both prevention and early intervention and cobble them together, or work to fit their CDEP into either prevention or early intervention. Neither of these is ideal.

- What specific support or policy change would be most beneficial to ensure continued vitality?

Ms. Hiramoto provided an overview, with a slide presentation, of the development of terminology and definitions, REMHDCO's initial efforts during Proposition 63, and the definition of "underserved." She emphasized the importance of language and definitions. When REMHDCO was established, the definition of "underserved" was long, complicated, and did not include much community input. The definition did not address groups, such as racial and ethnic communities, but was about the mental health system being underserved because individual needs were not being met. The definition was based on the individual Western model.

Ms. Hiramoto stated REMHDCO proposed a simple, neutral, all-inclusive definition that was rejected. She stated there is still hesitation to use the words "race," "ethnicity," or "LGBTQ." She stated it may be because of fear of backlash or the federal government. She stated, if the terms "race," "ethnicity," and "LGBTQ" are not used and discussed, they will not be addressed adequately. Disparities will continue to be an issue.

Ms. Hiramoto stated people historically talked about "discrimination" and "discriminatory practices." Then, there was a thought that those terms were negative and should be more positive, so it became "cultural competence" and "culturally competent services," which then changed to "cultural humility" and "reducing disparities." She stated Proposition 1 uses the term "equity." She stated the need to define "equity" and "measuring equity," because those terms are throughout Proposition 1.

- How are the children and youth doing?

Adrienne Shilton provided the provider perspective for children and youth. She stated children are in crisis, especially the most vulnerable youth in the state. Behavioral health issues and suicides are increasing. Youth coming into programs are younger and issues are more acute.

- What does the transition from the MHSA to the BHSA look like for child, youth, and family populations? What are challenges to implementing the BHSA?

Ms. Shilton stated the 4 percent set-aside at the CDPH for population-based prevention approaches is a piece of this puzzle to addressing this crisis, but the scale and the challenge is significant. Meeting the needs of the most vulnerable will only be successful with a concerted partnership at the state level with departments, plans, counties, and community-based organizations that are closest to the communities that are being served.

Ms. Shilton stated this pot of funding cannot be considered in isolation in terms of the scale of the need. There are not enough resources for the children and families who need them the most and families do not know where to go to access services.

Ms. Shilton stated building capacity within the BHSA and investing in prevention to reduce the need for more intensive interventions are essential goals. The entire system needs to be held accountable for meeting the needs of children and youth.

Ms. Shilton stated the youth mental health crisis is less visible and there is a political urgency and real pressure on the counties to address this. It is important that the

investments in early intervention and prevention in young people are considered floors and not ceilings and that they have transparency, meet the mandated targets, and assess the impact of these investments over time. When the advocates wrote the MHSA, there was always a thought that progress would be made so that the 80/20 percent for intensive services/PEI could one day be flipped to 80 percent for PEI and 20 percent for the more intensive services. She suggested dreaming larger about the BHSA as well.

- How can accountability and transparency be assured?

Ms. Shilton stated an important avenue is the current county planning process, which includes direct conversations with county leadership, supervisors, and communities who are invested. She encouraged the Commission to think about its role in fiscal transparency to ensure that the BHSA mandates are met with respect to both the 4 percent at the state level, and the 51 percent at the local level for children and youth. She encouraged the Commission to hold regular panels and informational sessions on BHSA implementation, like it is doing in today's meeting, and on things that may need to be adjusted or amended over time based on lessons that will be learned.

Le Ondra Clark Harvey provided the provider perspective for adults and older adults. She provided an overview, with a slide presentation, of the advocacy for diverse provider associations, provider preparation, pressing needs per population, and policy suggestions.

- What are providers doing to prepare for this shift?

Dr. Harvey stated providers are doing what she calls an exercise in retrofitting. They are planning conservatively, trying to maximize evidence-based practices, stretching their programs, working simultaneously to retain their staff, and reshaping their services in real time to respond to changing system demands, often before clear guidance is issued.

Dr. Harvey stated, to manage, providers are using strategies such as allowing children and youth providers to shift into adult services, which requires training; youth are moving into early intervention and wraparound programs; adult Full-Services Partnership (FSP) staff are being retrained in Assertive Community Treatment (ACT) to make them eligible; and clients are being reassessed across adult and older adult programs for fit. Much of this is financially driven. She stated this shift puts tremendous pressure on organizations that are already operating within thin margins and workforce shortages. She noted that all of this is happening while the system is evolving.

