CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
1340 Arnold Drive, Suite 200
Martinez, CA 94553
Ph (925) 313-9553
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

Mental Health Commission (MHC)

Wednesday, January 4th, 2023, ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://zoom.us/j/5437776481
Meeting number: 543 777 6481
Join by phone:
1 669 900 6833 US
Access code: 543 777 6481

AGENDA

I. Call to Order/Introductions (10 minutes)

II. Chair Comments/Announcements (5 minutes)
- **i. Review of Meeting Protocol:**
  - **No Interruptions**
  - **Limit two (2) minutes**
  - **Stay on topic**
- **ii. Brown Act Update (Rev 12/22)**

III. Public Comments (2 minutes per person max.)

IV. Commissioner Comments (2 minutes per Commissioner max.)

V. APPROVE December 7th, 2022 Meeting Minutes (5 minutes)

VI. "Get to know your Commissioner" – Kerie Dietz-Roberts, Commissioner, Mental Health Commission (MHC) (5 minutes)

VII. DISCUSS Committee membership and attendance (5 minutes)

VIII. RECEIVE Presentation: "Survival: The Effect of the 2020 Pandemic on Youth and Adolescents, inclusive of Sexual Assault and Suicide"; Leslie May, LMFT, Commissioner, MHC (30 minutes)

(Agenda Continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Mental Health Commission (MHC) Agenda (Page Two)

Wednesday, January 4th, 2023 ◊ 4:30 pm - 6:30 pm

IX. DISCUSS the response of the Behavioral Health Service (BHS) to the State Department of Health Care Services (DHCS) filing for the Federal Sec. 1115 California Behavioral Health Community-Based Continuum (CalBHC-BC) Medi-Cal Demonstration; Douglas Dunn, MHC Vice-Chair, and Dr. Suzanne Tavano, BHS (15 minutes)

X. DISCUSS BHS 2023-2024 Budget; Barbara Serwin, Commissioner (10 minutes)

- **Strategy for BHS budget development factoring the knowns and unknowns of Behavioral Health Continuum Infrastructure Program (BHCIP) Funding;**
- **BHS budget priorities;**
- **MHC budget concerns and priorities; and,**
- **Next steps**

XI. BHS Director's report, Dr. Suzanne Tavano (10 minutes)

XII. Adjourn

ATTACHMENTS:

A. Brown Act Updates (Revised December 2022)

B. Presentation: "Survival: The Effect of the 2020 Pandemic on Youth and Adolescents Inclusive of Sexual Assault and Suicide"

- **B1. Kids data 12.27.2022**
- **B2. 'Sex-abuse video victimizes child long after abuser is gone' AP/KRON 4**
- **B3. Victim Blaming Assignment**
- **B4. Department of Justice Report**

C. The Federal Sec. 1115 California Behavioral Health Community-Based Continuum (CalBHC-BC) Medi-Cal Demonstration

- **C.1 CalBHC-BC-Overview 11.15.2022**
- **C.2 CalBHC-BC-Demonstration External Concept Paper 11.14.2022**
- **C.3 Remarks: CalBHC-BC Demonstration Opportunity & Requirements**

***Note: CalBHC-BC Medi-Cal Demonstration includes:**

- **For Seriously Emotionally Disturbed (SED) children and adolescents in Short-Term Residential Treatment Program (STRTP) facilities, a Waiver from the maximum Medi-Cal 6-month reimbursement limit for stays in such facilities considered an Institute of Mental Diseases (IMD) with more than 16 beds.**
- **For adults diagnosed with a Serious Mental Illness (SMI), a 30-60 day Waiver from the Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion for persons 21-64 years of age in IMD facilities having more than 16 beds.**

Brown Act Guide

Rev. 12/22

Open Meeting Rules *for* CA's Local Mental/Behavioral Health Boards/Commissions

1. **The Basics**
2. **Frequently Asked Questions**
3. **Allowances:**
   - Public Emergency Allowances *(Expire 1/1/24) (**COVID-19 Emergency Ends 2/28/23**)*
   - Member Emergency & Just Cause Allowances *(In Effect 1/1/2023 - 1/1/2026)*

CA Association of Local Behavioral Health Boards & Commissions (CALBHB/C) supports the work of CA's 59 local mental and behavioral health boards & commissions. www.calbhbc.org/brown-act

Brown Act Open Meeting Rules *for*
CA's Local Mental Health / Behavioral Health Boards & Commissions

Revised September 2022

I. THE BASICS - Under the Brown Act, an agency must comply with the following:

Open & Public Meetings

A meeting is any gathering of a majority of the members (quorum) of a covered board, commission, or its standing committees to hear, discuss, or deliberate on matters within the agency's or board's jurisdiction. Meetings of public bodies must be "open and public". Actions may not be secret. Action taken in violation of open meetings laws may be voided.

Who is covered?

Public bodies of local agencies, including counties and cities, school and special districts.

- "**Legislative bodies**" of each agency, the agency's governing body, plus "covered boards," that is, any board, commission, committee, task force or other advisory body created by the agency, whether permanent or temporary.
- **Standing Committees** of a covered board or commission, regardless of number of members.

Who is not covered?

Ad hoc advisory committees (also called "work groups") consisting of less than a quorum of the covered board (or its standing committees) with a short-term, time-limited purpose.

Most non-profit organizations

State government agencies are instead covered by the Bagley-Keene Open Meeting Act.

Documents

- Treat documents shared with a majority of the board or commission as public. Distribute and post "without delay".

Posting:

- Agendas posted 72 hours in advance of regular meetings
- Agendas posted 24 hours in advance of special meetings (plus notification of local media)
- Agendas must be posted on the local agency's website

Public Participation:

- Public Comment before or during agenda items.
- Sign-In or identification is not required
- Non-disruptive recording and broadcasting is allowed

Teleconferencing - Note: "Allowances" on Pages 3-7

- Agendas must be posted at all teleconference physical locations
- Each teleconference location must be listed on the meeting notice and agenda
- Each teleconference location must be accessible to the public, allowing for public comment.
- At least a quorum of the members must participate from locations within the county (or jurisdiction)
- All votes must be by roll call.

Voting

- Conduct only public votes (no secret ballots)
- All teleconference votes must be by roll call.

II. FREQUENTLY ASKED QUESTIONS

Conference Attendance - If individual members attend a conference called by someone else, is this covered by the Brown Act? They are allowed to attend. The best practice is for board/commission members to sit apart from one another.

Closed Meetings - Is it permissible to conduct "Closed Meetings"? **Yes & No**, closed meetings are allowed under certain conditions, and with specific requirements:

Pending Litigation**:** Only if open discussion "would prejudice the position of the agency in the litigation". The litigation must be named on the posted agenda or announced in open session unless doing so would jeopardize the board's ability to service process on an unserved party or conclude existing settlement negotiations to its advantage. To qualify, the agency must:

- Be a party to pending litigation
- *Or* expect, based on certain specified facts, to be sued
- *Or* expect to file suit itself

Personnel: To discuss the appointment, employment, performance evaluation, discipline, complaints about or dismissal of a specific employee or potential employee. The employee may request a public meeting on any charges or complaints.

Not Allowed for discussing**:**

- General employment
- Independent contractors not functioning as employees
- Salaries
- The performance of any elected official, or member of the board or commission
- The local agency's available funds
- Funding priorities or budget

Lack of Quorum - A board, commission or a standing committee meeting has less than a quorum. Is it still required to meet openly? **Yes**, if it has either a set meeting schedule or a continuing subject matter jurisdiction, it is required to meet openly. (A quorum is required for members to conduct a vote.)

Serial Meetings - Members use individual contacts to collectively decide an issue. Is this a violation? **Yes,** information communicated to a quorum through a series of contacts (such as: individual phone calls ("daisy chain"), emails, chat messages, or a third person ("spoke and wheel")) is prohibited by the Brown Act.

Retreats - Are board/commission retreats subject to Brown Act Rules? **Yes**, if it is a meeting of a local board, commission or a standing committee, the event is subject to the requirements of the Brown Act.

IIIA. ALLOWANCES *for* MEMBERS: "Just Cause" or "Emergency" (*When not operating in a "Public Emergency*) ***In Effect 1/1/23 - 1/1/26***

A local board/commission member may participate remotely *without posting their physical location on the agenda* if all of the following requirements are met:

1) Quorum at Physical Location - At least a quorum of the members of the board/commission participate in person from a singular physical location clearly identified in the agenda.

2) Public Access - (Both Remote and In-Person)
   a) Remote Public Access - The public may access the meeting remotely through:
      i) A two-way audiovisual platform **or**
      ii) A two-way telephonic service and a live webcasting of the meeting
   b) In-Person Public Access to the physical location.

3) Circumstances: One of the following circumstances applies:
   a. "**Just Cause**" - The member notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. The provisions of this clause shall not be used by any member of the legislative body for more than two meetings per calendar year. **or**
   b. "**Emergency Circumstances**" - The member requests to participate in the meeting remotely due to emergency circumstances and the board/commission takes action to approve the request. The board/commission shall request a general description of the circumstances relating to the member's need to appear remotely at the given meeting. A general description of an item generally need not exceed 20 words and shall not require the member to disclose any medical diagnosis or disability, or any personal medical information.

4) Procedures:
   a) Member Request - A member shall make a request to participate remotely at a meeting pursuant to this clause as soon as possible. The member shall make a separate request for each meeting in which they seek to participate remotely.
   b) Board/Commission Response - The board/commission may take action on a request to participate remotely at the earliest opportunity. If the request does not allow sufficient time to place proposed action on such a request on the posted agenda for the meeting for which the request is made, the legislative body may take action at the beginning of the meeting.
   c) Disclosure - The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
   d) *BOTH* Audio & Visual Participation - The member shall participate through both audio and visual technology.

- *Continued on the Next Page* -

5) Limits to Remote Participation - The provisions of this subdivision shall not serve as a means for any member of a legislative body to participate in meetings of the legislative body solely by teleconference from a remote location for a period of more than three consecutive months or 20 percent of the regular meetings for the local agency within a calendar year, or more than two meetings if the legislative body regularly meets fewer than 10 times per calendar year.

DEFINITIONS:

"**Emergency circumstances**": A physical or family medical emergency that prevents a member from attending in person.

"**Just cause**" means any of the following:

1. A childcare or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner that requires them to participate remotely.
2. A contagious illness that prevents a member from attending in person.
3. A need related to a physical or mental disability.
4. Travel while on official business of the legislative body or another state or local agency.

"**Remote location**" means a location from which a member of a legislative body participates in a meeting other than any physical meeting location designated in the notice of the meeting. Remote locations need not be accessible to the public.

"**Remote participation**" means participation in a meeting by teleconference at a location other than any physical meeting location designated in the notice of the meeting. Watching or listening to a meeting via webcasting or another similar electronic medium that does not permit members to interactively hear, discuss, or deliberate on matters, does not constitute remote participation.

"**State of emergency**" means a state of emergency proclaimed pursuant to Section 8625 of the California Emergency Services Act (Article 1 (commencing with Section 8550) of Chapter 7 of Division 1 of Title 2).

"**Teleconference**" means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both.

"**Two-way audiovisual platform**" means an online platform that provides participants with the ability to participate in a meeting via both an interactive video conference and a two-way telephonic function.

"**Two-way telephonic service**" means a telephone service that does not require internet access, is not provided as part of a two-way audiovisual platform, and allows participants to dial a telephone number to listen and verbally participate.

"**Webcasting**" means a streaming video broadcast online or on television, using streaming media technology to distribute a single content source to many simultaneous listeners and viewers.

III B. ALLOWANCES: DURING PUBLIC EMERGENCIES - AB 2449 *(Expires 1/1/2024)* ***COVID-19 Emergency Ends 2/28/23***

Local boards and commissions **may meet solely by teleconference without providing any physical meeting addresses** during a proclaimed state of emergency in which state or local officials have imposed or recommended measures to promote social distancing.

Continuation of this allowance requires that the local agency must **place an item on the agenda** of a Brown Act meeting **once every thirty days** to make findings regarding the circumstances of the emergency and **vote** to continue using the law's exemptions for as long as it deems necessary. See below for specifics.

State of emergency exemptions from in-person requirements are permissible under the following conditions, and with the following requirements:

- The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.
- The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.
- The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees. [To continue the allowances, this vote must be agendized once every thirty days to make findings regarding the circumstances of the emergency and vote to continue using the law's exemptions for as long as it deems necessary.]

A local agency that holds a meeting under these circumstances is required to do all of the following, in addition to giving notice of the meeting and posting agendas as required under the Brown Act. These additional requirements are intended to protect the public's right to participate in the meetings of local agency legislative bodies.

- Allow the public to access the meeting and require that the agenda provide an opportunity for the public to directly address the legislative body pursuant to the Brown Act's other teleconferencing provisions;
- In each instance when the local agency provides notice of the teleconferenced meeting or posts its agenda, give notice for how the public can access the meeting and provide public comment;
- Identify and include in the agenda an opportunity for all persons to attend via a call-in or an internet-based service option;
- The legislative body need not provide a physical location for the public to attend or provide comments;
- Conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the public;
- Stop the meeting until public access is restored in the event of a service disruption that either prevents the local agency from broadcasting the meeting to the public using the call-in or internet-based service option, or is within the local agency's control and prevents the public from submitting public comments (any actions taken during such a service disruption can be challenged under the Brown Act's existing challenge provisions);
- Not require comments be submitted in advance (though the legislative body may provide that as an option), and provide the opportunity to comment in real time;
- Provide adequate time for public comment, either by establishing a timed public comment period or by allowing a reasonable amount of time to comment;

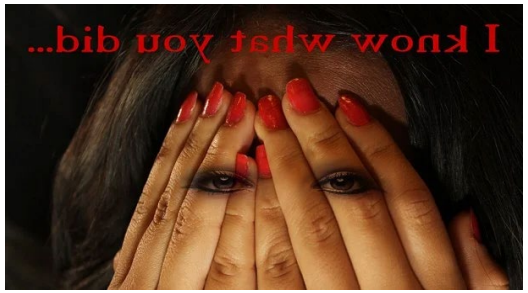
- If the legislative body uses a third-party website or platform to host the teleconference, and the third-party service requires users to register to participate, the legislative body must provide adequate time during the comment period for users to register, and may not close the registration comment period until the comment period has elapsed.

If the state of emergency remains active for more than 30 days, the board/commission must make the following findings by majority vote every 30 days to continue using the exemption to the Brown Act teleconferencing rules.

- The legislative body has reconsidered the circumstances of the emergency; and
- Either of the following circumstances exist: The state of emergency continues to directly impact the ability of members to meet safely in person, or State or local officials continue to impose or recommend social distancing measures.

  This means that a local agency will have to put an item on the agenda of a Brown Act meeting once every thirty days to make findings regarding the circumstances of the emergency and vote to continue using the law's exemptions for as long as it deems necessary. The public emergency allowances will sunset on January 1st, 2024.

Survival: The Effect of the 2020 Pandemic on Youth and Adolescents, Inclusive of Sexual Assault and Suicide



I Wish I Could Disappear

Presentation Purpose

- I am presenting this to enlighten the Commission, the Board of Supervisors, and Behavioral Health Services of the need to address this epidemic in our county.
- As former Commissioner Teresa Pasquini says, this is a “hair on fire” moment which needs to be addressed immediately. We don’t have time to wait for the “correct political climate” to address this fatality laden epidemic.
- The time has come to set aside ‘ego’ and work directly with local law enforcement, the F.B.I., and Homeland Security to address this runaway train and figure out how to stop it on the tracks!

Contra Costa Human Trafficking Task Force Award Information

Contra Costa Human Trafficking Task Force: Award Information
*from https://www.ojp.gov/Office for Victims of Crime

Awardee CONTRA COSTA, COUNTY OF

Award # 15POVC-22-GK-03664-HT

Areas Served: Contra Costa

Congressional District 5

Status Open

Funding First Awarded **2022**

Total funding (to date) **$750,000**

Original Solicitation OVC FY 2022 Enhanced Collaborative Model Task Force to Combat Human Trafficking

NOTE: $750,000.00 a year is not nearly enough money to combat Human Trafficking!

Congressman Jim Costa (CA-16) 11/16/22

WASHINGTON - Congressman Jim Costa (CA-16), who is the Chairman of the bipartisan Crime Survivors and Justice Caucus, voted to pass S. 4524 - Speak Out Act, a bipartisan, bicameral bill that would limit the use of non-disclosure agreements (NDAs) to silence survivors of sexual harassment or assault. This legislation now heads to President to sign into law.

“Too often, non-disclosure agreements (NDAs) are used by perpetrators to silence and manipulate survivors of sexual assault in the workplace. We must reform this broken system that prevents survivors from speaking out!” said Costa. “We must hold perpetrators accountable.”

The Speak Out Act would bring justice for survivors of sexual assault and harassment by:

- Prohibiting the use of pre-dispute NDAs between employers and current, former, and prospective employees, as well as independent contractors;
- Prohibiting the use of pre-dispute NDAs between providers of goods and services and consumers, and;
- Invalidating existing pre-dispute NDAs in cases that have not yet been filed.

Crime rates in **Antioch** by year Type 2006-2019

Read more: https://www.city-data.com/crime/crime-Antioch-California.html

- Rapes (per 100,000)
- 35 (34.5)
- 27 (26.5)
- 29 (28.8)
- 40 (39.5) 2009
- 32 (31.3)
- 21 (20.3)
- 29 (27.6)
- 25 (23.5)
- 54 (49.9) 2014
- 53 (47.9)
- 55 (49.1) 2016
- 51 (45.4)
- 56 (49.6) 2019
- 55 (48.8) 2018

A Second, Silent Pandemic: Sexual Violence in the time of COVID-19: Harvard University

A Second, Silent Pandemic: Sexual Violence in the time of COVID-19
May 1st, 2020

What happens when "safer-at-home" doesn't apply to everyone?

- NOTE: The term **sexual violence** refers to crimes like sexual assault, rape, and sexual abuse, which can be perpetrated by anyone. **Domestic violence** includes emotional, physical, and/or sexual harm by a current or former intimate partner. Research into the specific types of violence during and following emergencies is limited and often combines domestic and non-domestic sexual violence.

- For more than six weeks, the world has been consumed with talks of the global pandemic and subsequent lockdowns caused by COVID-19. As quarantine and stay-at-home efforts drag on, a second, silent pandemic persists. Evidence shows that **rates of sexual violence increase during states of emergency**, including natural disasters, active conflict, and health crises.

