June 21, 2024

Michelle Baass
Director, Department of Health Care Services
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Sacramento, CA 95899-7413

Dear Director Baass:

Thank you to the Department for inviting public stakeholder dialogue on the implementation of Proposition 1 and the state's transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA). Our coalition of children's advocates writes to you to uplift some key issues that we have been made aware of through dialogue with county administrators and community programs, as well as through participation in the Department's Proposition 1 informational sessions. Below are summaries of three implementation areas that require clear, explicit, written guidance from the Department in order to ensure the state delivers on its promise that the BHSA will keep children and youth whole, preserving and strengthening requirements for counties to prioritize child and youth investments.

1. **Make explicit that "early intervention" services are inclusive of (though not limited to) services that intervene early in the life course, and not only early in the disease or illness course.**

We were grateful for the Governor's willingness to include explicit language defining which children and youth are eligible for BHSA early intervention services in Proposition 1. *In the enacted portion of Section 5840, early intervention services may be provided to "(i) Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an adverse childhood experiences (ACEs) screening tool, involvement in the child welfare system or juvenile justice system, or experiencing homelessness. (ii) Individual children and youth in populations with identified disparities in behavioral health outcomes."*

Historically, counties have had a particular understanding of early intervention services within the MHSA that meant intervening only once a mental health condition developed. This interpretation left out most children from low-income communities of color. Specifically, the interpretation excluded children and youth who could not access the behavioral health system to get a diagnosis. It also excluded children and youth, especially Black boys and youth of color, who did not manifest symptoms of trauma or distress which solicited care from adults but rather drew punitive disciplinary actions and increased surveillance from schools and law enforcement.

This narrow interpretation is also in conflict with the necessary and historic reforms within CalAIM to expand eligibility for Specialty Mental Health Services (SMHS) to children and youth who have

experienced trauma and those who are system-involved. These reforms emphasize the fact that racism and marginalization interact with child development to create increased risk of poor mental health outcomes. BHSA honors the reality that children's and young people's mental health needs are dynamic and will vary based on the family and community context. These reforms also affirm the reality that intervening early in the life course is more trauma-informed and ultimately more likely to be effective, including cost-effective, in the long-term.

Counties are already publicly and privately asking for clarification on the definition of early intervention. Furthermore, Administration officials have sent mixed messages in public overviews of Proposition 1 that reinforce the misinformed interpretation of early intervention that limits services to only early in the disease/illness process, and not also early in the life course. Counties have also reported that the BHSA's narrowed priorities significantly reduce the eligible population of children and youth who can be served by the MHSA, and, in the past, narrow definitions of eligible programs have likewise limited their ability to meet the requirements to spend a majority of their early intervention funds on children and youth.

We strongly encourage the state to clarify for counties that state law has now been amended through Proposition 1 to make clear that the eligible population of children and youth for early intervention is aligned with the Medi-Cal SMHS definition of eligible children, and thus children and youth without a diagnosis may indeed have mental health needs that can be met through the BHSA.

2. The Department should convene a stakeholder process to develop guidance on BHSA reporting requirements that support the BHSA goals of strengthened oversight and accountability, especially for required investments in children and youth.

We were grateful when the Administration agreed to preserve and make statutory the clear set-asides for county children and youth spending that were put into MHSA regulations by the Mental Health Services Oversight and Accountability Commission 10 years ago. These regulations were originally established in response to counties insufficiently investing in true upstream prevention and intervening early in the life course, and required counties to spend the majority (51%) of their prevention and early intervention funds on children and youth, ages 0-25. Presently, the BHSA further requires counties to consider the unique needs of children between the ages of 0 and 5.

Previous requirements on minimum spend for children were not enforced because of poor fiscal reporting requirements and inadequate program reporting by counties. Consequently, county BHSA reports should offer activity, outcomes, and spending data that is disaggregated by discreet age groups, in addition to race/ethnicity, sexual orientation, and gender. Disaggregating spending data by age will be essential to proper oversight and accountability that ensures counties are meeting their minimum-spend obligations for children and youth. Disaggregated data also would improve local oversight by stakeholders, giving them a better sense of potential unmet needs for particular populations of children and youth in their communities.

Since the BHSA also requires a majority of state-administered BHSA Prevention funds to be spent on children and youth, the Department of Public Health (CDPH) likewise should have reporting requirements that allow stakeholders to have a good sense of the range of upstream prevention programs it is administering. Publicly reported spending and outcomes data from CDPH's BHSA

Prevention efforts should also be disaggregated by discreet age groups, gender, race/ethnicity, gender, and sexual orientation. We are encouraged by the State's stakeholder process to confer with counties on the reporting requirements. *However, we strongly suggest the department include children's groups in the oversight and accountability meetings to ensure those reporting requirements also work for the population they are intended to serve.*

3. **Housing interventions do not have to deprioritize youth and families.**

We remain concerned that language and rhetoric (e.g. "encampments") around how DHCS is developing guidance for housing interventions under BHSA includes no principle or prioritization for children, youth, and families. About one in four Californians who struggle with homelessness are unaccompanied youth or families with children. In addition, 1 in 4 California foster youth experience homelessness after living in the foster care system. These already vulnerable youth are facing unprecedented new challenges finding stable, affordable housing.

The Legislative Analyst's Office (LAO) observed that the proposal's funding for housing interventions is not likely to benefit many youth.[1] Proposition 1, for example, allocates half of the funding for housing supports to "persons who are chronically homeless, with a focus on those in encampments." As the LAO noted, adults are far more likely than children to meet the definition of chronically homeless (e.g. homeless for at least 12 months). Young people who are struggling with homelessness are more likely to be sleeping in a car, "couch-surfing" in the home of a friend, or living in severely substandard housing. While these youth are less publicly visible than adults living in encampments, they are equally in need of adequate housing. Housing supports for youth, moreover, can be particularly effective early interventions that will help these individuals avoid becoming chronically homeless. *We recommend that future guidance speak to the needs of homeless children, youth, and families*

We are glad to offer our coalition's expertise and thought partnership to the Department and the Administration as implementation of Proposition 1 begins in earnest. We look forward to collaborating on these important efforts to secure the future well-being of our state's children and youth.

Sincerely,

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[1] The Governor's Homeless Plan, LAO Report, February 2022, states that 16% of Californians experiencing homelessness are families with children and an additional 8% are youth under 24. If youth ages 24 and 25 are added to this statistic, the total number would likely be at least 25% of all individuals experiencing homelessness.