- What are the prevention and early intervention needs the CBHA is seeing by population?

Dr. Harvey stated the prevention and early intervention priorities are different by population, but the goal is the same – to stop problems from escalating into crises. She showed a slide about funding priorities that prevent escalation for the adult, older adult, and children and youth populations. She noted that, when children and youth go home from school, they go back to families and communities. Mental health and SUD conditions do not go away when school is not in session. Families also need help, which is why partnership with providers makes sense.

- What are policy suggestions to address the pressing need?

Dr. Harvey provided the following policy suggestions:

1. Clear and consistent guidance and reimbursement structures. Ambiguity slows implementation and discourages innovation.
2. Investment in shared data and electronic health record (EHR) infrastructure that supports real-time tracking, dashboards, and quality assurance tools that actually support care delivery.
3. Competitive rates. Quality and access must be paid for. This needs to be figured out.
4. Streamlined reporting requirements and outcome measures. Providers are drowning in administrative burden that takes time away from providing clinical care.
5. Flexibility to assign clients into early intervention services. Meeting people where they are, not just treating them like rigid check boxes.
6. Co-located behavioral health services in all housing sites. Housing and behavioral health must move together around the individual.
7. More capacity in school sites. Schools are where prevention can have the greatest long-term impact.
8. Startup funds and being creative around evidence-based practices and CDEPs to provide training and consultation. Providers cannot be expected to implement best practices without the resources to do so.

Dr. Harvey stated California has a great opportunity to lead the nation in what true prevention and early intervention can look like. For older adults, this means access to housing, transportation, and social connection. Being united can make this a reality for all populations, but this can only happen if policy, funding, and implementation are moving in alignment. Providers are ready, communities are asking for this, and the moment is now.

Executive Director Grealish highlighted the prevention-related work in the Commission's portfolio to help Commissioners better understand how the Commission's work relates to today's panel discussion.

Commissioner Comments & Questions

Commissioner Wilkes asked what was done with the California Advancing and Innovating Medi-Cal (CalAIM) managed care plan incentives.

Ms. Katsarov stated, as a managed care plan, CalOptima Health ensured that it was there every step of the way. With the investment dollars, CalOptima had many listening sessions with the community and providers to hear from them what they needed. With support from the board, CalOptima took those funds to community-based organizations, but soon learned that the infrastructure was outdated and the level of work needed was not able to be done. Orange County suggested bringing community providers into the health plan not just traditional health plan providers. This idea worked well.

Commissioner Wilkes asked what is happening with the Community Reinvestment Fund to bolster the work.

Ms. Katsarov stated Orange County invested \$50 million in a workforce program. She noted that individuals want to be seen by providers who look like them, speak the languages that they speak, and have similar experiences. The workforce funding went directly into those things.

Ms. Katsarov stated Community Reinvestment also funded Orange County's first allcove™ Youth Drop-in Center.

Ms. Katsarov stated the biggest challenge with Community Reinvestment dollars is how to do it within the timelines provided.

Commissioner Wilkes asked for an update on transitional rent.

Ms. Katsarov stated CalOptima worked with the county to stand up the transitional rent. CalOptima and the county will continue to meet in post-implementation huddles; they are committed to working out issues that may come up in the future.

Commissioner Gordon stated Sacramento County has good relationships with its four managed care plans. To ensure coordination, the First 5 Commission is now required to have a Memorandum of Understanding (MOU) with all managed care plans. Although this is a potentially fruitful partnership, the First 5 Commission does not have the staff to negotiate this additional work.

Commissioner Gordon stated the California Department of Education (CDE) has partnered with the county to improve access, but, as hard as the managed care plans try, there is no access for many families for many reasons. The CDE has worked with the reimbursement through Medi-Cal to place 60 clinicians in schools across the county, starting with the neediest schools. The CDE works with the FQHC to provide satellite clinicians rather than using county employees. These clinicians have been an asset to schools in providing a source of access, which is free and confidential. He suggested focusing on prevention and access and working to be more accepting of these partnerships where clinicians can be in every school in every neighborhood in California.