A Second, Silent Pandemic: Sexual Violence in the time of COVID-19: Harvard University

Populations at Increased Risk

- In March, minors made up half of the calls to the National Sexual Assault Hotline for the first time ever. "Unfortunately for many, and especially for children experiencing sexual abuse, 'stay at home' doesn't mean 'safe at home,'" said RAINN President Scott Berkowitz. Of minors who reported coronavirus-related concerns, 67% identified their perpetrator as a family member, and 79% said they were living with that perpetrator. This is unsurprising, as approximately 80% of sexual assaults are committed by someone known to the victim. Children living in foster care or with someone other than biological family may be particularly at risk.
- In addition to minors, individuals with physical disabilities, homeless residents, and those suffering from mental illness or substance misuse are particularly vulnerable to all types violence during emergencies.
- For more details on current guidelines, recommendations and resources for sexual violence victims in the United States, please visit RAINN.org.
- **Rape, Abuse & Incest National Networkhttp://www.rainn.org/**

Child Abuse: C.C. County District Attorney Office

Child Abuse cases are prosecuted by the Sexual Assault Unit. The unit handles the felony prosecution of physical abuse and child endangerment by adult offenders against minor children. The unit also handles all felony physical abuse cases against minors.

Prosecution

- The prosecution of these cases begins after a police investigation is completed. The police agency then presents this unit with the results of that investigation in the form of police reports. At this time charging decisions are made.
- The unit is a vertical prosecution unit, which means one Deputy District Attorney is assigned to the case from the beginning to the end. This enables more effective prosecution as the prosecutor has an in-depth knowledge of the case. In addition, this allows for a better relationship between the victim and the prosecutor.

Confidentiality

- The unit makes every effort to respect confidentiality requests of victims, and to deal with these cases in as sensitive and respectful a manner as possible.

Human Trafficking Unit

Human trafficking is a form of modern-day slavery. It consists of coercing and forcing vulnerable people into sex work or labor industries. Behind drug trafficking, it is the second most lucrative criminal enterprise. Traffickers will often prey upon transient or displaced people. Furthermore, victims do not have to be transported over state or national lines for human trafficking to occur. This makes human trafficking extremely hard to detect and prosecute as many people may not even be aware that they are being trafficked before it is too late.

- In an effort to curb human trafficking, California has enacted Senate Bill 1193, mandating that certain businesses post notices in English and Spanish about human trafficking. In 2017, additional measures were passed, expanding the number and types of businesses required to post notices.

- Sex Offenses | United States Sentencing Commission (ussc.gov)

- **Sentences???**

California Megan's Law Website

- Contra Costa County
- County: Contra Costa Postable Offenders: 1128
- Antioch ZIP Code: 94509 Postable Offenders: 143 (31)
- City: Danville Postable Offenders: 8
- City: Concord Postable Offenders: 135 (28)
- City: Martinez Postable Offenders: 43 (6)
- City: Lafayette Postable Offenders: 6
- City: Oakley Postable Offenders: 46 (3)
- City: Brentwood Postable Offenders: 43 (5)
- City: Discovery Bay Postable Offenders: 10

CDC: Teen Suicide Attempts Surged During COVID Lockdown by Caroline Downey

- The percentage of teenagers hospitalized for suspected suicide attempts surged during the COVID-19 lockdowns.
- A recently released CDC study showed that female adolescents ages 12 through 17 visited the emergency department (ED) for suicide attempts between February and March of 2021 at a nearly 51 percent higher rate compared to the same time frame in 2019 before the COVID-19 lockdowns and stay-at-home orders forced businesses and schools to close due to plummeting consumer demand and mandatory safety precaution.
- For a short period between March and April of 2020, ED visits for suspected suicide attempts among people ages 12 through 25 declined but then began to shoot up again during the summer of 2020. Between July and August, CDC researchers found that suspected suicide attempts rose over 26 percent among girls ages 12 through 17.

CDC: Teen Suicide Attempts Surged During COVID Lockdown by Caroline Downey

- While the increase in reported suicide attempts among girls did not directly correspond to more suicide deaths, the analysis states, “The findings from this study suggest more severe distress among young females than has been identified in previous reports during the pandemic, reinforcing the need for increased attention to, and prevention for, this population.”
- According to the CDC, among the factors contributing to the alarming trend are COVID-mitigation measures that have proven to be socially isolating, including “physical distancing,” “a lack of connectedness to schools, teachers, and peers,” “barriers to mental health treatment,” “increases in substance use,” and “anxiety about family health and economic problems.” The study noted that mental-health cases have spiked over the pandemic, suggesting they may be a function of children spending more time at home due to the lockdowns as well.

Suicide Attempts Surge In This California County (Evolve Treatment Centers)

- When the coronavirus pandemic hit, experts predicted it might significantly impact teen mental health. With no real school or extracurricular activities, and limited opportunities for socializing or getting out of the house, professionals guessed that teens with mental health issues such as depression, anxiety, self-injurious behavior, and suicidal ideation might be more at risk than ever.
- We can now see firsthand exactly how COVID-19 has impacted the mental health of adolescents in one area of California.
- The trauma center at John Muir Medical Center in Walnut Creek saw an unprecedented number of suicide attempts and self-injurious behavior among young patients, ABC News reports.
- As Dr. Mike deBoisblanc, head of the trauma unit at John Muir, said in the report: “We’ve never seen numbers like this, in such a short period of time…we’ve seen a year’s worth of suicide attempts in the last four weeks.”
- A spokesman for the Walnut Creek hospital clarified the doctor’s remarks. Typically, the hospital sees 20 to 25 suicide attempts a year and six deaths from suicide annually. So far, in 2020, there have been 21 suicide attempts and five deaths since January.
- According to the ABC report, doctors at Jon Muir have seen more deaths by suicide during this quarantine period than deaths from COVID-19.

Suicides in Contra Costa County

- Suicide is the third leading cause of death every year among Contra Costa County residents ages 15 – 34. In 2017, 107 residents died by suicide.
- Here are other statistics about self-injurious behavior and suicide in the county, according to Contra Costa Health Services:
- Between 2005–2007, 269 Contra Costa residents committed suicide
- On average, 90 Contra Costa residents commit suicide each year
- Males were more likely to commit suicide than females
- Teenagers and young adults ages 15–24 years are most likely to be hospitalized for self-inflicted injury (NSSI).
- Females are more likely to be hospitalized for self-injurious behavior than males
- Between 2005-2007, the highest number of suicides occurred among residents of Concord (35), Walnut Creek (30), Richmond (26) and Martinez (21).

How Therapists/Clinicians Work With Clients

- ✓ Practicing from a trauma informed lens
- ✓ Building rapport with a traumatized client
- ✓ Sexual assault/abuse issues and blame, self-blame, family blame
- ✓ Human trafficking issues
- ✓ Strategies for ensuring clients don't terminate therapy prematurely
- ✓ How to dismantle rape culture
- ✓ Motivational interviewing
- ✓ Harm reduction
- ✓ Specific trauma interventions to regulate the nervous system
- ✓ How to provide psychoeducation to help clients understand trauma,
- ✓ How to work best with LGBTQ clients and sexual assault/abuse
- ✓ How to work best considering multiple diverse cultures around sexual assault/abuse

The Need For Healing Before Returning Home

- Imagine being sexually assaulted by a person, repeatedly, and maybe by the persons' friends.
- Imagine being sexually trafficked from the city you are from and transported to Nevada, Georgia, Florida, before you are rescued.
- Imagine you are a 14-year-old child and have endured these torturous conditions for days or even months before you are rescued.
- Imagine how you feel when law enforcement tell you they are making sure you get home to your family, who have been missing you.
- Imagine thinking about the sexual acts you have been forced to perform.

Land and Farm

https://www.landandfarm.com/

- California Land 6.7 Acres - Tehachapi, CA
- Cumberland Rd., Bear Valley Springs, CA | Kern County, CA
- **$59,900**
- 6.7 acres
- Listing Status: Off Market
- Listing Type: Sale
- Property Type(s):
- Alternative Energy Residential Land Undeveloped Land
- Irrigated: No
- Residence: No
- Property ID: 30102302
- Property Description
- Owner will finance with a Down Payment of $2000 and a Monthly Payment of $680. No qualifying is necessary. Title is free and clear of liens or encumbrances. Access to this 6.70 acre Lot is guaranteed. Taxes are current. **Stunning Views, Paved Road, Power, Water**
- ****Shovel ready project**

Land and Farm

https://www.landandfarm.com/search/California-land-for-sale/

- This is a source for the County to purchase land and renovate existing property on the land or build properties which serve as recovery ranches for sexual assault victims and suicide ideation victims.
- Children, adolescents, and youths carry shame when they are saved or rescued from situations which have severely affected their mental health well-being. We need to be “forward thinking” in recovery and provide an environment where they can heal, continue getting their education, have their physical and mental health needs addressed daily.
- A holistic, idyllic environment would provide the space they need for healing. Hiking, animal therapy, gardening, farming, and fishing is a possibility.
- This would address major depressive disorder, abuse, trauma, substance abuse, PTSD, and existential therapies.

Grants and Loans

- **https://www.usda.gov/topics/farming/grants-and-loans**
  - **The USDA provides loans which the county could qualify for**
- **USA Grant Applications**
  - **Provides billions of dollars for organizations**
- **Federal Grants to State and Local Governments | U.S. GAO**
  - **Provides grants to government for public services**

Thank You

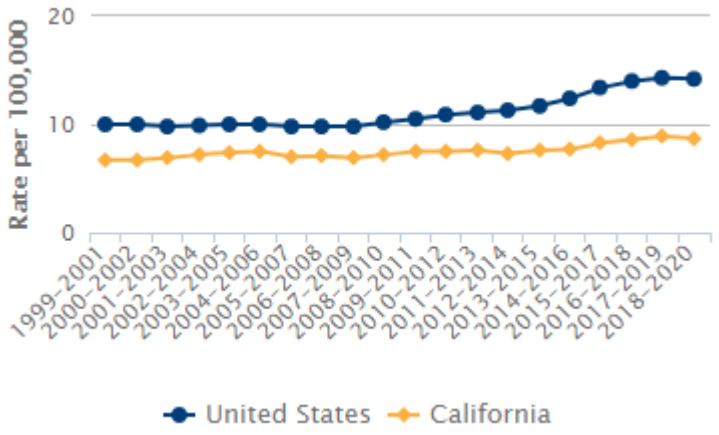
- Thank you for your attention to these important matters. Sexual abuse/assault/trafficking are NOT okay.
- We need to work toward strengthening laws which give the perpetrator more time for their crimes.
- We need to work toward making our children feel safe again.
- We need to work with families to help provide services for their children to feel safe walking to school, playing outside, shopping with their parents, and enjoying their childhood. There have been attempts of kidnapping with the parent present and this is not okay!

KidsData

POWERED BY PRB

Youth Suicide and Self-Inflicted Injury in California

Rate of Suicide Among Youth Ages 15-24



Definition: Number of suicides per 100,000 youth ages 15-24 (e.g., in 2018-2020, the suicide rate among California youth was 8.7 per 100,000).
Data Source: California Dept. of Public Health, Death Statistical Master Files; California Dept. of Finance, Population Estimates and Projections; CDC WONDER Online Database, Underlying Cause of Death (Apr. 2022).

Rate of Hospitalization for Self-Inflicted Injuries Among Youth Ages 5-20: 2015

Locations	Rate per 100,000
United States	62.7
California	36.5
Alameda County	34.3
Contra Costa County	66.8
Fresno County	32.5
Kern County	43.2
Los Angeles County	35.6
Orange County	40.0
Riverside County	30.0
Sacramento County	38.2
San Bernardino County	22.3
San Diego County	39.0
Santa Clara County	46.0

Definition: Number of hospital discharges for non-fatal self-inflicted injuries per 100,000 children and youth ages 5-20 (e.g., in 2015, there were 36.5 hospitalizations for self-inflicted injuries per 100,000 California children and youth).
Data Source: California Dept. of Public Health, EpiCenter (Feb. 2020); California Dept. of Finance, Population Estimates and Projections (Jan. 2020); CDC, WISQARS (May 2020).

Percentage of Students Who Seriously Considered Attempting Suicide in the Previous Year, by Gender: 2017-2019

What It Is

Kidsdata.org provides the following indicators of youth suicide and self-inflicted injury:

- The estimated percentage of students in grades 9, 11, and non-traditional programs who seriously considered attempting suicide in the previous year, by grade level, gender, level of school connectedness, parent education level, race/ethnicity, and sexual orientation
- The rate of suicide per 100,000 youth ages 15-24, along with the number of youth suicides by age group, gender, and race/ethnicity
- The number and rate of hospital discharges for self-inflicted injuries among children and youth ages 5-20 overall, and the number of discharges by age group

Why This Topic Is Important

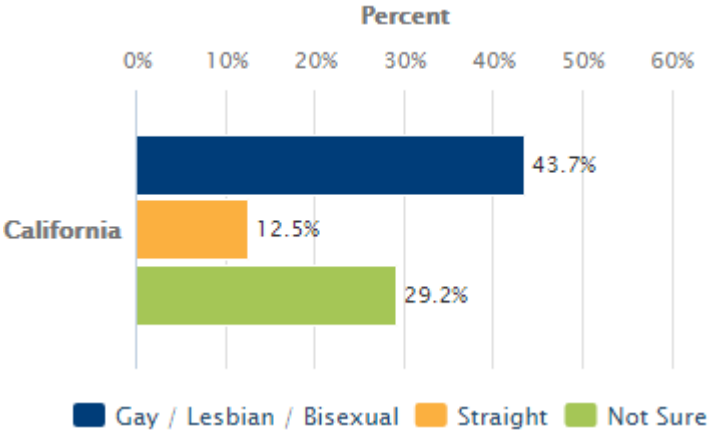
Suicide is the third leading cause of death for young people ages 15-24 statewide and nationally, behind only unintentional injuries and homicide. Rates of youth suicide and self-injury hospitalization, even among younger adolescents, have risen over the past decade. In 2018, the number of suicides among California youth ages 12-19 was 15% higher than in 2009, and incidents of youth self-harm requiring medical attention were 50% higher. While self-inflicted injuries typically are not the result of suicide attempts and do not involve intent to die, non-suicidal self-injury is a risk factor for suicide. A 2019 survey of U.S. high school students estimated that about one in five seriously considered suicide in the previous year, a figure more than 35% higher than findings from a decade earlier.

Suicide risk is higher for some groups than for others. While girls and young women more often seriously consider, plan, and attempt suicide, males are more likely than females to die by suicide—although the gap may be narrowing. Nationally, American Indian/Alaska Native youth have the highest suicide rate among racial/ethnic groups with data. In addition, LGBTQ youth are more likely to engage in suicidal behavior than their non-LGBTQ peers. Other common risk factors for youth suicide include prolonged stress, mental illness, disability, past suicide attempts, family history of suicide or mental disorders, poor family communication, stressful life events, placement in out-of-home settings, access to

California	Percent	
	Female	Male
Grade Level	Yes	Yes
Grade 9	21.1%	11.2%
Grade 11	20.2%	12.7%
Non-Traditional	26.2%	13.6%

Definition: Estimated percentage of public school students in grades 9, 11, and non-traditional programs who seriously considered attempting suicide in the previous year, by gender and grade level (e.g., in 2017-2019, an estimated 21.1% of female 9th graders in California seriously considered attempting suicide in the previous year).
Data Source: WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education (Aug. 2020).

Percentage of Students Who Seriously Considered Attempting Suicide in the Previous Year, by Sexual Orientation: 2017-2019



Definition: Estimated percentage of public school students in grades 9, 11, and non-traditional programs who seriously considered attempting suicide in the previous year, by sexual orientation (e.g., in 2017-2019, an estimated 43.7% of gay, lesbian, and bisexual students in grades 9, 11, and non-traditional programs in California seriously considered attempting suicide in the previous year).
Data Source: WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education (Aug. 2020).

lethal means, and exposure to suicidal behavior of others.

How Children Are Faring

In 2017-2019, an estimated 16% of California 9th and 11th graders and 17% of non-traditional students seriously considered attempting suicide in the previous year. At least 20% of girls in each grade level seriously considered suicide, compared with less than 13% of boys. Students with low levels of school connectedness were much more likely to have serious suicidal thoughts (32%) than their peers with medium (19%) or high (9%) connectedness. The proportion of gay, lesbian, and bisexual youth who seriously considered attempting suicide (44%) was about one and a half times the estimate for students unsure of their sexual orientation (29%) and more than three times the estimate for straight youth (13%).

The rate of hospitalization for non-fatal self-inflicted injuries among California children and youth ages 5-20 was 37 per 100,000 in 2015, down from 49 per 100,000 in 1991. While the state's rate of self-inflicted injury hospitalization has fluctuated over time, it has remained lower than the U.S. rate since 2010. Youth ages 16-20 account for the majority of discharges for self-inflicted injuries statewide: 1,949 of 3,136 in 2015 (62%).

In 2020, 174 California teens ages 15-19 and 299 young adults ages 20-24 were known to have committed suicide. Statewide, the rate of suicide among youth ages 15-24 in 2018-2020 was 8.7 per 100,000, compared with a national rate of 14.2 per 100,000. Following a decade of rising suicide rates—in which figures increased by more than 27% in California and more than 44% nationwide—neither the California nor the U.S. rate rose in 2018-2020.

Among younger children ages 5-14, there was an increase in suicides between 2019 and 2020 at both the national level and in California, where the number of suicides in this age group doubled (from 27 to 54). Statewide and nationally, many more boys and young men die by suicide than their female counterparts; in 2020, males accounted for three quarters of suicides among California youth ages 15-24.

View references for this text and additional research on this topic:
https://www.kidsdata.org/topic/34/youth-suicide-and-self-inflicted-injury/summary

Department of Justice
Office of Justice Programs

FOR IMMEDIATE RELEASE
TUESDAY, SEPTEMBER 20, 2022, 10 A.M. ET
BJS.OJP.GOV

BUREAU OF JUSTICE STATISTICS
CONTACT: SHEILA JERUSALEM
(202) 598-0793; Sheila.Jerusalem@usdoj.gov

WHILE VIOLENT VICTIMIZATION DECLINED FROM 1993 TO 2021, REPORTING TO POLICE ROSE FROM 2020 TO 2021

WASHINGTON — From 1993 to 2021, the rate of violent victimization in the United States declined from 79.8 to 16.5 victimizations per 1,000 persons age 12 or older, the Bureau of Justice Statistics announced. Violent victimization includes rape or sexual assault, robbery, aggravated assault and simple assault. The overall violent victimization rate did not change between 2020 and 2021.

