Client and Family Leadership Committee (CFLC) Teleconference Meeting Summary
Date: July 17, 2024 | Time: 3:00 p.m. – 5:00 p.m.

MHSOAC
1812 9th Street
Sacramento, CA 95811

Committee Members:	Staff:	Other Attendees:
Rayshell Chambers, Chair Richard Krzyzanowski Susan Wynd Novotny Larisa Owen Jason Robison Sharon R. Yates	Evonna McIntosh Lester Robancho	Steve Leoni Travis Lyon

*All Committee Members participated remotely.

Committee Members absent: Hufsa Ahmad, Donella Hyrkas Cecrle, Emery Cowan, Claribette Del Rosario, Robyn Gantsweg, Kylene Hashimoto, Kellie Jack, Rose Lopez, Kontrena McPheter, BeaJae North, and Vanessa Ramos.

Agenda Item 1: Welcome and Announcements

Commissioner Rayshell Chambers, Committee Chair, called the meeting to order at approximately 3:00 p.m., welcomed everyone, and reviewed the meeting agenda. She asked everyone to introduce themselves by answering an icebreaker question.

Evonna McIntosh, MHSOAC staff, reviewed the meeting protocols, called the roll, and stated a quorum was not achieved.

Agenda Item 2: General Public Comment

Steve Leoni, consumer and advocate, asked for a moment of silence and reflection in honor of Alice Washington, who recently passed away. Ms. Washington worked for many years at the California Institute for Behavioral Health Solutions (CIBHS) and was a consumer who had direct input into the wording of the Mental Health Services Act (MHSA). Ms. Washington was the lead on a section of the MHSA. Steve Leoni read that section aloud in commemoration and gratitude for Ms. Washington's work and accomplishments in the mental health field.

Agenda Item 3: Action – May 8, 2024, CFLC/CLCC Joint Meeting Minutes

Chair Chambers tabled this agenda item to the next meeting due to the lack of a quorum.

Agenda Item 4: CFLC Role in the Strategic Plan Implementation

Chair Chambers directed everyone's attention to the goals, objectives, and metrics of the MHSOAC Strategic Plan (2024-27), pages 11 to 16, and asked Committee Members to identify three priority goals as clients and family members to inform the Commission's Strategic Plan objectives, which will align with the state of California's behavioral health transformation.

Committee Member Feedback

Goal 2: Catalyze Best Practice Networks, Objective 1, support organizational capacity building.

- Put a California Statewide Office of Recovery in place by the end of this three-year plan. In order to help individuals move forward in their lives, the behavioral health system must be a recovery-oriented system.

Goal 2: Catalyze Best Practice Networks, Objective 3, develop adequate and reliable funding sources.

- Focus on elevating interventions and services that are not part of the Medi-Cal system, such as peer services and peer-run housing, now that Proposition 1 has limited the MHSA by moving everything to a Medi-Cal framework.
- Share the Behavioral Health Implementation PowerPoint outlining the Medi-Cal models, including peer services in county managed care programs (MCPs), which is included in the Proposition 1 Behavioral Health Implementation Framework on the continuum of care.
- Elevate funding models that can inform not only county MCPs but commercial MCPs and learn what counties are planning to do.
- As peer services are included in the Proposition 1 Behavioral Health Implementation Framework document, counties are looking at using clinical- and medical-based systems that already have access to billing Medi-Cal to provide Medi-Cal peer services, but those are the services that have the least efficacy to the practice of peer support. It is essential that MHSA dollars be used for peer services and peer providers that are **not** part of the Medi-Cal system. The Medi-Cal system has always been a challenge with the MHSA – individuals do not have access and do not want it. Something is needed that is community-based and accessible and does not require Medi-Cal. While counties need to draw down and do matching dollars, there are funding buckets for the way that the MHSA has been proposed that allow them to use Behavioral Health Services Act (BHSA) dollars and not bill Medi-Cal. It is essential that those dollars be used in that way for things like peer services that are not fundable any other way.
- The Mendocino County Behavioral Health Department put out a Request for Proposals (RFP) for peer wellness centers. Due to the uncertainties of Proposition 1, the county took a huge step back and did not award the RFP. The county had courageously built a peer program that was integrated with No Wrong Door and Open Door so that everyone could be welcomed regardless of their condition. Peers

have said that what is missing is access to services. The county has been working on increasing peer support services since 2004, but now the community has lost access to services with this step back. The point is how individuals are welcomed in. It is not peer-centered but is clinically-centered when it is about pulling down Medi-Cal dollars rather than being about what is best for the client.