Commissioner Gordon asked if what Sacramento County is doing with this mix of providers and others makes sense.

Ms. Shilton stated it is good to hear about the CDE's prevention work. She suggested adding linkages to community-based organizations along with the partnerships and the school-based clinicians, since the work needs to continue beyond the school day.

Commissioner Gordon stated the CDE has Family Navigators for every five schools who work on building relationships in the 0-5 space.

Dr. Harvey agreed that care must be grounded in the community, such as schools, churches, community organizations, and the use of cultural brokers for impact. She suggested a multi-pronged approach with everyone working together.

Ms. Katsarov agreed and stated the state's multi-payer fee schedule for braided funding allows professionals to be paid through managed care plans.

Commissioner Larsen asked what the Commission can do, while navigating the transition and moving into implementation, to address the prevention improvement goals sooner to avoid youth incarceration, hospitalization, and homelessness.

Ms. Cabrera stated the need for more accountability for the non-specialty mental health benefit in Medi-Cal and commercial insurance plans. The challenge is that the same quality or types of services or access for people with commercial insurance is not as available as with a safety net and many Medi-Cal beneficiaries and primary care physicians do not know about the non-specialty benefit. More than \$1 billion less and the cuts that are coming to Medicaid will mean fewer Medi-Cal eligible people, which will reduce county funding further for high needs populations.

Ms. Cabrera suggested that the Commission not only look at county behavioral health, but widen the lens and advocacy efforts to ensure that every part of the system is doing its part. Individuals should not be required to get to the point where they are disabled in order to qualify for county behavioral health services to get the treatment and the services that they need.

Ms. Hiramoto suggested that the Commission not limit its focus to just Proposition 1 or just people with a serious mental illness. The Commission had a discussion in the past where Commissioners decided that the Commission is broader than just Proposition 1; it is about the entire system.

Assembly Designee Pulmano asked how to evaluate the success of a public awareness campaign and how to measure increase in access, in actual receipt of services, and in the quality of life associated with that public awareness campaign.

Ms. Raymundo stated part of the CDPH's efforts has been thinking through this idea of theories of change to help consider what that metric might be to advance the 14 statewide goals. Another reason for thinking through large awareness campaigns is thinking through reach to create the biggest impact with limited funding.

Ms. Raymundo stated, while the CDPH is investing in large statewide awareness campaigns, it is also investing in community and trusted messengers who can take that message to historically underserved, marginalized, vulnerable communities that, right now, probably are not as willing to interact with large government. Trusted messengers in the community are needed – their expertise, their voice, their ability to access community. It is about how to couple statewide things with real investment in the community because reach is needed to create real impact.

Ms. Cabrera offered to forward to Commission staff the evaluations that RAND Corporation did for county behavioral health, and peer-reviewed studies that have looked at MHSA impacts on things like suicides, based on CDPH data.

Public Comment

Jazmin (attended remotely via Zoom) stated: Hi, everyone. I'm Jazmin with The Children's Partnership. Thank you, Commissioners, for the opportunity to comment today. I want to echo Adrienne Shilton's comments on the ongoing unmet mental health needs of children and youth in California, and emphasize a concern about how the Behavioral Health Services Act is being implemented and how California is at risk of inadequately serving children and youth through true early intervention.

Some of the upstream approaches often discussed with relation to BHSA are often limited to 988, mobile crisis teams, and crisis stabilization. And, while these services are essential, they are fundamentally crisis-oriented. They serve individuals who are already experiencing acute mental health challenges and symptoms. True upstream early intervention, particularly for children, supports communities, families, and young people before symptoms emerge, helping prevent mental health challenges and crisis from developing at all.

At the county level, we are seeing widespread cuts to children's prevention and early intervention programs in response to the state's new priorities, and many counties believe they have received a directive from the state to eliminate prevention entirely. So, rather than making a good faith effort to collaborate with their youth, families, and children and child-serving stakeholders to translate existing prevention programs into allowable early intervention direct service models. As a result, effective community-based direct service programs for children and families are being gutted, not because they lack impact, but because counties lack clarity and sufficient guidance on how to frame and fund them.

Counties need clear direction that upstream early intervention direct services for children are not only allowed under BHSA, but they are essential to its success. We appreciate the Commission's efforts to uplift the current challenges and budget pressures that are creating barriers to true upstream prevention and early intervention services.