The rate of violent victimization reported to police fell from 33.8 victimizations per 1,000 persons in 1993 to 7.5 per 1,000 in 2021. Although the rate of violent victimization reported to police in 2021 (7.5 per 1,000 persons) was similar to the rate in 2020, the percentage of violent victimizations reported to police in 2021 (46%) was higher than in 2020 (40%).

From 2020 to 2021, the violent victimization rate increased from 19.0 to 24.5 victimizations per 1,000 persons in urban areas while remaining unchanged in suburban or rural areas. Veterans experienced 247,290 violent victimizations (14.4 per 1,000) in 2021, which was not statistically different from 2020. A larger percentage of violent victimizations in 2021 (9%) than in 2020 (6%) resulted in the victim receiving assistance from a victim service provider.

In 2021, about 0.98% (2.7 million) of persons age 12 or older nationwide experienced at least one violent crime. About 6.25% (8.1 million) of households in the country experienced one or more property victimizations (burglary or trespassing, motor vehicle theft, or other household theft).

Criminal Victimization, 2021 (NCJ 305101) was written by BJS statisticians Alexandra Thompson and Susannah N. Tapp, Ph.D. The report, related documents and additional information about BJS's statistical publications and programs are available on the BJS website at bjs.ojp.gov. The NCVS Dashboard (N-DASH), an interactive online data visualization dashboard, is available at ncvs.bjs.ojp.gov.

The Bureau of Justice Statistics of the U.S. Department of Justice is the principal federal agency responsible for collecting, analyzing and disseminating reliable statistics on crime and criminal justice in the United States. Alexis R. Piquero is the director.

The Office of Justice Programs provides federal leadership, grants, training, technical assistance and other resources to improve the nation's capacity to prevent and reduce crime, advance

racial equity in the administration of justice, assist victims and enhance the rule of law. More information about OJP and its components can be found at www.ojp.gov.

###

https://apnews.com/a749889073eccc7e0d9d5e6c6af38b92

AP

Sex-abuse video victimizes child long after abuser is gone

By MICHAEL REZENDES and HELEN WIEFFERING - Associated Press
Dec 22, 2022

FILE - A "playground ahead" warning stands by the side of a road on the outskirts of Bisbee, Ariz., Oct. 26, 2021. Bisbee was home to Paul and Leizza Adams six children, before Paul and Leizza were charged with child sexual abuse.
Dario Lopez-Mills - staff, AP

By MICHAEL REZENDES and HELEN WIEFFERING - Associated Press

The video of a man raping his 9-year-old daughter was discovered in New Zealand in 2016 and triggered a global search for the little girl.

Investigators contacted Interpol and the pursuit eventually included the FBI, the U.S. State Department and the Department of Homeland Security. Months later, investigators raided the Bisbee, Arizona, home of Paul Adams, arrested him and **rescued the girl** in the video along with her five siblings.

While Adams can no longer physically hurt his daughter — he died by suicide in custody — the videos live on, downloaded and uploaded by child pornographers across the U.S. and around the globe, growing ever more popular even as as police, prosecutors and internet companies chase behind in a futile effort to remove the images.

The number of times the Adams video has been seen soared from fewer than 100 in 2017 to 4,500 in 2021, according to data provided to The Associated Press with the permission of the girl and her adoptive mother, Nancy Salminen. The tally was produced by the National Center

for Missing and Exploited Children, a nonprofit that tracks child pornography on the internet and works with law enforcement agencies throughout the world.

People are also reading...

1. **Lincoln counselor accused of Medicaid fraud**
2. **Claims against estate of deceased Lincoln businessman now extend to Louisiana**
3. **Kaufman award presented**
4. **At the Courthouse**

“That’s the horrendous part about it,” Salminen said. “You can’t just say that’s in the past and shut the door and move on. She will never be able to turn her back on what’s happened.”

The ongoing victimization of the child could have been avoided.

Six years before the video surfaced in Auckland, Adams, a member of the Church of Jesus Christ of Latter-day Saints, widely known as the Mormon church, confessed to his bishop that he abused his daughter, identified by the AP as MJ.

But a prominent church lawyer told the bishop to keep the abuse secret. And as a result, MJ was brutalized for seven more years. Today, she continues to be victimized almost daily in a different way, as the video, and others Adams took, circulate on the internet. Details of the Mormon officials' cover-up of the Adams rapes were reported in an **AP investigation** in August.

The data provided to the AP also shows that police in the U.S. referred the Adams video, or portions of it, to NCMEC for identification 1,850 times since it was discovered, contributing to nearly 800 arrests on federal child pornography charges last year alone.

Those arrested comprise a coast-to-coast catalog of men — women rarely traffic in child pornography, the data shows — that defies economic or geographic boundaries. A random sampling includes:

— Kurt Sheldon, 31, a librarian in Putnam County, Florida, was arrested in September 2020 for possession of child pornography and using Snapchat to solicit pornography from a 12-year-oid girl. Sheldon was sentenced to nearly 22 years in federal prison.

— Joseph Mollick, 58, a physician affiliated with the University of California, San Francisco Medical Center was arrested in October 2021. Federal officials charged him with using the social media application Kik to upload 2,000 child pornography videos and images. Mollick pleaded not guilty.

— Jared Faircloth, 24, a U.S. Air Force airman, was arrested in October 2021 in Cream Ridge, New Jersey, for downloading more than 2,800 child sex abuse videos and images through the BitTorrent network. Faircloth pleaded guilty to federal charges and is awaiting sentencing.

— Harold "HL" Moody, Jr., 39, a former communications director for the Arkansas Democratic party, was arrested in November 2018 for distributing child pornography in online chatrooms. The Little Rock resident pleaded guilty to federal charges and is awaiting sentencing.

LIMITS OF COMPUTER SLEUTHING

The seeming immortality of the Adams video underscores the limits of computer sleuthing by a global network of investigators racing to stop internet child pornography, and it reveals how advances in data storage and video technology have outpaced efforts to stop it.

Permanently removing the images from the open internet is nearly impossible, child sex abuse experts say, because pornographers throughout the world are constantly downloading the images, storing them and reposting them.

"That's what makes the whole crime type so abhorrent," said Simon Peterson, the New Zealand customs agent who discovered the Adams video, during an interview with the AP. Victims of online child pornography, he said, "have to wake up every morning knowing that there's imagery of those terrible times in their lives still out there, and that people are accessing it for their own gratification."

The Adams case has also highlighted **a glaring loophole** in state child sex abuse reporting laws. Adams, a member of the Mormon church, confessed he was abusing his daughter to his Bishop, John Herrod, in 2010. In Arizona, clergy are among the professionals required to report child sexual abuse to police or child welfare officials.

But when the bishop called the church's "help line" for advice, **Merrill Nelson,** a lawyer representing the church, directed him to withhold the information from police and child welfare officials.

According to legal documents, Nelson, who was also a Utah legislator, pointed to an exception in the state's mandatory child sex abuse reporting law that allows clergy to keep information revealed during a confession to themselves. The so-called clergy-penitent privilege is on the books in 33 states, the AP found.

Behind this veil of church secrecy, Adams continued molesting MJ and, five years later, started raping her younger sister as well, beginning when she was just 6 weeks old. He was also taking videos and photographs of the abuse and posting them to the internet, including the nine-minute video that was eventually his undoing.

A WORLDWIDE QUEST

It was November 2016 when Peterson and his team of agents in Auckland raided the home of a 47-year-old farm worker whom they'd been watching online for months.

"He knew what we were there for," Peterson recalled. "And by the end of the morning we'd arrested him, interviewed him and charged him for exporting and possessing child sexual abuse material."

For weeks the investigators pored over the computers and cell phones they had seized in the raid, and shortly before Christmas, Peterson found the Adams video, which the farmworker had downloaded from an internet site based in Russia.

Agents who chase child pornographers often see the same images over and over. But Peterson said the Adams video was different. After running it through a New Zealand database of seized child pornography, and a second database maintained by Interpol, the organization that helps law enforcement agencies work across countries, Peterson suspected the video might be new, and the child depicted might still be in danger.

He could also see obvious clues that could help identify the rapist and his victim.

"We could see both their faces for a start," Peterson said. "And they were talking throughout it, as well. We could tell from the accent if it wasn't Canadian, it was American. So we could narrow it down pretty quickly."

Interpol sent the video to NCMEC, which acts as a clearinghouse for agencies investigating child pornography throughout the world. Computer analysts there isolated several images of Adams' face and sent them to Homeland Security Investigations, which in turn sent them to the FBI, where analysts tried unsuccessfully to identify them with facial recognition technology, according to summaries of the case compiled by the U.S. Justice Department and the Department of Homeland Security.

The FBI's Operation Rescue Me then turned to the State Department to compare the images to those in a database of visa and passport photos and found eight potential matches. Investigators finally zeroed in on Adams and his daughter through his wife's Facebook page. They were also able to determine that the video was made on June 20, 2015, and that Adams was a U.S. Border Patrol employee who had that day off, so he was free to create the video at home.

On Feb. 8, 2017, about six weeks after Peterson discovered the video in New Zealand, Homeland Security agents arrested Adams on the job at the Naco, Arizona, border crossing while federal agents raided his home, seized electronic devices and rescued his six children.

"It was quite emotional," Peterson said. "We don't get success often."

A GLOBAL GLUT OF CHILD PORN

Over the last several years, sightings of child sexual abuse material on the internet have skyrocketed.

Under federal law, every internet platform based in the United States is required to report discoveries of child pornography on their social media pages to NCMEC's Cyber Tipline. Last year, the organization received 29 million reports, up from 21 million in 2020, and 18 million in 2019 — a 61% increase over just two years.

The vast majority of these reports stem from child pornography posted on the open internet and do not account for additional child porn posted to the dark web, where producers and consumers of child sexual abuse material — or CSAM — operate with near complete anonymity.

"It's nearly impossible to fully estimate and scope how much CSAM is on the internet, whether that's open web, P2P (peer-to-peer) file sharing or the dark net," said John Shehan, vice president of NCMEC's Exploited Children Division.

But investigators agree that the surge in reports by companies with open internet platforms such as Facebook indicates an enormous increase in the volume of child sexual abuse material on the internet. These investigators attribute the increase to advances in technology that have made it easier and less expensive for amateurs to take pornographic videos with their cellphones and to store vast amounts child pornography at minimal cost on remote servers or external hard drives.

Erin Burke, the Homeland Security section chief for the agency's Cyber Crimes Center, said it's common for investigators to find child pornographers with "terabytes of files." A single terabyte is enough space to hold hundreds of hours of video and can be stored on a remote server for as little as $25 a month, or on an external hard drive that can cost less than $100.

Investigators also attribute the sharp rise in internet child pornography to the worldwide travel restrictions imposed during the coronavirus pandemic.

Unable to visit countries where child prostitution proliferates, some pornographers resorted to a practice known as "sextortion," in which an online perpetrator lures a child into sending compromising selfies. If the child later refuses to produce more explicit images, the perpetrator threatens to post the selfies the child initially created to the child's social media contacts, which typically include family members.

"That's one of the bad outcomes of COVID," Burke said. "It was bound to happen anyway but it just kind of sped up that process."

On Monday, the U.S. **Justice Department issued an alert** on a related scheme in which young sextortion victims are also extorted for money, citing more than 3,000 victims and multiple suicides this year.

Another chilling outcome of the pandemic, Burke said, is the advent of live streaming of child sexual abuse for audiences ranging from a handful to thousands. On platforms that offer live video chats and end-to-end encryption, viewers who pay minimal, untraceable fees may choose from a menu of child victims of varying ages, including infants, and request to see specific sex acts.

Burke said Homeland Security investigators have found that much of the live streaming originates in the Philippines and is performed for U.S. and Western European audiences. English is commonly spoken in the Southeast Asian nation and high-quality internet service is available, she said. At the same time, harsh economic conditions provide an incentive for families to participate.

“They’re mostly abusing family members,” Burke said. “It’s not grabbing kids off the street.”

As the volume of internet child sexual abuse material has soared, so too have the number of agencies working to stop it. Homeland Security and the FBI both have special units dedicated to tracking down child pornographers. Along with NCMEC, they work closely with more than 60 local branches of the Internet Crimes Against Children Task Force Program, with units spread throughout the U.S.

Internationally, Homeland Security and NCMEC work with investigators at Interpol and law enforcement agencies throughout the world, including those in the other “Five Eyes” countries — Canada, Great Britain, Australia, and New Zealand — which cooperate in a range of intelligence activities.

RESTITUTION

In the six years following the discovery of the nine-minute Adams video, law enforcement agencies in the U.S. have seized thousands of images of MJ's abuse and have referred the material to NCMEC for positive identification. In turn, NCMEC has cataloged the identities of those arrested who may have possessed or trafficked the images and given the information to MJ’s lawyers, who can sue each perpetrator for up to $150,000 in restitution under federal civil law, in addition to restitution that may be available through criminal proceedings.

Lynne Cadigan, one of several attorneys representing three of the Adams children, said MJ will seek compensation from the child pornographers.

But she and Salminen, the girl's adoptive mother, lay most of the blame for the sexual abuse on officials of the Mormon church, who knew Adams molested MJ as early as 2010 and did nothing to stop it.

“She went to church with people who didn’t help her and as a result thousands of people are looking at the video and there’s nothing she can do about it,” Cadigan said.

Two years ago, the three Adams children filed a lawsuit that accuses the church, two bishops and a third Mormon official of conspiring to keep the years of abuse by their father out of the hands of civil authorities.

As part of the lawsuit, the Arizona Court of Appeals on Dec. 15 ruled that the church does not have to turn over disciplinary records for Adams, who was excommunicated in 2013. The court also ruled that a church official who attended a disciplinary hearing could refuse to answer questions from the plaintiffs' attorneys during pretrial testimony, based on the clergy-penitent privilege. Lawyers for the three Adams children said they plan to appeal.

Attorneys for the church say the bishops who knew that Adams abused his daughter — John Herrod and Robert “Kim” Mauzy — did nothing wrong by taking a lawyer’s advice and withholding the information because Adams told Herrod about the abuse during a spiritual confession, triggering the privilege.

In a statement to the AP, the church said it had no knowledge Adams was recording himself abusing his two daughters and posting the material on the internet until 2017. “The Church had no idea that these videos were being created or circulated until after Paul Adams was arrested," the statement read. "The church supports all efforts to prosecute anyone who possesses or distributes these heinous and disturbing videos.”

Adams might never have stopped raping his two daughters if Peterson hadn’t discovered the nine-minute video in New Zealand. But unlike Adams, the video may never be stopped.

“They’re living with it for the rest of their lives,” Peterson said. “It’s on the internet. It’s not going anywhere.”

——

AP investigative reporter Jason Dearen, video journalist Jesse Wardarski and data journalist Justin Myers contributed to this story.

——

To contact AP's investigations team, email **investigative@ap.org**

Victim Blaming Assignment:

"Blaming the Victim of Acquaintance Rape: Individual, Situational, and Sociocultural Factors" by Claire R. Gravelin1 *, Monica Biernat2 and Caroline E. Bucher. *Other articles will be cited.

This article focused on the study of blaming the victim for sexual assault; the categories of sexual assault; rape myths; acquaintance rape vs. stranger rape; the attitudes that gender plays a role in these attacks; the situations in which sexual assault occurs; views on how appearance plays a role; how much force and resistance there was during an attack; how much the race and socioeconomic status plays a role in attacks; does the media and sexual objectification play a role in attacks; what role patriarchy has in sexual assaults; and 'rape culture.' There was no mention of numbers of rapes that have not been reported, due to assorted reasons. I would like to see a study on this which focuses on all the areas these researchers cited in their publication.

THE now ex-President of the United States, Barack Obama, addressed the trauma rape victims endure due to their assault, as well as the 'secondary trauma'

The results of this study concluded more research needs to be conducted in the people who commit these acts, the situation in which rape occurs, if blaming is based on diverse cultures, and why victim blaming is the "go to" in acquaintance rape.

The Categories of Sexual Assault

In this article, authors did not address adults versus adolescents, and they didn't address what type of 'acquaintances' perpetrators were. In *Types of Sexual Assault from the Women's and gender Center of Marshall University* (2020), they specifically describe sexual assault as:

- Rape—sexual intercourse against a person's will
- Forcible sodomy—anal or oral sex against a person's will
- Forcible object penetration—penetrating someone's vagina or anus, or causing that person to penetrate her or himself, against that person's will
- Marital rape
- Unwanted sexual touching
- Sexual contact with minors, whether consensual or not
- Incest (Sexual intercourse or sexual intrusion between family members.)
- Any unwanted or coerced sexual contact
- Sexual harassment

Victim Blaming Assignment:

- Solicitation of minors through the Internet
- Possession of child pornography

*Types of Sexual Assault - Women's & Gender Center (marshall.edu)

Acquaintance Rape vs. Stranger Rape

The number of sexual assaults reported is 1 out of every 5 women will be sexually assaulted during their lifetime. These are the same numbers reported in the University of New Hampshire article https://www.unh.edu/sharpp/rape-culture. Based on the university article, the numbers this article cite seem to be too low because their numbers are based on nationwide reports. I was not surprised that the victims reported the perpetrator was an acquaintance of theirs because these types of assaults are easier and more opportunistic. What I did notice is the age groups of the assaults was not cited.

In *About Sexual Assault*, National Sexual Violence Resource Center (NSVRC), they cite 1 out of 5 women have experienced rape or attempted rape during their lifetime (Black et al., 2011). In terms of acquaintance rape, three out of four 'adolescents' (74%) were victimized by an acquaintance and 1.5 were family members. https://www.nsvrc.org/about-sexual-assault#:~:text=Victims%20often%20know%20the%20person%20who%20sexually%20assaulted,they%20knew%20well%20%28Kilpatrick%2C%20Saunders%2C%20%26%20Smith%2C%202003%29.