- It is not accessible when the only individuals who can access mental health care are individuals who are eligible or already enrolled in Medi-Cal. Individuals need to have immediate access to community behavioral health care for mental health and substance use, even when they do not qualify for Medi-Cal. That is what peer services offer.
- Peer support services that are not part of the Medi-Cal system need to be maximized by accessing the 17.15 percent flexible Behavioral Health Services and Supports (BHSS) bucket in Proposition 1's proposed allocation buckets.

Goal 3: Inspire Innovation and Learning, Objective 3, accelerate learning and adaptation in public policies and programs.

- Peer services is a new model across California.
- Peer-run housing is an innovation that needs to be scaled across the state. The current voucher system does not work for individuals who are willing to immediately move into a sober living situation due to the length of time it takes to attain voucher approval.
- Consider innovative community-defined strategies that can also intersect with the private sector.
- Other counties have put out RFPs that were shut down and sunsetted their prevention programs to reformat their budgets to coincide with what counties are being told they must cut in order to align with the Proposition 1 funding buckets, which will significantly change county ability to do prevention and early intervention. One of the caveats of peer support is that individuals do not begin by saying they have high needs – relationships and trust are built on shared experience. Only then will individuals share their needs.
- The strategic plan is wonderful, but the landscape has changed since it was developed.
- The landscape has indeed changed – it is more difficult to get access to funding sources, but they do exist.
- It is this Committee's job to bring a bold understanding on the effect that Proposition 1 has had in service delivery and best-practice models that work that are not part of what is being funded.
- Sometimes, county staff does not understand much about the services that are internal or contracted out, but they continue because they think these clinical services do something are or a part of something. That is part of it. That needs to be brought to the surface. The Commission and this Committee must be a loud voice

about what is being affected. It is important to note that there are other funding methods but, in the short-term, many individuals are being lost in the gap. This is just one example.

- Funding went back to the county because it was unspent.
- Learn how to partner with the MCPs by doing listening sessions and stakeholder community planning. It is important to go outside of the standard LISTSERVs to reach into the service provider trenches so they can have a voice. This needs to be done better.
- Explore how to reach out and partner with MCPs and what resources the Commission has for targeted conversations with service providers deeper in the trenches by going to counties or sending surveys to community-based organizations. It is important to gather data on the impacts.
- County directors should evaluate decisions being made locally through the strategic plan objectives. Data can be deceptive if not in context without a historical perspective. Individuals are afraid to have an open, honest, critical discussion about what is going on. Building a safe and trusting environment is one of the things the peer support movement does.
- Be responsive to the individuals who need services rather than making the individuals who need services conform to the delivery system that the state is willing to fund. The money should not be the obstacle. Some of the things that work the best require the least amount of funding.
- That is important in terms of advocacy. A gap exists between systems and policy makers. Counties are happy to go through the Medi-Cal system because it is easier. The problem is that elected officials do not understand the gap between what works for individuals and what individuals want and the current funding system. The way they try to fix issues is by throwing more money at them. This is not what the people want. There is a way to do housing that is less expensive and more accessible.
- There is a need for messaging to respond to the fact that the MHSA has not fixed the system in its 20 years in existence.
- The messaging must be clear that there was not 20 years of the MHSA. There was a recession in 2008 where MHSA funds were used to supplant everything that was going on in every county in California in the mental health system so that service providers did not lose contracts and clinics did not need to lay people off.
- If they are serious about elevating peer services through Medi-Cal, there are decades of research that show that individuals have the best outcomes and the most efficacy of services for peer services when they are provided through organizations that value peer services and are aligned with the principles and practices – those are community-based organizations. The standalone site that is already certified to bill Medi-Cal does not have that – it is set up for a different system. If Proposition 1 is serious about effective peer services, use that standalone, directly-operated site as a passthrough for the payment of Medi-Cal that can then be contracted to the

community-based organizations that are providing the services and are billing through the county Medi-Cal system. That is one way this can be done but, unless they are building a way for that to happen through the community-based organizations, it is not going to happen.

- Individuals do not want to go to the clinic. A way must be considered to get the payment happening through community-based organizations that the person experiences as community rather than a clinic.
- As individuals retire, California is losing institutional knowledge around the MHSA. It is important to agree on definitions. The strategic plan needs to show how the language translates into action on the ground and how goals can be measured.

Public Comment

Steve Leoni stated appreciation for the discussion about the loss of institutional memory over the decades on the work of the MHSA. The speaker agreed that counties and communities have a disconnect and that it is important to standardize definitions. The speaker cautioned that, if a Statewide Office of Recovery is put into Proposition 1, it will be an office advocating to get people into clinical services and on forced medication and then into recovery. Their idea of recovery is not clients' and family members' idea of recovery. The Statewide Office of Recovery will need to be defined very clearly.

Agenda Item 5: Adjournment

Chair Chambers stated the next CFLC meeting will be held on September 25, 2024. She adjourned the meeting at approximately 5:00 p.m.