We urge the Commission to synthesize what you have heard today and work with the administration to ensure counties are not wholly abandoning prevention-rooted programs, but instead creatively and responsibly translating them into early intervention strategies that meet BHSA requirements, while still meeting the needs of children and families. If the BHSA is truly about long-term outcomes, then investing early, before crisis, must be a priority, not an afterthought. Thank you.

Courtney Armstrong (attended remotely via Zoom) stated: Hi, Commissioners and panelists. This is Courtney Armstrong from the First 5 Association. I want to thank the panelists for this important conversation today, and also very strongly support Jazmin's comments before me. I feel like she really covered it, but just wanted to highlight a few key points from the First 5 Association's perspective. We appreciate the proposal for the population-based prevention funding that was released from CDPH and the effort to balance both statewide prevention efforts with the funding for local communities, and would urge the Department to consider shifting that balance even a bit more to ensure that there are more funds available to community efforts.

As Jazmin mentioned, the MHSA has been the predominant funding source for early childhood mental health programs in California, and the majority of those funds have been spent on group-based services, such as consultation, parenting support, screening, and linkage to care or clinical intervention programs that are paired with group interventions and training. These programs are uniquely positioned to help families overcome barriers to access, mitigate further mental health concerns, and are most likely to reach families from historically marginalized communities.

First 5 Association remains concerned that the transition to BHSA, as you've heard, is resulting in significant loss of funding for these services and will result in even a lack of access for families who need the help most. We're encouraging the Department of Public Health and DHCS to ensure, in addition, that county First 5s are explicitly included as eligible applicants for the population-based prevention funds.

First 5s are uniquely positioned as local early childhood experts with deep community knowledge, and they serve as community hubs that connect CBOs, local government, parents, and caregivers across all 58 counties. First 5s also have proven infrastructure that is already being leveraged by other state investments, and so this presents an opportunity for better use of limited resources. Excluding First 5s would risk inequitable distribution of resources, and is particularly disadvantaging rural communities that lack organizational capacity to compete for these funds independently. Thank you.

Gulshan Yusufzai (attended remotely via Zoom) stated: Good morning, Commissioners. Thank you for the opportunity to provide public comments. My name is Gulshan Yusufzai. I'm the Executive Director of MAS – Social Services Foundation. For 18 years, MAS-SSF has focused on serving refugees and immigrants from the Middle East, South Asian, and North African communities in Sacramento County. MAS-SSF is one of the organizations funded by the California Reducing Disparities Project. So, under the API hub and specifically serving Afghan refugees. As you might be aware, due to the refugee crisis in 2021, Sacramento is now the top city – the number one city, in fact – in the United States for Afghan refugees.

We've been able to provide outreach and education in five languages to inform our community why it's important to access services and access services early on, especially since this community comes to the U.S. from experiencing war for over 40 years. Afghan refugees are at high risk and continue to be attacked and traumatized by the current federal administration.

Our CDEP is a peer support program with both prevention and early intervention. We have seen, for the past 9 years through the CRDP and 18 years of serving our clients, that both prevention and early intervention are needed to support the community. We've had many successes, but to mention just a few, we've trained over 101 community members to become peer support specialists and held education events, and conducted outreach to thousands in English and four other languages.

And lastly, due to the severe trauma, we have to create trust by conducting outreach and education in a culturally competent manner. And then, once the community comes to us, we provide direct services on an individual basis because of the hundred peer support specialists that we trained – and we match them. And then, due to the stigma, cultural expectations, how refugees see the United States, and severe trauma, both prevention and early intervention services have to be provided to prevent the community from becoming severely ill. Thank you.

Ebony Harper (attended remotely via Zoom) stated: Hello, my name is Ebony. I'm from the Gender Health Center. And Stacie touched on this, but cultural interventions are needed and I want to talk to you today about preventative and, more importantly, about what actually works. California has lived through an important chapter of this story back in 2010. Counties came together to form what became CalMHSA, a joint powers

authority to coordinate statewide mental health prevention campaigns. That work funded Each Mind Matters, SanaMente, and Know the Signs. It was rooted in population health research.