In *Sexual Assault* (ACOG, Committee Opinion, N. 777, April 2019), the authors states rape and date rape are assaults by a person the victim knows. They statutory rape of consensual sex with someone younger than a specific age. 'Incest' is rape by a family member. Their scope of the study did not include childhood sexual abuse. Sexual Assault | ACOG.

The Attitudes That Gender Plays a Role in These Attacks

The article speaks to 'patriarchy' being a worldwide factor and there is a long-held belief that "sexual assault is motivated by power, with violence against women a function of gendered sex roles that support male domination and female exploitation" ("Blaming the Victim of Acquaintance Rape: Individual, Situational, and Sociocultural Factors" by Claire R. Gravelin1 *, Monica Biernat2 and Caroline E. Bucher, 2019).

In The Impacts of Gender Role Socialization on Health and Culture by Christopher Liang and Nicole L. Johnson (2019), the authors speak to the fact that socialization at an early age can amplify cultural problems as both boys and girls grown into

adulthood. Girls have been taught to be appeasing and attractive to men, which we all know through television ads, movies, videos, and social media.

The article goes on to state socialized behaviors can be the "fuel to violence against women." Boys have been taught to not show emotions, to be tough, to be aggressive and not take 'no' for an answer in every aspect of their lives. Authors have stated that men's suicide rates and drug addictions have increased. I can agree with what this article is saying because during a recent trip to a health store, there were men and adolescents (with their parents) who were buying 'performance enhancing vitamins and powdered drinks (supposed to be vitamin infused) because they are playing sports in their schools and as extracurricular activities. My thought was what are all these 'vitamins' doing to their brain and how many 'chemicals' are in these supplements, rather than vitamins?

When it comes to normalizing sex, these learned behaviors normalizes sexual assault behaviors. As we know, universities are ripe hunting ground for perpetrators who have received scholarships (sports) through political advocacy and social status, rather than academic abilities. The 'jocks' feel entitled to exhibit this criminal activity as a sort of 'rites of passage.'

Violence against women has been normalized in professional sports. From January 1, 2012, to September 14, 2014, 33 NFL players were arrested on charges involving domestic violence, battery, assault, and murder. 15 of those players were arrested for violence against women. (https://www.si.com/nfl/2014/09/11/nfl-players-arrested-domestic-violence-).

In 2017, the NFL reported 44 players had been accused or convicted of crimes involving sexual assault, sexual violence, domestic abuse, or rape (Famous NFL Players Still Playing Who Have Been Accused Of Domestic Or Sexual Assault (theodysseyonline.com). some NFL and NBA players have been accused of unlawful sexual contact with a minor, child pornography, and statutory sexual assault (Athletes and sports figures accused of sexual harassment or assault - New York Daily News (nydailynews.com). unfortunately, these articles support the theory the patriarchal society and adverse learned behaviors of boys and young men which can lead to the belief of 'entitlement' within the rape culture.

Appearance and Sexual History

The researchers state 32 studies included data on victims' appearance and sexual history and 15 studies manipulated some component of the data. In one study (Payne et al., 1999) perpetrators blamed myths of "It is usually only women that are dressed suggestively" and "A lot of women lead men on then cry rape."

Victim Blaming Assignment:

In 2019, Abigail Anaba updated an article she published in 2014, Research on the Relationship between Rape and Dressing - Anabagail (abigailanaba.com). She shares an article that states there are four categories of rape: sexual gratification, anger rape, power rape, and sadistic rape. Power rape is used when a person wants to have control and dominate another human being (Rathus, S.A., Nevid, J.S., and Fichner-Rathus, L. (2005). Human sexuality in a world of diversity (6th ed.) Boston, MA: Allyn and Bacon). The second issue she addresses is a woman's appearance. She cites an article that says 'yes,' a woman can be chosen because of something she wears. This is called 'Victim Precipitation Theory,' which we all recognize as victim blaming (Victim Precipitation Theories (what-when-how.com). She concludes her article by stating no matter what, rape is never the fault of the woman.

In another article, *More Than a Body*, author Lindsay Kite (2015, 2020) conducted a study and found that women are often 'objectified' as well as boys and men. Females have become so objectified until some consider them "objects to be bought and sold." She also states this kind of thinking supports the victim blaming mentality that puts the weight on women, everyone's definition of what is appropriate dressing is different, and objectification is not determined or dissuaded by the type of clothing that is worn (Female Objectification: Who's Really to Blame - More Than A Body).

Victim and Perpetrator Race

The author states extraordinarily little research has been done on race factors of rape. She only found five (5) research studies on this topic. She states this poses as a problem because more non-White women are victimized than White women. there was no significant difference on the assailant's race. In another study she cites, respectable Black victims were blamed less than 'party girls' and this was prominent when the perpetrator was Black versus White. White men who raped Black women or girls defense was the victim was a 'party girl' but Black men were judged harsher whether the girl was a 'good girl or party girl,' according to the defense (Dupuis, E. C., and Clay, J. A. (2013). The role of race and respectability in attributions of responsibility for acquaintance rape. Violence Vict. 28, 1085– 1095. doi: 10.1891/0886-6708.VV-D-12-00013).

In Race, Gender And Sexual Harassment (2018), NPR KQED's Lulu Garcia-Navarro interviewed Kimberle' Crenshaw and Anita Hill about the role race and gender had during the Ford-Kavanaugh hearings (Race, Gender And Sexual Harassment : NPR). Ms. Crenshaw was Ms. Hill's attorney when she accused Clarence Thomas of sexual harassment 27 years ago. This consensus was that race does play a significant part

in getting convictions of sexual assault against Black women. there have always been stereotypical views about the Black woman's body and sexualization.

Since this is Black History Month, I must speak to the objectification of Black women. an article was written by Christina Montford (2014) for the Atlanta Black Star newspaper titled *Fetishism of Black Women in Mainstream Culture Continues to Rage, Helped Along by Celebrities*. She asked questions as to why women are objectified, then cited an interview by *People Magazine* with the famous photographer, Jean-Paul Goude, who shoots many Black women and was obsessed with Grace Jones. He stated Blacks were the focus of his work due to the shapes of their bodies, because he has 'jungle fever.' He claimed he was not objectifying these women but allowing them to celebrate their sexuality (Fetishism of Black Women in Mainstream Culture Continues to Rage, Helped Along by Celebrities (atlantablackstar.com).

The article titled When Black Women Reclaimed Their Bodies: The fight for sexual justice during Reconstruction (Feimster, 2018) speaks about the fight Black women abolitionists and rights advocates fought for sexual justice in 1833. Their fight included recognizing women as fully human and not the 'property' of owners. They demanded the right to consent to sexual relationships and end the horrific practice of rape, sexual assault, and childbearing vessels (How formerly enslaved black women fought for human dignity and sexual justice. (slate.com).

Conclusion

I read this article several times and it seemed vague, and the conclusions of the study didn't seem to narrow down causation, only conjecture. It does not focus on types of rape (i.e., vaginal, anal, fondling, oral copulation, object, etc.) and only focuses on the 'word' rape.

There is much that needs to be researched on this subject matter because of all the different variables. One thing for sure is women and girls (some boys and men, too), are living in a pre-colonial domination world. Although we have the #MeToo movement, there is much to be done to rectify the damage that rape culture has done. This includes educating girls and women on changing their mindset as to what is considered 'sexy', not supporting some of these social media icons who encourage you to wear outfits that barely cover your nipples and pelvic region (which objectifies you), and education of caregivers on how to talk to their boys and girls about respecting each other from the cradle to adulthood.

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration

November 15, 2022

DHCS

Agenda

- Overview
- The CalBH-CBC Demonstration
  - Vision, Objectives and Approach
  - Continuum of Care
  - Populations of Focus
- Demonstration Approach
  - Demonstration Structure
  - Key Demonstration Components
  - Implementation Plan
- Next Steps

Overview: Section 1115 Demonstration Opportunity (1/2)

As part of CalAIM, California committed to pursuing a Section 1115 Demonstration to support adults with serious mental illness (SMI) and children and youth with serious emotional disturbance (SED). DHCS will submit the demonstration to the Centers for Medicare and Medicaid Services (CMS) following a robust stakeholder process.

- **CMS' 2018 guidance** permits states to use 1115 demonstrations to receive federal financial participation (FFP) for short-term care provided to Medicaid members living with SMI/SED in qualifying institutions for mental disease (IMDs), provided states establish a robust continuum of community-based care and enhance oversight of inpatient and residential treatment settings.*
- **California was the first state to obtain a similar waiver allowing IMD expenditure authority for SUD care provided in IMDs** in exchange for strengthening SUD services under the Drug Medi-Cal Organized Delivery System (DMC-ODS). DHCS intends to use this experience to design and implement the SMI/SED demonstration.

**Per CMS guidance, this Section 1115 opportunity is limited to short-term stays in psychiatric hospitals and mental health residential treatment settings, defined as stays that are no longer than 60 days, with a requirement for a statewide average length of stay of 30 days. See CMS State Medicaid Director Letter; CMS FAQ; CMS FAQ #2; CMS FAQ specific to QRTPs (applicable to many STRTPs).*

Overview: Section 1115 Demonstration Opportunity (2/2)

As part of CalAIM, California committed to pursuing a Section 1115 Demonstration to support adults with serious mental illness (SMI) and children and youth with serious emotional disturbance (SED). DHCS will submit the demonstration to the Centers for Medicare and Medicaid Services (CMS) following a robust stakeholder process.

- In October of 2021, **CMS created new flexibility to secure FFP for longer stays in Short Term Residential Therapeutic Programs (STRTPs) classified as IMDs** for youth in the child welfare system for a period of up to two years. States must submit a detailed plan with key milestones and timeframes for transitioning children out of STRTPs that are IMDs.
- DHCS has **released an external concept paper detailing the proposed approach** to the Section 1115 Demonstration for stakeholder feedback.

Demonstration: Vision and Objectives

DHCS' vision for the CalBH-CBC Demonstration is to ensure a robust continuum of community-based behavioral health care services is available to all Medi-Cal beneficiaries living with SMI and SED across the state.

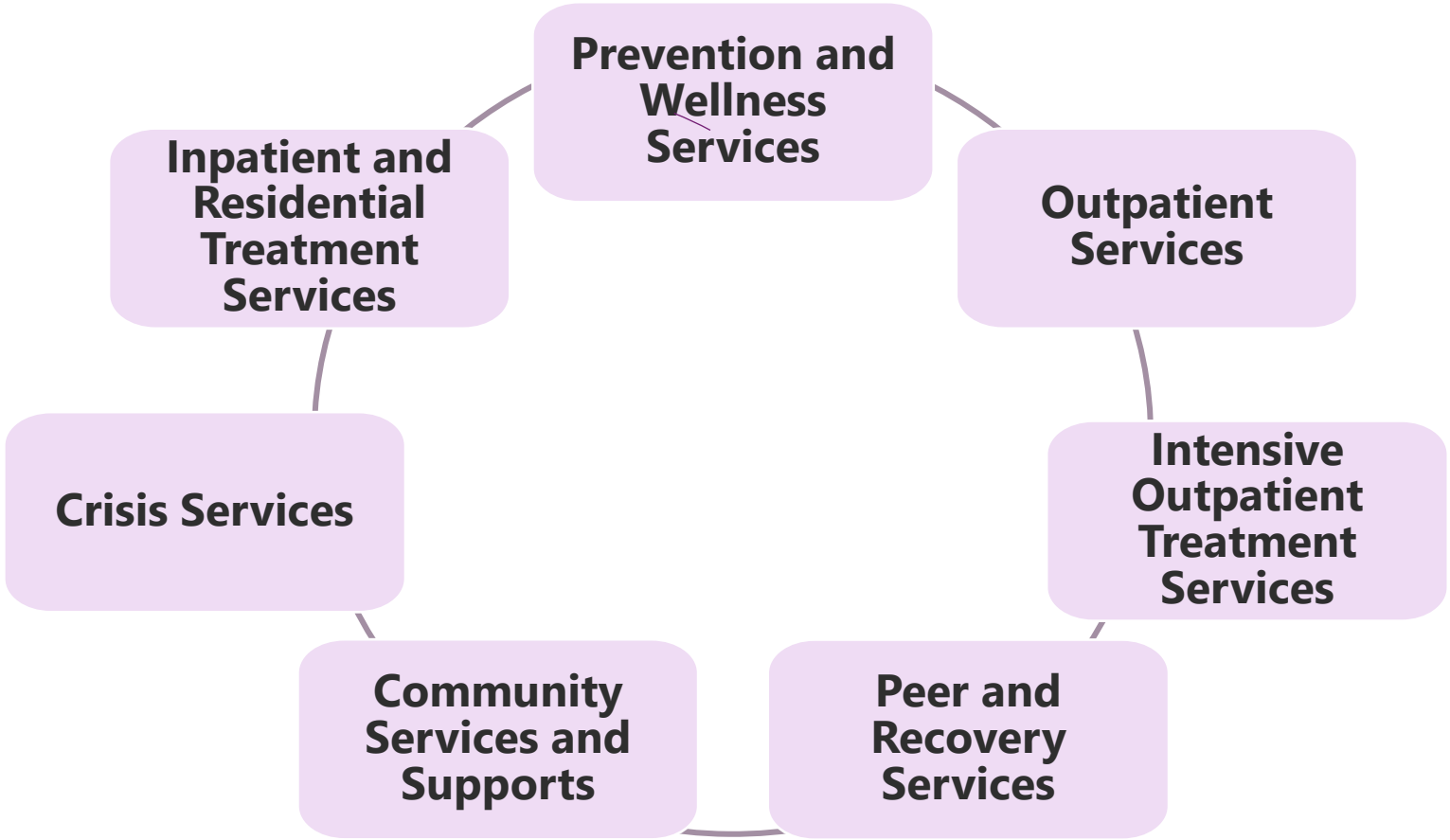
1. Amplify the state's ongoing investments in behavioral health and further strengthen the continuum of care.
2. Meet the specific mental health needs of children, individuals who are justice-involved, and individuals experiencing homelessness.
3. Ensure care provided in institutional settings is high-quality and time-limited.

Demonstration: Approach

- **Strengthen the statewide continuum of community-based services** and evidence-based practices available through Medi-Cal, leveraging concurrent funding initiatives, including clarifying coverage requirements for evidence-based practices for children and youth.
- **Support statewide practice transformations** and improvements in the county-administered behavioral health system to better enable counties and providers to strengthen the continuum of community-based services; to improve the quality of care delivered in residential and inpatient settings; and to strengthen transitions from these settings to the community.
- **Improve statewide county accountability** for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- **Establish a county option to enhance community-based services** through coverage of evidence-based practices that reduce the need for institutional care and improve outcomes.
- **Establish a county option to receive FFP for services provided during short-term stays in IMDs,** contingent on counties meeting robust accountability requirements; ensuring that care is provided in an institutional setting only when medically necessary and in a clinically appropriate manner; offering a full array of enhanced community-based services; and reinvesting new Medi-Cal funding into community-based care.

Demonstration: Continuum of Care (1/3)

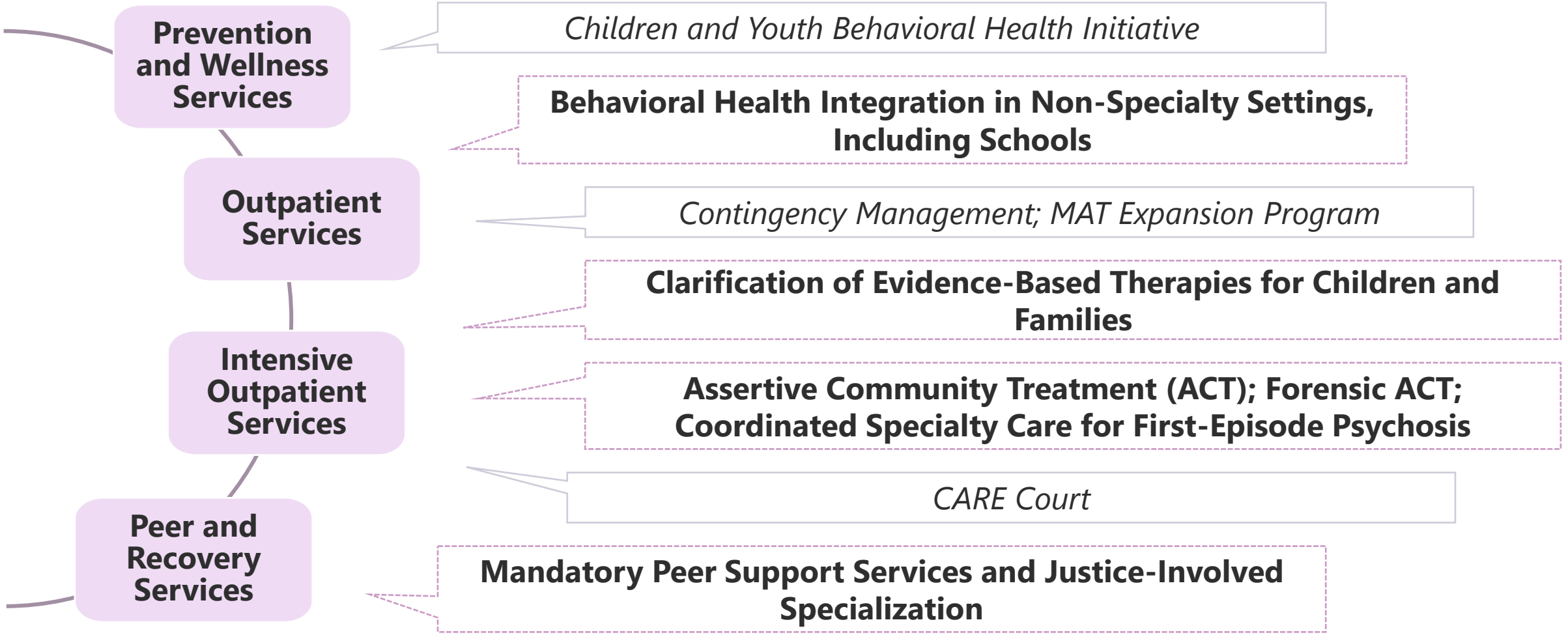
The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.*



*In following slides, proposed CalBH-CBC Demonstration initiatives are in **bold**; existing initiatives are *italicized*.

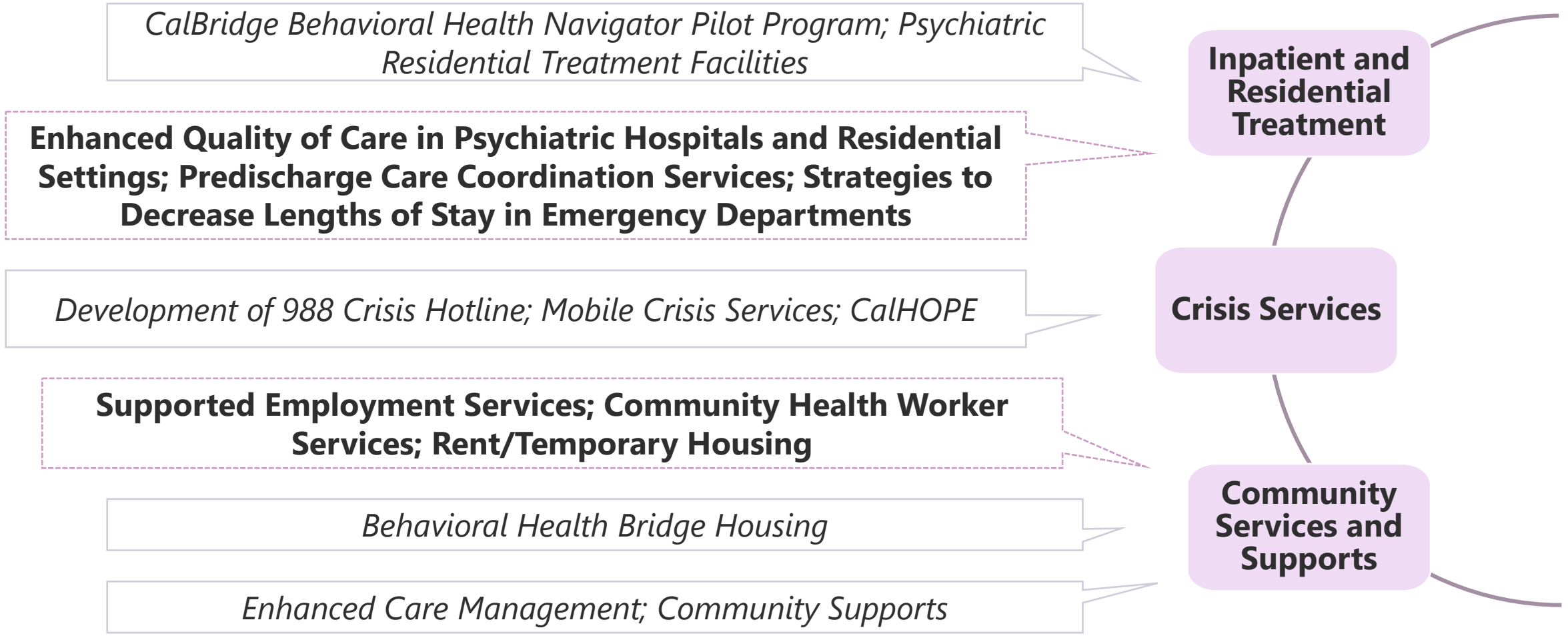
Demonstration: Continuum of Care (2/3)

The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.



Demonstration: Continuum of Care (3/3)

The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.



Demonstration: Populations of Focus (1/3)

In identifying the key elements of the demonstration, DHCS dedicated particular attention to the needs of populations that experience a disproportionate impact of behavioral health conditions. Some components will be implemented statewide, while others will be available at county option.

Children and Youth

- ✓ Clarify statewide service coverage requirements and issue guidance for specific evidence-based family and in-home therapies.
- ✓ Strengthen statewide, cross-agency coordination for youth in child welfare through a joint child welfare/specialty mental health behavioral health assessment and cross-sector incentive pool.
- ✓ Promote activity stipends for youth in child welfare to promote social and emotional well-being.

Demonstration: Populations of Focus (2/3)

In identifying the key elements of the demonstration, DHCS dedicated particular attention to the needs of populations that experience a disproportionate impact of behavioral health conditions. Some components will be implemented statewide, while others will be available at county option.

Individuals Experiencing or at Risk of Homelessness

- ✓ Establish new benefits to help beneficiaries find and keep employment and housing, including Community Health Worker services and Rent/Temporary Housing (for up to six months for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness).
- ✓ Incentivize counties to reduce homelessness among beneficiaries with SMI/SED.
- ✓ Coordinate with MCPs to connect beneficiaries to Community Supports, ECM and other initiatives.
- ✓ Strengthen behavioral health services for beneficiaries with severe impairments.

Demonstration: Populations of Focus (3/3)

In identifying the key elements of the demonstration, DHCS dedicated particular attention to the needs of populations that experience a disproportionate impact of behavioral health conditions. Some components will be implemented statewide, while others will be available at county option.

Individuals who are Justice-Involved

- ✓ Offer new services for individuals who are justice-involved, including Forensic Assertive Community Treatment, Peer Support Services with forensic specialization, and Rent/Temporary Housing (for up to six months for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness).
- ✓ Provide technical assistance to increase collaboration with law enforcement and collaborative courts, including CARE courts.
- ✓ Coordinate with other initiatives to support individuals who are justice-involved.

Demonstration Approach

Approach: Demonstration Structure (1/2)

DHCS proposes a two-pronged structure of the demonstration: statewide service improvements and supports and additional demonstration components available at county option.

Statewide Service Improvements and Supports

- **Clarification of evidence-based family and in-home therapies**. DHCS proposes to clarify coverage requirements and ensure access to specific evidence-based therapies for children and youth.
- **Targeted improvements for youth in child welfare**. DHCS intends to implement a cross-sector incentive pool, activity stipends, and an initial child welfare-specialty mental health assessment at the entry point into the child welfare system.
- **Statewide practice transformation.** Centers of Excellence, a statewide incentive program, promotion and standardization of quality of care in residential and inpatient settings, and other tools will help ensure beneficiaries receive the appropriate level of care.

Approach: Demonstration Structure (2/2)

DHCS proposes a two-pronged structure of the demonstration: statewide service improvements and supports and additional demonstration components available at county option.

Demonstration Components Available at County Option

- **Option to enhance community-based services.** Counties will have the option to offer new evidence-based practices, including Assertive Community Treatment, Forensic Assertive Community Treatment, Supported Employment, Coordinated Specialty Care for First Episode Psychosis, Community Health Worker Services, and Rent/Temporary Housing (see footnote on slide 6).
- **Option to receive FFP for short-term stays in IMDs.** Counties that agree to certain conditions can opt-in to receive FFP for short-term stays in IMDs contingent on:
    1. Complying with **all** statewide requirements (see previous slide);
    2. Implementing **all** new community-based services (see above); and
    3. Meeting other CMS requirements.

Approach: CMS Implementation Plan (1/3)

CMS has outlined a series of milestones that states and participating facilities must meet to receive IMD expenditure authority. In parallel with the demonstration application, DHCS will submit an implementation plan to CMS that explains how California will meet all CMS requirements building on the state's ongoing investments.

Statewide Milestones:

- **Interoperability.** Develop and enhance interoperability and data sharing.
- **Bed tracking.** Improve statewide capacity to track availability of inpatient and crisis stabilization beds.
- **Annual assessments**. Assessments of the availability of mental health services throughout the state.
- **Financing plan**. Plan to increase availability of non-hospital, non-residential crisis stabilization services.
- **Assessment tool**. Use of an evidence-based patient assessment tool to help determine appropriate level of care and length of stay.
- **Pre-discharge care coordination**. Participating IMDs provide intensive pre-discharge, care coordination services.
- **Housing transitions**. Assess the housing situation of individuals transitioning out of participating IMDs and connect with community services.

Approach: CMS Implementation Plan (2/3)

CMS has outlined a series of milestones that states and participating facilities must meet to receive IMD expenditure authority. In parallel with the demonstration application, DHCS will submit an implementation plan to CMS that explains how California will meet all CMS requirements building on the state's ongoing investments.

Statewide Milestones (cont.):

- **Utilization review.** MCOs ensure access to appropriate levels of care and ensure appropriate inpatient/residential admissions and lengths of stay.
- **Screen and assess comorbid conditions.** Screen for co-morbid physical conditions and SUDs.
- **Post-discharge contact.** Psychiatric hospitals and residential treatment settings must contact each discharged beneficiary within 72 hours of discharge.
- **Behavioral health integration.** Increase integration in schools and primary care settings.*
- **Children and youth.** Specialized settings and services for children and youth.*

**DHCS is already meeting milestones related to behavioral health integration and children and youth on a statewide basis through current initiatives and programs.*

Approach: CMS Implementation Plan (3/3)

CMS has outlined a series of milestones that states and participating facilities must meet to receive IMD expenditure authority. In parallel with the demonstration application, DHCS will submit an implementation plan to CMS that explains how California will meet all CMS requirements building on the state's ongoing investments.

Opt-In County Milestones:

- **Licensing and accreditation.** Participating IMDs are licensed and accredited by a nationally recognized entity.
- **ED Strategy.** Implement strategies to prevent or decrease lengths of stays in Emergency Departments.

Approach: Key Demonstration Components (1/2)

The demonstration may include the following initiatives. Many may be statewide while others may be implemented as part of a county option to offer an enhanced continuum of care and receive FFP for short-term stays in IMDs.

Strengthen Statewide Continuum of Community-Based Services

- ✓ Clarification of Coverage Requirements for Evidence-Based Practices for Children and Youth
- ✓ Cross-Sector Incentive Pool
- ✓ Activity Stipends
- ✓ Initial Child Welfare/Specialty Mental Health Assessment

Support Statewide Practice Transformations

- ✓ Statewide Centers of Excellence
- ✓ Statewide Incentive Program
- ✓ Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
- ✓ Promotion and Standardization of Quality of Care in Residential and Inpatient Settings

Improve Statewide County Accountability for Medi-Cal Services

- ✓ Transparent Monitoring Approach
- ✓ Establishment of Key Performance Expectations and Accountability Standards in County Mental Health Plan Contract
- ✓ Streamlined Performance Review Process

Approach: Key Demonstration Components (2/2)

The demonstration may include the following initiatives. Many may be statewide while others may be implemented as part of a county option to offer an enhanced continuum of care and receive FFP for short-term stays in IMDs.

County Option to Enhance Community-Based Services

- ✓ Assertive Community Treatment
- ✓ Forensic Assertive Community Treatment
- ✓ Supported Employment
- ✓ Coordinated Specialty Care for First Episode Psychosis
- ✓ Community Health Worker Services
- ✓ Rent/Temporary Housing*

County Option to Receive FFP for Short-Term Stays in IMDs

- ✓ FFP for Short Term Stays in IMDs
- ✓ Requirement to Provide All Enhanced Community-Based Services for Beneficiaries Living with SMI/SED
- ✓ Incentive Program for Opt-In Counties
- ✓ Other CMS Requirements

**For up to six months for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system.*

Next Steps

Demonstration: Next Steps

DHCS is committed to working with stakeholders to ensure the CalBH-CBC Demonstration is aligned with the needs of beneficiaries living with SMI/SED across the state.

- **Concept Paper Feedback.** Stakeholders are invited to submit written feedback to the CalBH-CBC Demonstration concept paper by email to CalBHCBC@dhcs.ca.gov by January 13, 2023. Please include "CalBH-CBC Demonstration Feedback" in the subject of the email.
- **Public Comment.** DHCS intends to release the CalBH-CBC Demonstration application for public comment following the concept paper feedback period.
- **Submission of Demonstration Application and Implementation Plan.** DHCS intends to submit the final CalBH-CBC Demonstration application and implementation plan to CMS following stakeholder review, CalBH-CBC Demonstration webinar sessions, and incorporating feedback received during public comment.

Questions?

Appendix

Context: Major Behavioral Health Initiatives

The CalBH-CBC Demonstration will complement and amplify ongoing state initiatives and investments in behavioral health care.

CalAIM Initiatives

- ✓ Justice-Involved Initiative
- ✓ Community Supports
- ✓ Enhanced Care Management
- ✓ Peer Support Services

CalAIM BH Initiatives

- ✓ Contingency Management
- ✓ BH Payment Reform
- ✓ No Wrong Door
- ✓ Screening and Transition Tools
- ✓ Updated SMHS Criteria
- ✓ Documentation Redesign
- ✓ DMC-ODS Renewal

2022-23 Budget

- ✓ Behavioral Health Bridge Housing
- ✓ MAT Expansion Program
- ✓ Complex Care Dollars for IST Populations
- ✓ CARE Court
- ✓ Mobile Crisis Services Benefit

Other Programs

- ✓ Psychiatric Residential Treatment Facilities
- ✓ Children and Youth Behavioral Health Initiative
- ✓ BH Continuum Infrastructure Program
- ✓ BH Integration Incentives Program
- ✓ Housing and Homelessness Incentive Program

Context: Crisis Initiatives

The CalBH-CBC Demonstration can help to link DHCS, CalHHS and other state partner initiatives across 988, mobile crisis services and other efforts into one coordinated statewide strategy for integrating a robust crisis continuum into the broader behavioral health continuum of care.

Crisis Call Center (988)

- ✓ CalHHS is leading a stakeholder process to support implementation of the 988 crisis call center line.

Mobile Crisis

- ✓ DHCS submitted a State Plan Amendment that establishes a new Medi-Cal mobile crisis services benefit in October 2022.*
- ✓ DHCS distributed BHCIP Round 1 funding for mobile crisis planning and implementation grants.

Crisis Receiving and Stabilization Services/Ongoing Crisis Treatment

- ✓ DHCS is proposing a practice change for crisis residential treatment to align with national standards.
- ✓ BHCIP Round 5 "Crisis Continuum" Request for Application available November 2022.

**Many counties already operate mobile crisis teams*

2022

The California Behavioral Health Community-Based Continuum Demonstration

EXTERNAL CONCEPT PAPER

NOVEMBER 2022

The California Behavioral Health Community-Based Continuum Demonstration

External Concept Paper

November 2022

Table of Contents

Introduction

As highlighted in the California Department of Health Care Services' (DHCS) comprehensive 2022 assessment of California's behavioral health landscape ***Assessing the Continuum of Care for Behavioral Health Services in California*** (2022 Assessment), California faces a growing crisis exacerbated by the COVID-19 pandemic.[1] Prior to the pandemic, the rate of serious mental illness (SMI) in California increased by 50 percent from 2008 to 2019.[2] As of 2019, nearly one in 20 (4.5 percent) adults in California was living with SMI, a rate expected to grow as more mid-to-post-pandemic data becomes available.[3] At the same time, one in 13 children in California was living with a serious emotional disturbance (SED), with rates of depression and suicide higher among youth who are low-income, Black, American Indian and Alaska Native, Latino, and LGBTQ.[4,5,6] Of particular concern is the approximately 25 percent of California residents with SMI who are experiencing homelessness and, therefore, at higher risk of justice involvement. Among incarcerated individuals, data suggest that close to one in three are living with an SMI.[7]

In the face of COVID-19, even more people are living with serious mental health or substance use disorders (SUDs) related to social isolation, economic hardship, loss of family members and other disruptions.[8] For children and youth, in particular, the pandemic has exacerbated mental health and SUD issues, prompting the American

---

[1] CDC, Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24-30, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm; CDC, National and State Trends in Anxiety and Depression Severity Scores Among Adults During the COVID-19 Pandemic — United States, 2020-2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7040e3.htm; CDC Drug Overdose Deaths in the U.S. Top 100,000 Annually, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[2] SAMHSA, California Behavioral Health Barometer Volume 6. https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf.

[3] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

[4] Holzer C and Nguyen H, "Estimation of Need for Mental Health Services." Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.

[5] "Native American Youth Depression and Suicide," Child Welfare Information Gateway, Department of Health & Human Services. Available at https://www.childwelfare.gov/topics/systemwide/diverse-populations/americanindian/wellbeing/depression/.

[6] Chapin Hall, Missed Opportunities: LGBTQ Youth Homelessness in America, https://voicesofyouthcount.org/wp-content/uploads/2018/05/VoYC-LGBTQ-Brief-Chapin-Hall-2018.pdf, April 2018.

[7] "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding," Californian Budget and Policy Center, March 2020. Available at https://calbudgetcenter.org/wpcontent/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[8] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. Available at https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

Academy of Pediatrics and other leading national associations to declare a public health emergency. Nationally, suicide rates among youth between the ages of 10 and 18 have increased, as has the rate for Black and Hispanic youth between the ages of 10 and 24.[9] In California, hospitals have reported a significant increase in the number of adolescents seeking psychiatric treatment in emergency departments (EDs) since the beginning of the pandemic.[10]

In response, the DHCS has made strengthening California's behavioral health system a top priority, particularly for individuals with the greatest needs. DHCS is making unprecedented investments in expanding behavioral health services, housing and social supports for individuals living with mental illness and/or an SUD. For Medi-Cal beneficiaries, these initiatives include a robust Medi-Cal initiative, California Advancing and Innovating Medi-Cal (CalAIM), which includes:

- the renewal of California's Section 1115 demonstration to provide a comprehensive continuum of care for SUD treatment through the Drug Medi-Cal Organized Delivery System (DMC-ODS);
- behavioral health payment reform;
- revamping the access criteria and process used to connect Medi-Cal beneficiaries to specialty mental health services (SMHS);
- adding new services for the most vulnerable beneficiaries, including Enhanced Care Management (ECM) and Community Supports; and
- other policies designed to improve access and increase quality of care.

In addition, DHCS will launch a new mobile crisis benefit and a new treatment for stimulant use disorder (contingency management) under Medi-Cal in 2023. However, significant gaps remain in the current continuum of care available to Medi-Cal members living with SMI/SED, particularly among children and youth (including those involved in child welfare), individuals who are experiencing or at risk of homelessness, and those who are justice-involved.

To help address these significant gaps, DHCS intends to apply for a new Medicaid Section 1115 demonstration to expand access to and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with SMI and SED.

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration aims to amplify the state's ongoing investments in behavioral health and further strengthen the continuum of care for Medi-Cal beneficiaries. It will take advantage of 2018 guidance from the Centers for Medicare & Medicaid Services (CMS)

[9] CDPH, "Suicide in California – Data Trends in 2020, COVID Impact, and Prevention Strategies," July 2021. Available at https://www.psnyouth.org/wp-content/uploads/2021/08/Suicide-in-California-Data-Trends-in-2020-COVID-Impact-and-Prevention-Strategies-Slide-Deck.pdf.