Counties learn from examples that internalize stigma around mental health. It was higher in Spanish-speaking Latina communities, LGBT communities, ethnic communities, and culturally-specific campaigns. They invested in communities based on organizations and higher education partnerships and they did it by dedicating a portion of MHSA funds specifically to prevention.

At Gender Health Center, we see every day that mental health does not show up the same way for everyone. A Black trans woman navigating violence, housing instability, and discrimination is not experiencing the same barriers as a white cisgender college student. We must prioritize trans mental health. Even though we're being attacked nationally, we really need to prioritize trans mental health right now.

Lynn Rivas (attended remotely via Zoom) stated: Hi. I am the Executive Director of CAMHPRO, the California Association of Mental Health Peer-Run Organizations. I also have been diagnosed with a severe mental illness, and I have personal experience of recovery in a peer-run organization. Many peer-run organizations were funded by PEI funds. The changes are threatening to have a devastating impact on those organizations, with some organizations facing closure. This would be a tragedy, because peer-run organizations offer something effective and unique in terms of stigma reduction, reduction in hospitalizations, connection to community, and quality of life.

The work done by peer-run organizations is evidence-based and a best practice. However, I'm not interested in mourning the demise of these organizations; rather, I want to see counties partner with them such that these very organizations provide the peer workers that are required in Full-Service Partnerships, ACTs, and FACT teams. Consumers deserve the quality of peer services and fidelity to the recovery model that peer-run organizations provide and which are not likely duplicated by non-peer-run organizations. I look forward to seeing counties dig deeper and meet the desires of their community. Thank you.

Jason Robison (attended remotely via Zoom) stated: Hi. Thank you. My name's Jason Robison and I am a person with lived experience. I'm a person in long-term recovery. I'm also on the board of directors of CAMHPRO and I'm the Chief Program Officer for a peer-run organization. And I really appreciated the story that Dr. Clark Harvey told about the 17-year-old who started hearing voices. And I want to use that as an example of where we can improve opportunities to connect with people.

If every person that had an initial onset of psychosis was connected to somebody in recovery who had experienced psychosis themselves, we would do a great deal to prevent escalation. And when we talk about workforce shortages, there is an abundance of people with that experience in communities in self-help support groups that family navigators and peer specialists are able to connect with.

We've talked a long time; we've talked for decades about the peer workforce, and I hope, sincerely, that we can really invest in scaling this so that everybody is able to

connect with somebody that has lived through the experience they're going through. Thank you.

Noemi Tungui (attended remotely via Zoom) stated: Hi. Yes. My name's Noemi Tungui. I am also someone with lived experience – growing up undocumented most of my life, speaking Spanish only when I came to this country, and really struggling through mental health challenges and navigating the different health systems. I'm also a program manager for a mental health and domestic violence prevention and early intervention program, and I work with Mixteco/Indigena Community Organizing Project. We currently receive PEI funds, we're a CDEP, and we've seen, through rigorous evaluation, when culture is prioritized, when communities who look and come from lived experience, with rigorous training, are providing the support for other people struggling through mental health challenges. It really works and we see that through our, again, many years of rigorous local and state evaluation.

So, I just want to provide a little bit of input on the whole process of Prop. 1, because it's been a little ambiguous and a little question mark as to what we can expect for the future. And here at the local level in Ventura County, I know that a lot of us are struggling to see how we will sustain our programs come June, when a lot of our programs will sunset.

And so, just navigating the split between prevention and early intervention has been challenging and, for people who don't have the time to attend panels like these, it really is even a bigger challenge. So, I do want to encourage more panels like this and also taking them to the local levels, to counties that really just need this information, and to get more answers as to what the process will look like coming down from the state to the local level.

Again, it's bringing a lot of fear as to all the folks who will no longer have programs available to them at a time that it's most needed. I think a lot of our community is still feeling the impact of navigating July 10th, when we had a huge ICE raid here and many people were taken. We're experiencing that every single day here in our county. So, we need programs that are community-led, that are culture-led. And so, I want to see counties really prioritizing what we're hearing here about prioritizing LGBTQIA and BIPOC migrant communities. I want to see that that actually translates to that at the local level. So, thank you so much for providing this time. Thank you.

Lashawn Francis (attended in person) stated: Good morning, everyone. Thank you all for your patience. It's been a long morning. My name is Lashawn Francis. I'm with Children Now. I've worked very closely with a lot of you in this room, with the passage of SB 326 and the implementation of Proposition 1.