[10] Wiener, Jocelyn. "Stranded in the ER: Can California change its treatment of kids in crisis?" Cal Matters, September 27, 2021. Available at https://calmatters.org/health/2021/09/children-suicide-residential-treatment-crisis-california/.

that allows states to secure federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Disease (IMDs), designated psychiatric facilities with more than 16 beds, as long as they meet certain standards.[11] Consistent with California's priorities, these standards require that states build out their continuum of community-based care and ensure that the care provided in institutional settings is high-quality and time-limited. California's proposed goal for the CalBH-CBC Demonstration, based in large part on the findings from data and stakeholder perspectives described in the 2022 Assessment (Box 1),[12] is to strengthen the state's continuum of community-based behavioral health care services and to better meet the needs of Medi-Cal beneficiaries living with SMI and SED across the state.

Box 1: Key Issues and Opportunities Identified in California's 2022 Report *Assessing the Continuum of Care for Behavioral Health Services in California*[13]

- **Community-based treatment, including crisis care.** It is critical to have a comprehensive approach to behavioral health treatment that includes a robust continuum of crisis services (e.g., 988 Crisis Line, Mobile Crisis and CalHOPE) and emphasizes community-based treatment and supports (e.g., Supported Employment and linkages to Community Supports, affordable housing and permanent supportive housing), and prevention (e.g., Children and Youth Behavioral Health Initiative).
- **Children and youth.** More treatment options (e.g., multisystemic therapy) are vital for children and youth living with significant mental illness and SUDs, including those involved in child welfare (e.g., activity stipends).
- **Evidence-based practices.** More can be done to ensure that evidence-based and community-defined practices (e.g., Assertive Community Treatment) are used consistently and with fidelity.
- **Justice-involved populations.** Building a system to effectively address the behavioral health needs – and related housing, economic and physical health issues – of the most vulnerable, including individuals who are justice-involved (e.g., Forensic Assertive Community Treatment), at risk of or experiencing homelessness (e.g., rent), and severely impaired (e.g., Community Assistance, Recovery and Empowerment (CARE) Court) is critical.

[11] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[12] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California; Data, Stakeholder Perspectives, and Implications," January 10, 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

[13] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California; Data, Stakeholder Perspectives, and Implications," January 10, 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

The proposed demonstration approach also includes elements designed particularly for children and adolescents, adults who are experiencing or at risk of homelessness, and those who are justice-involved. Specifically, the demonstration aims to expand community-based services to transition-age youth and adults; provide family-based services and supports to high-risk children and youth; connect people living with mental illness and SUDs to employment, housing, and social services and supports; and reduce the risk of individuals entering the criminal justice system due to untreated mental illness. In addition, the proposed demonstration will provide counties with the option to receive FFP for short-term stays in IMDs if counties meet specified conditions to ensure they provide a robust continuum of community-based services and provide high-quality care in institutional settings when it is medically appropriate.

Box 2: Faces of the CalBH-CBC Demonstration

Sasha was diagnosed with schizophrenia as a young adult. She struggled with loneliness, depression and erratic behavior at home and at school. After her parent's divorce, she left home and began living on the street. Over the past five years, Sasha has frequently presented in the ED, has been arrested and detained in jails, and has received intensive psychiatric care, including inpatient hospitalization, residential treatment and 5150 stays. Often, she remains stable and on medication for a short period after leaving a facility, but without robust supports in the community, she sometimes stops taking her medication, and her condition destabilizes.

Through the CalBH-CBC Demonstration, Sasha will meet with a care coordinator before discharging from a short-term inpatient treatment stay. Her care coordinator can connect Sasha with an Assertive Community Treatment team who will be dedicated to supporting Sasha in managing her condition and living independently in the community. Together, they will be able to work on her continued treatment and goals. Sasha will be able to access supported housing, better manage her medication and begin job coaching offered as a Supported Employment service.

Through CalAIM, DHCS is building a Medi-Cal system that is standardized, simplified and focused on helping individuals live healthier lives. The CalBH-CBC Demonstration will complement the state's efforts to strengthen California's behavioral health continuum of care and improve access to mental health services.

This concept paper describes DHCS' proposed approach to the CalBH-CBC Demonstration, provides information about the 2018 CMS guidance that establishes the demonstration opportunity and describes key features of the proposed demonstration. **Stakeholders are encouraged to review the concept paper and provide comments via email to CalBHCBC@dhcs.ca.gov no later than January 13, 2023, to inform the development of the demonstration application.** Stakeholders also will have the opportunity to respond to and comment on a complete draft of the demonstration application before it is submitted to CMS.

Federal Demonstration Opportunity and Requirements

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration takes advantage of the Medicaid opportunity described in a November 2018 State Medicaid Director Letter (SMDL) detailing options to adopt innovative delivery system reforms for adults living with SMI and children living with serious emotional disturbance SED.[14] The SMDL describes how states can use existing authorities to improve care for these populations and outlines a new opportunity for Section 1115 demonstrations to support individuals living with SMI/SED.

The Section 1115 demonstration opportunity is focused on building out a full continuum of mental health services while also permitting states to secure FFP for services provided during short-term stays, defined as stays up to 60 days, in psychiatric hospitals or residential treatment settings that are considered IMDs.[15] In addition to excluding FFP for any part of any stay that exceeds 60 days, the Section 1115 demonstration opportunity also requires states to meet a statewide average length of stay of 30 days for all stays included in the demonstration.

CMS has recently allowed states to seek expenditure authority for services provided to children and youth involved in the foster care system in qualified residential treatment programs that are IMDs. These programs are referred to as short-term residential therapeutic programs (STRTPs) in California. There is an exemption on the length-of-stay limitations allowing residential treatment for up to two years. To obtain an exemption, states must provide CMS with a plan for transitioning children and youth out of STRTPs that are IMDs over a two-year period.[16]

CMS' goals for the demonstration opportunity include reduced utilization and lengths of stay in EDs among beneficiaries living with SMI/SED, reduced preventable readmissions to residential treatment settings, improved availability of crisis stabilization services, and improved care coordination and access to community-based services. In addition to the length-of-stay limitations referenced above, demonstration approval is contingent on states' provision of robust, evidence-based treatment options for community-based care and improved quality of care in various institutional settings, including a maintenance-of-effort requirement for community-based outpatient treatment, a strong crisis system, and appropriate oversight and monitoring of IMDs.

[14] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[15] Ibid.

[16] CMS, "Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements," October 19, 2021. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf.

States must also describe plans to meet additional milestones outlined by CMS in a formal implementation plan, described in more detail in the "Demonstration Implementation and Phasing" section below and included in Appendix 2.

Proposed CalBH-CBC Demonstration Approach

Through the CalBH-CBC Demonstration, California intends to strengthen the provision, coordination and integration of mental health and SUD services across the continuum by building on the federal requirements set forth in CMS' 2018 guidance. The demonstration approach reflects the state's ongoing commitment to ensuring that services are provided in the least restrictive setting appropriate for a beneficiary's needs. DHCS recognizes that a comprehensive continuum of community-based care for Medi-Cal beneficiaries living with SMI/SED, inclusive of housing supports and other community supports, ensures that residential care and inpatient care are available when medically necessary and clinically needed to stabilize and transition adults, children and youth to community-based care.

The proposed CalBH-CBC Demonstration includes five key components designed to strengthen the continuum of care available to Medi-Cal beneficiaries across the state with significant behavioral health needs. The five components – summarized below in Figure 3 and outlined in more detail in succeeding sections – are:

1. **Strengthening the statewide continuum of community-based services** and evidence-based practices available through Medi-Cal for individuals living with SMI or SED, leveraging concurrent funding initiatives, including clarifying coverage requirements for evidence-based practices for children and youth.
2. **Supporting statewide practice transformations** and improvements in the county-administered behavioral health system to better enable counties and providers to strengthen the continuum of community-based services and evidence-based practices; to improve the quality of care delivered in residential and inpatient settings; and to strengthen transitions from these settings to the community, including:
    - developing Centers of Excellence (COEs), as defined below;
    - offering incentives to counties for expanding quality improvement; infrastructure and improving performance on quality measures;
    - providing statewide tools to connect beneficiaries living with SMI/SED to appropriate care;
    - promoting and standardizing the quality of care in residential and inpatient settings; and
    - increasing coordination with wraparound supports and services, including housing supports.

3. **Improving statewide county accountability** for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance and oversight.

4. **Establishing a county option to enhance community-based services** through coverage of specific evidence-based practices that can reduce the need for institutional care and improve outcomes, particularly for individuals who are justice-involved or who are experiencing or at risk of homelessness. These services, which counties can cover on a voluntary, opt-in basis as indicated, include:

    - Assertive Community Treatment (ACT);
    - Forensic Assertive Community Treatment (FACT);
    - Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP);
    - Supported Employment;
    - Community Health Worker Services; and
    - Rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system.

5. **Establishing a county option to receive FFP for services provided during short-term stays in IMDs**, contingent on counties meeting robust accountability requirements. These requirements include ensuring that care is provided in an institutional setting only when medically necessary and in a clinically appropriate manner; that the county offers a full array of enhanced community-based services; and that the county reinvests any net new Medi-Cal funding into community-based care.

Specific features of the demonstration were designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI/SED (Figure 1). In identifying the key elements of the demonstration, DHCS also dedicated particular attention to the needs of populations that experience a disproportionate impact of behavioral health conditions, including children and youth, individuals who are experiencing or at risk of homelessness, and individuals who are justice-involved (Figure 2).[17] The proposed initiatives in the demonstration are also designed to benefit beneficiaries with the most severe impairments due to SMI and/or SUD, including those receiving services in Community Assistance, Recovery and Empowerment (CARE) Court. Through the CalBH-CBC Demonstration, DHCS intends to examine and address disparities in access and outcomes among American

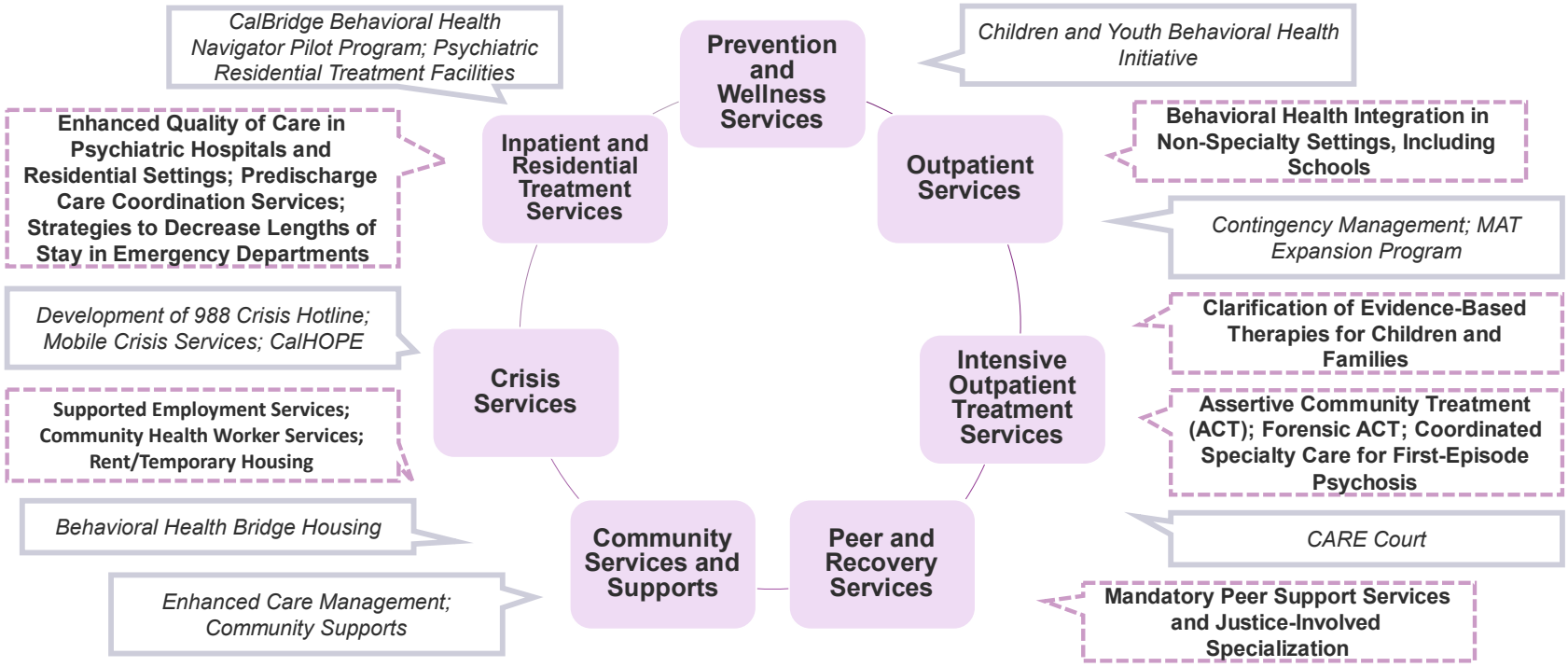
[17] The CalCBC Demonstration will not directly address individuals who are currently deemed Incompetent to Stand Trial (IST). Per CMS guidance, "FFP will not be available through these demonstrations for services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the facility by operation of criminal law." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Indian/Alaska Native individuals, Black individuals and other populations experiencing worse health outcomes and inequities related to race, ethnicity, gender identity, sexual orientation, age or other demographic features consistent with DHCS' Comprehensive Quality Strategy.[18] DHCS, for example, intends to incorporate strategies to address these disparities into performance measurement and incentive programs under the CalBH-CBC Demonstration.

[18] DHCS, "Comprehensive Quality Strategy," 2022. Available at https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf.

Figure 1: Building Out the Continuum of Care for Individuals Living with SMI/SED

Key: Proposed CalBH-CBC Demonstration initiatives are in **bold with purple outline.** *Existing initiatives are italicized.*



Note: This depiction does not identify all ongoing initiatives; additional details about California's other initiatives and investments in behavioral health are detailed in Appendix 1. Some of the proposed CalBH-CBC Demonstration features are specific to counties that opt in to receive FFP for care provided during short-term stays in IMDs.

Figure 2: Populations of Focus

Children and Youth	Individuals Experiencing or at Risk of Homelessness	Individuals Who Are Justice-Involved
• Clarify statewide service coverage requirements and issue guidance for specific evidence-based family and in-home therapies. • Strengthen statewide, cross-agency coordination for children and youth in child welfare through a joint Child Welfare/Specialty Mental Health behavioral health assessment and a cross-sector incentive pool. • Provide activity stipends for children and youth in child welfare to promote social and emotional well-being and counteract the harmful effects of trauma.	• Establish new benefits to help beneficiaries find and keep employment and housing, including Community Health Worker Services and up to six months of rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system. • Incentivize counties to reduce homelessness among beneficiaries living with SMI/SED. • Coordinate with Medicaid managed care plans (MCPs) to connect beneficiaries to Community Supports, ECM and other related initiatives. • Strengthen behavioral health services for people with severe impairments, including those served by CARE Court.	• Offer new services specifically for individuals who are justice-involved, including Forensic Assertive Community Treatment; Supported Employment; Peer Support Services, including services with forensic (e.g., justice-involved) specialization; and up to six months of rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness and leaving correctional settings. • Provide technical assistance to increase collaboration with law enforcement and collaborative courts, including CARE Court.[19] • Coordinate with other statewide initiatives to support individuals who are justice-involved, including Community Supports, Enhanced Care Management, CalAIM Justice-Involved initiatives, and mobile crisis services.

[19] Community Assistance, Recovery and Empowerment (CARE Court); more information available at https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf.

Figure 3: Key Components of the CalBH-CBC Demonstration Proposal

Key Demonstration Components				
Statewide			**County Options**	
Strengthen Continuum of Community-Based Services	**Support Practice Transformations**	**Improve Statewide County Accountability for Medi-Cal Services**	**Option to Enhance Community-Based Services**[20]	**Option to Receive FFP for Short-Term Stays in IMDs**

• Clarification of Coverage Requirements for Evidence-Based Practices for Children and Youth:
  ○ Multisystemic Therapy
  ○ Functional Family Therapy
  ○ Parent-Child Interaction Therapy
  ○ Potentially Additional Therapeutic Modalities
• Cross-Sector Incentive Pool for Foster Youth
	• Statewide COEs
	• Statewide Incentive Program
	• Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
	• Promotion and Standardization of Quality of Care in Residential and Inpatient Settings
		• Transparent Monitoring Approach
		• Establishment of Key Performance Expectations and Accountability Standards in County Mental Health Plan Contract
		• Streamlined Performance Review Process
			• ACT
			• FACT
			• Supported Employment
			• CSC for FEP
			• Community Health Worker Services[21]
			• Rent/Temporary Housing for Up to Six Months for Beneficiaries Who Meet the Access Criteria SMHS, DMC and/or DMC-ODS Services and Who are Homeless or at Risk of Homelessness, Including Individuals Transitioning from Institutional Care,
				• FFP for Short-Term Stays in IMDs
				• Requirement to Provide All Enhanced Community-Based Services for Beneficiaries Living with SMI/SED
				• Incentive Program for Opt-In Counties
				• Other CMS Requirements Related to Accreditation and ED Strategy

[20] For individuals under 21, counties already must provide all medically necessary services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. In addition, elements of many of these services are covered as part of existing Medi-Cal benefits even if they are not currently billed as a bundled service. The Cal BH-CBC Demonstration will not remove or reduce any existing requirements for covered benefits.

[21] To support county behavioral health outreach and engagement.