There are a few things that I wanted to highlight. One, I wanted to say ditto to all of the other children's advocates who showed up today and made comment. But one of the things that I think you all heard repeatedly was how much confusion that there was around what's expected and how much conversation there is. And I would actually say one of the reasons for that is we haven't done cleanup language for SB 326. If you read the bill, like I have multiple times, you'll notice that the level of "mays" and "shalls" is probably a litigious lawyer's dream. This is something that I think really is going to be problematic as we start to be challenged by counties, as we start to be challenged by

providers about what is expected from them. So really having the administration and the Legislature go back and be clearer about what the intent was in language is going to be necessary moving forward.

The other thing I'll say, because I really do appreciate the way Stacie always grounds us in history and the importance of history, is I'm always amazed as a children's advocate how many people are pro-kid, because, if that were true, I would be out of a job. And the reality is, when the 51 percent was mandated for prevention and early intervention in the original MHSA, that came about through regulations. That was not part of the original proposition. That was something that advocates fought for and was implemented 10 years in to the proposition. And that came out through regulations.

So, what you see before you now, under SB 326, is actually stronger language that prioritizes kids in the amount of 51 percent with prevention and earlier intervention. Now, the bad thing is, a lot of counties were not able to meet that 51 percent in the previous version, so it's really going to be incumbent upon us to make sure that 51 percent is being met under Proposition 1. So, we're going to have to do math, right? And we're going to have to make sure that that is actually being realized, even though we know that funds are less going forward.

So, really flagging that a lot of the conversation around children and youth has been great, and I've appreciated it, but also acknowledging that our kids tend to be last when we think about investments because they don't present in the same way as adults do. Right? So, we just did a huge investment to tackle homelessness, but what we really did was try to tackle visible homelessness, because the amount of young people who are not visibly homeless will not show up on our radar, and it doesn't become politically expedient to do so. So, really just flagging that our children and youth truly are some of our most vulnerable people in the state and, unless we are actively searching for the investments that include them, the investments that uplift them, we're going to miss the mark. Thank you.

Commissioner Discussion

Chair Rowlett suggested that the March Commission meeting be another 2-day meeting. He asked that the next Commission meeting be scheduled for March 26 and 27, 2026.

Chair Rowlett asked Commissioners to send questions related to this panel to staff who will then send them to all panelists for their responses. He asked staff to invite the panel back for further discussion at the March Commission meeting.

5: Strategic Plan Update – Action

Chair Rowlett stated the Commission updates its strategic plan every three years. The current strategic plan was approved by the Commission in January 2024. Two months later, California voters approved Proposition 1, ushering in a behavioral health transformation that has engaged the entire public health system, including the Commission. The Commission has welcomed 11 new Commissioners, started implementing the BHSA, and continues work on the Innovation Partnership Fund (IPF).

He stated the need to revisit the strategic plan, refocusing the Commission's strategic direction.

Chair Rowlett stated, at the end of the presentation, the formation of a time-limited Strategic Plan Advisory Committee will be proposed to help guide development of the updated strategic plan in partnership with the community. He asked staff to present this agenda item.

Executive Director Grealish stated the current strategic plan has been in place for almost two years, but, with the changes from the MHSA to the BHSA, an update is needed to account for the new mandates that are part of this transformation.

Executive Director Grealish provided an overview, with a slide presentation, of the 2024-27 strategic plan, goals, what has been accomplished, changes under the BHSA, broader MHSA to BHSA changes, and the CBH strategic plan update. She stated the Commission has broad advisory authority but specific budgetary authority and is 100 percent funded from the Behavioral Health Services Fund (BHSF).

Chief Counsel Gallardo continued the slide presentation and discussed the BHSA legislative intent, BHSF, and CBH BHSA funding allocations. She stated Slide 11, a chart showing the percentages of the funds distributed from the BHSF, effective July 1, 2026, provides a visual picture of the BHSA funding buckets. She stated the Commission's funding comes from a 3 percent catch-all for "state directed purposes" within the 10 percent State Administration bucket. Funding for the DHCS, the California Health and Human Services Agency (CalHHS), CDPH, the Department of Health Care Access and Information (HCAI), and the Behavioral Health Planning Council also comes from this 3 percent catch-all.