Key Demonstration Components				
Statewide			County Options	
Strengthen Continuum of Community-Based Services	**Support Practice Transformations**	**Improve Statewide County Accountability for Medi-Cal Services**	**Option to Enhance Community-Based Services**[20]	**Option to Receive FFP for Short-Term Stays in IMDs**
• Activity Stipends for Youth in Child Welfare • Initial Child Welfare/Specialty Mental Health Behavioral Health Assessment at Entry Point into Child Welfare			Leaving Incarceration, and Youth Transitioning Out of the Child Welfare System	

Strengthening the Statewide Continuum of Community-Based Services

The CalBH-CBC Demonstration aims to expand and strengthen the continuum of community-based care, especially for children, youth and their families. While a comprehensive set of community-based services for children and youth is currently coverable under Medi-Cal pursuant to the EPSDT mandate, DHCS intends to establish clear guidance to support implementation of specific evidence-based practices statewide. DHCS proposes clarifying statewide coverage requirements and ensuring access to at least three specific evidence-based services that can be delivered at home or in the community under current Medi-Cal coverage authority: multisystemic therapy, functional family therapy and parent-child interaction therapy. These services are known to help reduce the institutionalization of high-risk children and youth, including those who are involved in the juvenile justice system and those who have been removed from their homes, experienced homelessness, or confronted other major disruptions. DHCS' guidance will include specific service definitions, provider qualifications, implementation requirements and dedicated billing codes to incentivize provider delivery and monitor utilization and performance.[22] With the COEs, resources will be available to support county and provider implementation of these and other services with fidelity to service models, and reflecting cultural factors and the diversity of California children and youth.

1. **Multisystemic Therapy** (MST). MST is an evidence-based intensive family- and community-based intervention for children and young people aged 11-17 who are at risk of out-of-home placement in either care or custody due to a history of arrest or behavioral health issues. DHCS intends to issue guidance to counties that clarifies and streamlines Medi-Cal coverage of and reimbursement for MST as a bundled service for qualifying children and youth.[23]

2. **Functional Family Therapy** (FFT). FFT is a family-based prevention and intervention program for high-risk youth between the ages of 11 and 18 that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice.[24] DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for FFT.

3. **Parent-Child Interaction Therapy** (PCIT). PCIT is an evidence-based, short-term treatment designed to teach parents strategies that will promote positive behaviors in children and youth who exhibit disruptive or externalizing behavioral

[22] While these three services could be clarified as covered through other mechanisms, DHCS proposes to include coverage requirements as part of the CalBH-CBC Demonstration as part of meeting CMS expectations that SMI/SED demonstrations build out community-based care options.

[23] Currently, MST is billable under discrete components through SMHS covered in the Medi-Cal State Plan.

[24] FFT is coverable under the SMHS therapy benefit in the Medi-Cal State Plan.

problems.[25] DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for PCIT.

In addition, the CalBH-CBC Demonstration may request authority from the federal government to make targeted improvements statewide for children and youth who are involved in the child welfare system. A substantial share of such children and youth have or are at risk of developing significant behavioral health conditions, both due to being removed from their homes and due to the circumstances that led to the removal.[26] With the goal of identifying improvements in the system of care for children and youth in child welfare, the California Department of Social Services (CDSS) and DHCS hosted a Foster Care Model of Care Workgroup between June 2020 and April 2021. While the CalBH-CBC Demonstration is not intended to serve as a vehicle for implementing a comprehensive approach to responding to these recommendations, it does propose to carry out a number of recommendations delivered by the workgroup.[27] DHCS intends to work with stakeholders to further consider how to best address the needs of children and youth in the child welfare system.

- **Cross-Sector Incentive Pool.** Given the complex and overlapping systems that serve children and youth in the child welfare system, DHCS proposes to establish a cross-sector incentive pool to collectively reward MCPs and county behavioral health and child welfare agencies for meeting specified outcome measures for children and youth in the child welfare system.[28] This cross-sector pool will incentivize the three systems to work together to address the needs of foster children and youth in their communities and address concerns about cross-sector accountability. Based on the initial implementation experience with children and youth in the child welfare system, DHCS may seek to expand this pool to promote improved outcomes and accountability for children and youth involved with juvenile justice and the Department of Developmental Disabilities. To facilitate shared accountability among the three systems, DHCS and CDSS may require contract changes and a Memorandum of Understanding to ensure MCPs and county behavioral health and child welfare agencies share data and work together to improve outcomes. As part of these contract changes, MCPs would be required to have a dedicated Foster Youth Liaison on staff to enable

[25] PCIT is coverable under the SMHS therapy benefit in the Medi-Cal State Plan.

[26] Polihronakis, Tina, "Information Packet: Mental Health Care Issues of Children and Youth in Foster Care," April 2008. Available at http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Mental_Health.pdf.

[27] DHCS, "Foster Care Model of Care Workgroup." Available at https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx.

[28] To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

effective oversight and delivery of Enhanced Care Management (ECM). The Foster Care Liaison would have expertise in child welfare services, county behavioral health services, and other sectors; ensure appropriate ECM staff attend child and family team meetings; and ensure managed care services are closely coordinated with other services. The Foster Care Liaison would be a management-level position at the MCP with responsibility to oversee the ECM providers with foster care children and youth in their caseload, provide technical assistance to MCP staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with county and community partners.

- **Activity Stipends.** Many children and youth in child welfare do not have access to the activities that support physical health, mental wellness, healthy attachment and social connections – all protective factors that promote resilience and prevent mental illness and substance use. In response, DHCS intends to develop a new benefit for children aged 3 and older in the child welfare system to be used for activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma.[29] These payments would support activities not otherwise reimbursable in Medi-Cal, such as mindfulness-based stress reduction, movement activities, sports, leadership, nature activities, music and art programs, and other activities to support healthy relationships with peers and supportive adults. DHCS intends to request federal expenditure authority to support the activity stipends in the CalBH-CBC Demonstration application, which will be administered by the CDSS and county child welfare agencies.

- **Initial Child Welfare/Specialty Mental Health Assessment at Entry Point into Child Welfare.** As part of the Foster Care Model of Care Workgroup, the County Behavioral Health Directors Association and the County Welfare Directors Association proposed a joint home visit with the child welfare worker and a specialty mental health provider for every child or youth entering the child welfare system. DHCS proposes that a specialty mental health provider accompany the child welfare worker during the home visit, approximately 30 days following a hotline call, after a hearing substantiating an allegation of abuse or neglect, and upon the child's entry into the child welfare system. The specialty mental health provider would do a comprehensive behavioral health assessment to identify mental health and/or substance use conditions related to the child and/or the family, identify necessary social supports, and then connect the child and family

[29] To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

(both the biological family and the resource family, as appropriate) to any needed clinical or community services. As part of the CalBH-CBC Demonstration, DHCS proposes to develop standards and requirements for the behavioral health assessment and cross-agency collaboration.

Supporting Statewide Practice Transformations

DHCS recognizes that successful implementation of the proposed CalBH-CBC Demonstration will require significant new investments in workforce capacity, service infrastructure, information technology and data exchange at the county behavioral health plan and provider levels. Moreover, it is important to offer tools that help Medi-Cal beneficiaries living with SMI/SED find and use the appropriate treatment options. The CalBH-CBC Demonstration proposes to seek federal expenditure authority to fund statewide COEs, a statewide county behavioral health incentive program and tools to help ensure that beneficiaries are connected to the appropriate level of care. A separate incentive program available only to counties that opt to receive FFP for short-term stays in IMDs is discussed in the "County Option to Receive FFP for Short-Term Stays in IMDs" section below.

- **Statewide COEs.** DHCS proposes to establish and fund COEs to provide training and technical assistance to providers and counties on demonstration implementation. COEs can provide orientation, training, coaching, mentoring, fidelity monitoring and other supports needed to build and sustain capacity in delivering evidence-based practices through a culturally sensitive lens. For example, DHCS anticipates that COEs may provide support to counties and providers in delivering evidence-based practices for children and youth,[30] ACT/FACT services, Supported Employment, crisis services and other evidence-based practices (e.g., motivational interviewing, motivational enhancement therapy, suicide prevention). DHCS will engage stakeholders on opportunities to incorporate community-defined practices and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services, given the rich diversity in California's communities. One or more COEs might be established to support implementation of CARE Court in the context of the CalBH-CBC Demonstration, focused on ensuring CARE Court participants receive robust, evidence-based behavioral health services. Establishment of COEs will be aligned with other efforts to deliver training and supports to enhance delivery of evidence-based practices and community-defined practices, such as grant funding through the Children and Youth Behavioral Health Initiative.

[30] Evidence-based practices for children and youth may include services for which coverage and billing will be clarified, such as MST, FFT, and PCIT, as well as services for which coverage and billing is already clarified, such as Intensive Care Coordination.

- **Statewide Incentive Program.** DHCS recognizes the need for investments in county behavioral health plans to improve equity, quality and access to care for beneficiaries with behavioral health needs. As part of the CalBH-CBC Demonstration, DHCS intends to incentivize MHPs and DMC-ODS counties to build a robust quality improvement program, to improve performance on quality measures, and to reduce disparities in access and outcomes.

  All counties will be eligible to receive financial incentives based on their work to establish a robust quality infrastructure (e.g., integrating processes that allow it to assess and adjust provider availability and services to address the cultural, ethnic, racial, and linguistic needs and preferences of its members). In addition, after an initial period of quality infrastructure incentive opportunities, counties will later be able to receive financial incentives for demonstrating specific performance improvements. County performance improvement measurements will be based on various behavioral health-related quality measures included in the DHCS Comprehensive Quality Strategy (CQS)[31] Section 1915(b) Special Terms and Conditions[32] and Section 1115 SMI/SED Monitoring Protocol (DHCS' SMI/SED Monitoring Protocol, which must be developed by DHCS and approved by CMS in advance of demonstration implementation).[33,34] Performance improvement measurements will also include rates specific to populations experiencing disparities in behavioral health care access and outcomes, specifically children and youth; individuals who are justice-involved; individuals experiencing or at risk of homelessness; the LGBTQ+ population; and American Indian individuals, Black individuals and other populations experiencing disparities as identified in DHCS' Health Equity Roadmap.[35]

  Design features of this new statewide incentive program will be aligned with other DHCS incentive programs, such as the MCP baseline quality rate adjustment scoring methodology.

- **Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care.** Along with building out the continuum of care, it also is important to help identify the appropriate level of care for Medi-Cal beneficiaries and to connect them to treatment. As highlighted in the 2022 Assessment, it is

[31] DHCS, "DHCS Comprehensive Quality Strategy." Available at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx.
[32] "California Advancing & Innovating Medi-Cal (CalAIM) Waiver Special Terms and Conditions." Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-stc.pdf.
[33] "1115 Demonstration State Monitoring & Evaluation Resources," Medicaid.gov. Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html.
[34] "Monitoring Metrics for Section 1115 Demonstrations with SMI/SED Policies," Medicaid.gov. Available at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-monitoring-metrics.pdf.
[35] DHCS, "DHCS Comprehensive Quality Strategy." Available at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx.

unacceptable for anyone living with SMI or SED to wait days or weeks for treatment for urgent matters. As required by the 2018 CMS guidance and the CMS Implementation Plan, DHCS intends to use the CalBH-CBC Demonstration to review the required use of standardized, evidence-based level-of-care tools and develop resources to help individuals who require inpatient treatment find an appropriate facility.

  - **Patient Assessment Tool.** DHCS proposes to build on the current SMHS requirement for using the Child and Adolescent Needs and Strengths (CANS) tools for children and youth aged 6-20 for performance data reporting purposes to help guide level-of-care determination and inform treatment planning for select intensive SMHS, including a stakeholder input process. For adults, aligned with requirements in Medi-Cal managed care, DHCS anticipates allowing county MHPs to choose from among available evidence-based assessment tools to guide level-of-care and length-of-stay determinations for mental health inpatient and residential treatment services (e.g., Level of Care Utilization System (LOCUS), InterQual or Milliman Clinical Guidelines (MCG)). CMS has instructed states to require providers and plans to use an evidence-based, publicly available patient assessment tool to help determine appropriate level of care and length of stay.[36]
  - **Treatment Bed Availability Platform.** To meet the CMS requirement to improve its capacity to track the availability of inpatient and crisis stabilization units, DHCS is exploring options to track the availability of inpatient and crisis stabilization beds on a statewide basis, making it easier to help people who require higher levels of care to find appropriate treatment options more quickly.[37]

- **Promotion and Standardization of Quality of Care in Residential and Inpatient Settings.** DHCS proposes to build on CMS Implementation Plan requirements and use the CalBH-CBC Demonstration as an opportunity to ensure that all residential and inpatient facilities, including IMDs, provide care consistent with clinical and quality standards for utilization, integrated care, and care transitions. Clinical standards of care stipulate that residential and inpatient treatment providers identify and ensure that their patients' comorbid physical and/or SUD needs are treated. They also require that residential and inpatient care are used when clinically indicated, for only as long as needed to prepare individuals to transition to community-based care. To achieve these goals, DHCS intends to require all mental health inpatient and residential facilities to screen

[36] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.
[37] Ibid.

and address beneficiaries' comorbid physical conditions and SUDs either directly or through the facilitation of referrals.

DHCS is committed to ensuring that individuals who are ready for discharge from inpatient and residential treatment are supported during the transition and connected to community-based services and supports, including housing. DHCS proposes to require all mental health and residential facilities and counties to meet CMS requirements related to employing a utilization review process to ensure access to appropriate levels of care and appropriate inpatient/residential admissions and length of stay, conducting intensive predischarge care coordination, incorporating housing needs during discharge planning and making referrals to community services before discharge, and following up with beneficiaries within 72 hours of discharge. In addition, as part of the demonstration, DHCS proposes adding a new county option to provide up to six months of rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness after receiving treatment in an institutional setting, further supporting counties' efforts to assist individuals in finding housing.

Improving Statewide County Accountability

DHCS plans to work with counties to strengthen the community-based care continuum, supporting behavioral health delivery system transformation through incentives, robust technical assistance and oversight. In partnership with counties and other stakeholders, DHCS proposes to design a transparent monitoring approach to ensure that an array of community-based care options are available and accessible to beneficiaries. The approach is expected to include clear expectations for providers, counties and DHCS, and to allocate resources in a way that reflects these expectations. The goal is to pair incentives and support with clear expectations and accountability to improve performance and better serve Medi-Cal beneficiaries.

Specifically, DHCS anticipates amending the county MHP contract to (1) establish key performance expectations and accountability standards, (2) build on goals and standards included in the state's Medi-Cal Comprehensive Quality Strategy and other quality and evaluation initiatives, and (3) outline incentive payment opportunities. For example, DHCS may amend the contract to include demonstration-related coordination requirements with the MCPs and other entities; new reporting requirements; and network adequacy requirements beyond those already in place, with associated penalties for noncompliance, consistent with DHCS sanction policies. Using measure reporting and on-site reviews, DHCS also envisions streamlining and enhancing its performance review process. DHCS is working toward a multiyear plan to transition from triennial SMHS to biennial to annual reviews over a five-year timeline. For example, counties may be required to report on new measures across key domains that align with the state's demonstration goals, including:

- increasing use of community-based behavioral health care, particularly for children and youth in child welfare and justice-involved individuals;
- diverting individuals experiencing crisis from EDs (as clinically appropriate), juvenile halls and jails;
- effective collaboration and support for Medi-Cal beneficiaries who become CARE Court respondents;
- improving coordination with MCPs for children involved in child welfare;
- addressing the behavioral health needs of individuals experiencing homelessness;
- improving beneficiary experiences;
- decreasing use of longer-term residential and acute inpatient treatment;
- making improvements in supporting individuals in the least restrictive, most independent and community-based setting that appropriately meets their needs; and
- strengthening provider networks.

As detailed above, DHCS also proposes to provide significant support to counties and providers through investments in training and technical assistance through the development of COEs and incentive programs. Finally, after other oversight approaches have been exhausted, DHCS may also utilize corrective action plans (CAPs) and sanctions for persistent gaps in performance, consistent with existing policies.

County Option to Provide Enhanced Community-Based Services

Under the proposed CalBH-CBC Demonstration, all counties will have the option to provide one or more important, evidence-based, community-based services to the extent not already covered or required to be covered under EPSDT. (As noted below, if a county opts in to receiving FFP for short-term stays in IMDs, it will need to provide all of these services.) The new services, including ACT, FACT, Supported Employment, CSC for FEP, Community Health Worker Services and rent/temporary housing,[38] offer important support to individuals with behavioral health needs and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system. These are established, evidence-based practices that can reduce the need for institutional care and improve outcomes, including for individuals who are justice-involved or who are experiencing or at risk of homelessness.[39]

[38] Rent/temporary housing services will be available for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system.

[39] "Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration," Judge David L. Bazelon Center for Mental Health Law, September 2019. Available at http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf.

While components of ACT, FACT and CSC for FEP are currently coverable under Medi-Cal, DHCS proposes to cover each treatment as a bundled service to ensure they are fully reimbursable under Medi-Cal, to ensure access to these services as a Medi-Cal benefit, and to improve performance monitoring and visibility into service utilization. In parallel with the CalBH-CBC Demonstration, DHCS intends to submit a State Plan Amendment (SPA) authorizing county MHPs to deliver ACT, FACT, and CSC for FEP and Community Health Worker Services.[40] Similar to current Medi-Cal coverage of Peer Support Services, these benefits will be available as a county option. DHCS proposes to cover Supported Employment and rent/temporary housing through Section 1115 Demonstration authority. Consistent with current guidance, DHCS will clarify that beneficiaries under age 21 are entitled to receive all medically necessary services that are coverable under the State Plan, regardless of whether the beneficiary under the age of 21 resides in a county that chooses to cover these services on a voluntary basis.

- **ACT.** ACT provides a person-centered, comprehensive approach to care for individuals living with SMI, using a multidisciplinary team that typically consists of a psychiatrist, a nurse, case managers, peers and other professionals. ACT is widely considered to be one of the most robust community-based and cost-effective treatment options that can reduce institutional care and support individuals living with SMI who are at risk for involvement in the criminal justice system and for homelessness.[41] As of 2018, 33 states cover ACT as a Medicaid benefit.[42] In California, counties operate a similar model through Full Service Partnership (FSP) teams funded by the Mental Health Services Act (MHSA). While FSP teams provide a multidisciplinary approach to mental health care, they may not always operate with full fidelity to the evidence-based ACT model (e.g., not operating with clinical caseload, interdisciplinary team composition, frequency of team meetings and/or service availability consistent with the service model). Robust support and monitoring are essential for verifying that teams are delivering services in accordance with fidelity standards and facilitating intended outcomes for ACT services. By including ACT as a required benefit for opt-in counties, DHCS can optimize FFP for ACT services and help ensure that the

[40] To support county behavioral health outreach and engagement..
[41] SAMHSA. ACT EBP Kit. Available at https://store.samhsa.gov/sites/default/files/d7/priv/theevidence_1.pdf.
[42] Kaiser Family Foundation. “Medicaid Behavioral Health Services: Assertive Community Treatment.” Available at https://www.kff.org/medicaid/state-indicator/medicaid-behavioral-health-services-assertive-community-treatment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

model is offered with fidelity.[43] ACT, along with FACT, also will be an important part of the services to which participants in CARE Court are likely to be referred.