Executive Director Grealish noted that this PowerPoint will be a good reference for everyone moving forward to help get a sense of where the strategic plan is now, what the Commission's funding authority is now, and where the Commission is looking to go.

Executive Director Grealish stated that CBH commissioned Leading Resources, Incorporated (LRI) to work with staff to update the strategic plan.

Commissioner Comments & Questions

Assembly Designee Pulmano referred to Slide 20 on the IPF and stated the required purpose of the IPF programs and practices that the Commission approves is anchored with county programs. To effectuate that requirement under Proposition 1, it must be clear on the application process how that grant is anchored to a county program for each priority population. It needs to be very clear that all grantees are thinking about this from the beginning. The same is true for the Behavioral Health Student Services Act (BHSSA) grants. She stated it ought to be common practice when it is a requirement under statute.

Commissioner Fairweather stated what was heard this morning was that much of the community-based work is being lost. Veterans are a culture that has been siloed and excised from general public and behavioral health, aging, and every other system in California; however, veterans and others fit into different buckets within the county priorities. Much of what the counties are dealing with is about the need to look at the

individual and eligibility, which fractures care in the community. The definition of supporting the county plans should not be a one-to-one and supporting those who are eligible under this or that. The definition should be broader, supporting not individual programs or eligibilities, but the concepts and the community members. She cautioned against using language that is too rigid. The language should allow for community agility and the understanding and approaches that are much needed for all these different communities.

Commissioner Gordon stated the prevention mandate is placed with public health to be population-based. He asked about the implications for First 5s trying to get involved in work with mental illness and prevention. He stated that work should be customized to the area of work, in terms of access.

Executive Director Grealish suggested giving this question to the prevention panel to learn how the landscape has shifted, where those expectations should be, and where that conversation needs to go.

Senate Designee Swartz stated one of the basic priorities of the strategic planning process needs to be level setting about the role of the Commission, how the existing system works, and where the Commission fits in.

Commissioner Brown stated, even though the Commission's allocation funding has decreased, the Commission still has a significant role in terms of the advisory element to the state, which includes research and reporting out on certain things. He suggested looking for areas to research and report to the Legislature.

Leading Resources, Inc.

Executive Director Grealish stated the Workforce Optimization Advisory Committee (WOC) commissioned LRI to work with staff to update the strategic plan. She asked the Leading Resources team to facilitate the discussion.

Eric Douglas, Senior Partner, LRI, reviewed the timeline for the strategic planning process. He suggested standing up the time-limited Strategic Plan Advisory Committee to help with the strategic planning process. He asked Commissioners to make suggestions for the new strategic plan.

Commissioner Questions & Discussion, continued

Assembly Designee Pulmano suggested including wellness coaches as a new category in the slide of the proposed refinement to the goals and objectives.

Commissioner Contreras suggested calling out housing more specifically in the goals and objectives. He suggested including community input opportunities in the timeline and ensuring that community input is centered throughout the strategic planning process.

Senate Designee Swartz suggested highlighting the Commission's independence and advisory role.

Chair Rowlett suggested capturing the sentiment of today's public comment about the loss of PEI and the ramifications of that in the strategic plan.

Commissioner Brown noted that SUD is not in the Commission's existing strategic plan and, with the exception of the legislative intent of Proposition 1, there is no mention of SUD in the strategic planning materials.

Public Comment

Michael Fields (attended in person) stated: Hello. My name is Michael Fields. I'm with Peer Recovery Services, a peer-run organization in San Joaquin County, and I've been involved with them for 14 years, and I've, candidly, not been involved with the Commission for Behavioral Health up until yesterday. I was online yesterday, very impressed. Can't tell you how much. Very impressed with this morning.

One of the great things about today was that I got to meet some of you in person, and I'm grateful for that in terms of the future. I do have lived experience, dually diagnosed in recovery from substances for 33 years, very proud of that, and I'm in recovery from mental health challenges for 26 years, and I'm very excited about that.

My recovery didn't become complete until I added peer support to my treatment plan, and I didn't know that peer support was a thing until about 15 years ago. But having said that, peers are one of the prioritized CBH roles and capabilities for the goals and objectives that you guys will be working on. And I have three organizations that I want to encourage you to consider, if you haven't already, which you probably have. One is Cal Voices. Of course, CAMHPRO. I'm really impressed with Lynn and Sher. Jason Robison is like a role model. I want to grow up and be like him, and he's someone worth listening to. So that's all I wanted to share. Thank you.

Stacie Hiramoto (attended in person) stated: Stacie Hiramoto, REMHDCO. Thank you for the opportunity to comment on this plan. I really appreciate that Commissioner Contreras and others are supporting making sure that community input is included and listened to. And I look forward to the Committee meetings where I hope that we can really determine what is in the law, what is not in the law, what are the priorities, and make it clear, because I'm a little confused right now, but that's maybe because I'm tired, but anyway. Anyway, good luck on this process. And again, please include the community. Thank you.

Laurel Benhamida, Ph.D., (attended remotely via Zoom) stated: This is Laurel Benhamida, and I just want to support Stacie's comments that she just made. And I'm very hopeful now that you're reexamining that strategic plan, because it was a matter of concern. Thank you.

Commissioner Discussion

Action: Chair Rowlett asked for a motion to establish a new time-limited Advisory Committee – the Strategic Plan Advisory Committee – pursuant to Welfare and Institutions Code § 5845(f)(4) and Commission Rules of Procedure 6.1(B). Assembly Designee Pulmano made a motion, seconded by Commissioner Callan, that:

- *The Commission establishes a new time-limited Advisory Committee – the Strategic Plan Advisory Committee – pursuant to Welfare and Institutions Code § 5845(f)(4) and Commission Rules of Procedure 6.1(B).*

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

The following Commissioners voted “Yes”: Commissioners Bontrager, Brown, Callan, Contreras, Senate Designee Swartz, Cross, Fairweather, Fernandez, Gordon, Assembly Designee Pulmano, Larsen, Mitchell, Southard, Thomas-Beckett, and Wilkes, and Chair Rowlett.

Chair Rowlett noted that the Strategic Plan Advisory Committee charter has been included in the meeting materials. He appointed Commissioners to the Strategic Plan Advisory Committee as follows: Commissioner Larsen as Chair, Commissioner Fernandez as Vice Chair, and Commissioners Brown, Callan, Carnevale, Fairweather, Thomas-Beckett, Tsai, and Wilkes as Committee members.

Mr. Douglas asked a series of questions to facilitate a discussion around the new strategic plan as follows:

- What questions do you have about the presentation?

Commissioner Larsen asked if the mission, vision, and north star are something that this Commission should address.

Mr. Douglas stated it is. Those refinements will be made as part of the new Committee’s work.

Commissioner Callan suggested that the new Advisory Committee have a focus on what its advisory role is, especially on what it is advising per meeting and where that advice goes.

- What priorities would you like to see in the updated strategic plan?

Commissioner Gordon stated it would be helpful to level set the relationship between the Commission and the administration in terms of sharing information, ideas, and strategies.

Commissioner Southard suggested that the strategic plan include how the behavioral health workforce shortage will be addressed as a part of the Commission’s work.

Commissioner Callan suggested incorporating prevention for 0 to 5 years old, crisis status, and FSPs and other programs in the long term, keeping an eye on that and bringing it into the system even though it is not part of it.

- What other issues or topics do you think need to be addressed in updating the strategic plan?

Assembly Designee Pulmano stated evaluation is key. Second is the use of data to advance the mission of the Commission, not just for purposes of evaluation.

Commissioner Wilkes suggested children, youth, and those priority populations when it comes to children and youth being involved in homelessness, foster care, justice involvement, behavioral health, and institutionalization.

Chair Rowlett Chair Rowlett stated Designee Swartz’s question level set perfectly. The administration desired to bring the Commission under it, but the Commission

maintained independence because of advocacy from the Legislature. He suggested looking at how the strategic plan maintains the Legislature's intent because there is a message there. He asked how to incorporate the advisory capacity into a strategic role and how to operationalize specific advisory roles and components that inform Proposition 1 to then make recommendations to the Legislature.

6: Adjournment

Chair Rowlett thanked everyone for their participation and stated the next full Commission meeting will take place in Sacramento on March 26, 2026. There being no further business, the meeting was adjourned at 1:00 p.m.