- **FACT.** FACT builds on the evidence-based ACT model by making adaptations based on criminal justice issues – in particular, addressing criminogenic risks and needs.[44] FACT has been shown to improve the functioning of individuals who are enrolled in the treatment, as well as to reduce hospitalizations, homelessness, incarceration, and violations of probation and parole. In opt-in counties, FACT can complement parallel initiatives designed to better meet the health care needs of the justice-involved population, such as the CalAIM Justice-Involved Initiatives, the California Health and Human Services Agency (CalHHS) Incompetent to Stand Trial Workgroup, and Assembly Bill 1976.[45]

- **CSC for FEP.** CSC for individuals experiencing FEP is an evidence-based practice that has demonstrated improved outcomes for youth and young adults following an initial psychotic episode. Young adults participating in CSC programs experience significantly greater symptom reductions, fewer hospitalization episodes, and better school and work participation compared with those in usual treatment for early psychosis.[46] Most CSC programs currently operated in California counties are underwritten using Substance Abuse and Mental Health Services Administration (SAMHSA) funds, or MHSA or other state and local funds, and philanthropic contributions to supplement what is reimbursable by Medi-Cal. By including CSC for FEP in opt-in counties, California can dramatically improve the lives of individuals who often feel terrified and hopeless when confronting an initial psychotic episode.[47] This initiative would be coordinated with the Children and Youth Behavioral Health Initiative to ensure that work in this area is synergistic and not duplicative, particularly if CSC for FEP is chosen by the expert task force as one of the prioritized, evidence-based treatments.

- **Supported Employment.** Supported Employment is an evidence-based practice that helps individuals living with SMI obtain and maintain paid competitive jobs through vocational assessment, job-finding assistance and job skills training. It has been shown to reduce health care costs and to help keep individuals stably

[43] Many components of ACT are coverable under the Medi-Cal State Plan via existing benefits such as therapy or medication support services. Section 1115 authority would allow DHCS to cover ACT as a bundled service and include vocational services.

[44] SAMHSA, "Forensic Assertive Community Treatment." Available at https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf.

[45] Assembly Bill No. 1976, September 29, 2020. Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1976.

[46] Srihari VH et al., "First-Episode Services for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial," Psychiatric Services, February 2, 2015. doi:0.1176/appi.ps.201400236. 66(7), 705-712.

[47] Many components of CSC are coverable under the Medi-Cal State Plan using existing benefits like targeted case management and medication support services. Section 1115 authority would allow DHCS to cover CSC as a bundled service and include vocational services.

housed by ensuring they have access to regular income.[48] Currently, some counties directly fund Supported Employment for some individuals living with SMI/SED and/or SUD, but it is not a Medi-Cal reimbursable service, and therefore counties are not able to leverage federal funding to expand access.[49] In addition, DHCS intends to seek authority to provide stipends to individuals who have experience with the criminal justice system and are reentering the community to encourage their ongoing participation in and completion of Supported Employment services, and promote community integration and improved outcomes.

- **Rent/Temporary Housing.** Housing supports, including services that help individuals find, move into and retain housing, are critical to the treatment and recovery of individuals living with serious behavioral health conditions. As part of the CalBH-CBC Demonstration, DHCS proposes to allow counties to cover rent/temporary housing for up to six months for certain high-need beneficiaries. Beneficiaries must meet the access criteria for SMHS, DMC and/or DMC-ODS services and be homeless or at risk of homelessness. This can include individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, inpatient and residential treatment facilities, and acute care hospitals from stays attributable to a mental health condition or substance use disorder; transitioning out of a correctional facility; or transitioning out of the child welfare system. Coverage of rent/temporary housing through the CalBH-CBC Demonstration will build upon other housing supports available through MCPs as Community Supports services, including housing transition navigation services, housing deposits to assist with one-time expenses, and housing tenancy and sustaining services. Rent/temporary housing services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria.

- **Community Health Worker Services.** Through the CalBH-CBC Demonstration, DHCS proposes to cover Community Health Worker Services as an optional service that counties can opt in to cover. The optional Community Health Worker Services benefit will support county behavioral health providers to perform outreach and support engagement of beneficiaries in behavioral health prevention and treatment services.

County Option to Receive Federal Financial Participation for Short-Term Stays in IMDs

As part of the CalBH-CBC Demonstration, counties that agree to certain conditions ("opt-in counties") can opt to receive FFP for services provided during short-term stays

[48] Bon, Gary and Robert Drake. "Making the case for IPS supported employment," Adm Policy Ment Health. 2014 Jan;41(1):69-73. doi: 10.1007/s10488-012-0444-6. PMID: 23161326.

[49] Other states, including Illinois, Washington and Maryland, have similarly used the SMI/SED demonstration opportunity to add Supported Employment as a covered benefit.

in IMDs consistent with applicable requirements described in federal guidance. To participate, a county must agree to cover the enhanced set of community-based services described above, reinvest dollars generated by the demonstration into community-based care (described in more detail in the "Demonstration Financing and Reinvestment" section below), and meet robust accountability requirements to ensure that IMDs are used when medically necessary and provide high-quality care. DHCS also intends to request authority in the CalBH-CBC Demonstration to establish an incentive program for opt-in counties that can be used to help counties and providers prepare for and sustain the implementation of demonstration features. In addition, as part of the implementation planning process (described in more detail in the "Demonstration Implementation and Phasing" section below), opt-in counties must demonstrate that beneficiaries have sufficient access to current SMHS benefits. A key condition for participation will be the proven availability of community-based services covered as SMHS so that the expansion of Medi-Cal coverage for inpatient and residential treatment provided in IMDs under this waiver facilitates access to such care only when medically necessary and clinically appropriate, and does not result in overutilization or inappropriate use of institutional care as a result of lack of access to community-based services.

- **FFP for Short-Term Stays in IMDs.** Opt-in counties may be able to secure FFP for the cost of Medi-Cal services provided to beneficiaries in IMDs during short-term stays.[50] To date, CMS has determined that a short-term stay covered under the demonstration can be no more than 60 days and that the statewide average length of stay must be no more than 30 days in participating IMDs. (There can be temporary exceptions for children and youth in STRTPs; these facilities would not be included in the calculation of the statewide average for a two-year period). Even under a demonstration, CMS will not cover the cost of room and board associated with the stay unless the setting qualifies as an inpatient facility under section 1905(a) of the Social Security Act. In addition, CMS guidance clarifies that FFP is not available for services provided in nursing homes that qualify as IMDs, nor for services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the IMD facility by operation of criminal law.[51]
- **Requirement to Provide All Community-Based Services for Beneficiaries Living with SMI/SED.** DHCS proposes requiring opt-in counties to cover all of

[50] Only beneficiaries whose County of Responsibility is an opt-in county will be able to access these services when medically necessary and clinically appropriate. FFP will not be available for services provided to beneficiaries in IMDs whose County of Responsibility does not opt in to this opportunity. For example, a county that does not opt in will not be able to receive FFP for services provided in an IMD to their residents, regardless of whether the IMD is located within another county that opts in. This is how the DMC-ODS program works today.

[51] DHCS continues to seek federal approval to cover a targeted set of Medi-Cal services during a 90-day period prior to release from prisons, jails and youth correctional facilities and improve care management through reentry as part of the CalAIM Justice-Involved Initiative. The CalAIM Justice-Involved Initiative does not propose to cover services provided in IMDs.

the enhanced community-based services described above, specifically ACT, FACT, CSC for FEP, Supported Employment, Community Health Worker Services, and rent/temporary housing. In addition, DHCS proposes requiring all opt-in counties to cover Peer Support Services, including for individuals who are justice-involved, through the Peer Support Specialist Certification Program with a forensic (i.e., justice-involved) area of specialization.[52]

- **Incentive Program for Opt-In Counties.** Opt-in counties may need to make significant investments to meet the requirements for receiving FFP for IMDs, including building networks for required benefits, conducting oversight of participating IMDs, and meeting other state and federal requirements. As part of the CalBH-CBC Demonstration, DHCS proposes implementing an incentive program for opt-in counties to support county MHPs and providers participating in the demonstration to prepare for and implement all of the enhanced community-based services that are required for counties seeking to opt in to the IMD opportunity. Counties that do not participate in the option to receive FFP for short-term stays in IMDs but that choose to implement all of the community-based services described above may also participate in the opt-in county incentive program. Counties that do not participate in the option to receive FFP for short-term stays in IMDs but that choose to implement none or some of the community-based services described above may not participate in the opt-in county incentive program but can still participate in the statewide county incentive program described above.

  Opt-in county MHPs may receive incentive payments for:

  - supporting startup and capacity development (e.g., receiving approval of implementation plan and implementing standardized universal patient release of information forms);
  - meeting process metrics (e.g., submitting first year of reporting on baseline for performance and participating in fidelity review on implementation of new benefits); and
  - demonstrating improved outcomes on new benefits.

  In each year of the program, DHCS anticipates requiring a portion of incentive payments earned to be passed through to provider organizations to support investments in workforce, data, information technology and other areas.

- **Meeting Other CMS Requirements.** In accordance with CMS Implementation Plan requirements, DHCS proposes requiring all mental health inpatient and residential facilities in opt-in counties to have accreditation from a nationally recognized entity, except for psychiatric hospitals that are certified by the California Department of Public Health (CDPH) as meeting the Medicare

[52] DHCS, "Behavioral Health Information Notice No: 21-041," July 2021. Available at https://www.dhcs.ca.gov/Documents/CSD_BL/BHIN-21-041.pdf.

Conditions of Participation.[53] In addition, MHPs in opt-in counties may need to describe strategies to prevent or decrease the lengths of stay in EDs among beneficiaries living with SMI/SED. These strategies may include strengthening crisis response and stabilization options, and successfully transitioning clients who seek care from a hospital ED to placements in their county behavioral health continuum. These strategies to prevent or decrease the lengths of stay in EDs will be included in the county implementation plans, described in more detail in the "Demonstration Implementation and Phasing" section below.

Demonstration Financing and Reinvestment

Demonstration Financing

The proposed CalBH-CBC Demonstration represents a significant expansion in the continuum of behavioral health care for Medi-Cal beneficiaries across the state. In particular, the demonstration is committed to expanding community-based benefits for people living with SMI and SED, including children and youth, and individuals who are experiencing or at risk for homelessness and incarceration; promoting practice transformation; incentivizing counties and providers to implement changes; and establishing tools to ensure that individuals are connected to the right type and level of care.

Continuing Investments in Behavioral Health

Currently, counties pay for the cost of care provided to many individuals in IMDs as well as other services not currently covered under Medi-Cal (e.g., ACT/FACT) using county funds such as MHSA and Realignment funds, as well as federal funds such as the SAMHSA Mental Health Block Grant for early SMI/FEP. If the CalBH-CBC Demonstration is approved, counties will begin receiving FFP for the cost of these services, allowing counties to maximize the use of their limited county resources for community-based care.

- **Leverage MHSA Funding.** In particular, county participation in the proposed CalBH-CBC Demonstration will allow counties to maximize limited MHSA funding to support community mental health services for individuals living with SMI and SED. Counties currently use MHSA funds within the Medi-Cal program. Counties also use MHSA to fund prevention and early interventions, as well as community services and supports for individuals with mental health needs and services for low-income individuals who remain uninsured.

  As detailed above, FSP programs commonly include services that are similar to ACT and FACT for individuals with SMI. While many components of ACT and FACT, including therapy and medication supports, are coverable under the Medi-Cal State Plan as discrete services, vocational supports and housing expenses

[53] "Psychiatric Hospitals," CMS.gov, December 2021. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PsychHospitals

are not covered. DHCS also does not currently cover ACT or FACT as a bundled service under the Medi-Cal program. Many counties are currently using limited MHSA funds to pay for ACT- and FACT-like services for Medi-Cal beneficiaries; while many of these dollars can be matched under Medi-Cal, a percentage cannot be without a new SPA clarifying State Plan coverage for ACT. Similarly, some counties currently provide Supported Employment and CSC for FEP to qualifying individuals, including Medi-Cal beneficiaries using MHSA funds. If the demonstration is approved, counties will be able to use MHSA funding for the nonfederal state share of these newly covered Medi-Cal services and will be able to draw down FFP.

- **Requirement to Reinvest in Behavioral Health.** DHCS proposes to extend this requirement to counties that take up the option to cover short-term inpatient and residential mental health care services in IMDs, as well to all counties that participate in statewide and county incentive programs to support quality improvement and practice transformation. DHCS is committed to ensuring the infusion of new Medi-Cal funding available through this Demonstration on a statewide and opt-in basis, including new FFP to support the delivery of services currently funded through MHSA and Realignment, or through and for statewide and county incentive programs are reinvested in the behavioral health delivery system. DHCS is committed to ensuring the new Medi-Cal funding available as a result of the CalBH-CBC Demonstration is reinvested in expanding the provision of behavioral health services and capacity in community-based settings.

  Accordingly, DHCS proposes that counties participating in the demonstration, including those receiving county incentive funding in the statewide and/or opt-in programs and providing certain services covered under the demonstration, will expend new funding from the demonstration on Medi-Cal behavioral health service provision, quality improvement or capacity expansion. DHCS intends to effectuate this requirement through a financing plan and amendments to state-county behavioral health contracts. DHCS proposes to require opt-in counties to submit an implementation plan (described in more detail in the “Demonstration Implementation and Phasing” section below) that will include a “financing plan” section to prompt the county to describe its proposed plan for reinvesting the equivalent amount of new Medi-Cal funding associated with its participation in the CalBH-CBC Demonstration into the provision or capacity expansion of behavioral health services. This will help position each county to use the new funding to address the unique behavioral health needs of its residents. The financing and implementation plan will be subject to DHCS approval. In addition, to ensure the new Medi-Cal funds available to all counties under the proposed county incentive program are reinvested in behavioral health service provision or capacity expansion, DHCS proposes to amend county MHP contracts and state-county DMC-ODS contracts.

The implementation plan requirements will provide examples of allowable reinvestment modalities that are not duplicative of concurrent funding initiatives (e.g., the Behavioral Health Continuum Infrastructure Program (BHCIP) or the Behavioral Health Quality Improvement Program (BH-QIP)). These allowable reinvestment modalities may include, but are not limited to:

- covering the nonfederal share of Medi-Cal behavioral health services;
- investing in housing and homelessness strategies and partnerships with community-based organizations and other relevant entities;
- supporting connections with other justice initiatives;
- providing wraparound services and supports not reimbursable by Medi-Cal;
- hiring additional behavioral health clinicians, providers and staff;
- enhancing provider payment rates (e.g., to build capacity and expand workforce); and
- investing in quality improvement infrastructure.

In addition, DHCS proposes to require counties to commit to maintaining aggregate behavioral health expenditure levels consistent with Realignment and MHSA statutory and regulatory requirements to ensure that funds deposited into behavioral health-related county accounts are not diverted, reduced or redirected from these accounts or expended for purposes other than allowable behavioral health service provision or administration provided for by these authorities.

Counties opting in to the Demonstration will be required to attest to this requirement in their implementation plan. DHCS intends to review each county's reinvestment proposal using structured and standardized evaluation criteria. DHCS may require counties to attest to their adherence to the approved financing plan and will develop a monitoring approach such that participating counties demonstrate compliance with the financing plan via administratively efficient methods. The approved implementation plan will be incorporated into the state-county MHP contract and state-county DMC-ODS contract by reference. DHCS proposes to amend all county behavioral health plan contracts to ensure that general funds and federal funds associated with the statewide county incentive programs are reinvested in behavioral health service provision or capacity expansion and that Realignment and MHSA funding is not diverted, reduced or redirected from allowable behavioral health provisions.

Demonstration Implementation and Phasing

DHCS intends for most proposed features of the CalBH-CBC Demonstration to "go live" at implementation but recognizes that some elements of the demonstration will take longer to stand up. In parallel with the demonstration application, DHCS intends to develop an implementation plan that describes how the state will meet a series of CMS milestones. DHCS, in turn, may require opt-in counties to demonstrate readiness to

participate in CalBH-CBC Demonstration activities by submitting a county-specific implementation plan.

CMS Implementation Plan

CMS has outlined a series of milestones that states and participating facilities must meet to receive IMD expenditure authority as part of the SMI/SED Section 1115 demonstration opportunity (Appendix 2).[54] In parallel with the CalBH-CBC Demonstration application, DHCS will submit a formal implementation plan to CMS that explains how California will meet all CMS requirements. This implementation plan must be approved by CMS before FFP will be available for any IMD expenditures. DHCS envisions applying many CMS requirements to opt-in counties and qualifying facilities and may require a select number of changes statewide. DHCS' approach to meeting the implementation plan milestones that are detailed in Appendix 2 include:

- **Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Promotion and Standardization of Quality of Care in Residential and Inpatient Settings" subsection above.
- **Improving Care Coordination and Transitions to Community-Based Care.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Promotion and Standardization of Quality of Care in Residential and Inpatient Settings" subsection above.
- **Increasing Access to Continuum of Care, Including Crisis Stabilization Services.** DHCS intends to build on ongoing investments to meet the requirements of this milestone statewide, including:
- **Increasing Availability of Community-Based Crisis Services.** In tandem with this Demonstration, DHCS and CalHHS are strengthening the crisis system using BHCIP and other investments focusing on 988 Lifeline Efforts, creation of a Mobile Crisis Medi-Cal benefit, and improved access to Crisis Stabilization Units.
    - **Treatment Bed Availability Platform.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Supporting Statewide Practice Transformations" section above.
    - **Patient Assessment Tool.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Supporting Statewide Practice Transformations" section above.
- **Earlier Identification and Engagement in Treatment, Including Through Increased Integration.** DHCS proposes to leverage key features of the CalBH-

[54] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

CBC Demonstration to meet the requirements of this milestone to engage children and adolescents in treatment early, including through the provision of Supported Employment and CSC for FEP. The CalBH-CBC Demonstration will be synergistic, not duplicative, of efforts in the Children and Youth Behavioral Health Initiative and the Student Behavioral Health Incentive Program. CalHHS' Children and Youth Behavioral Health Initiative focuses on prevention and early intervention, including in schools and primary care settings, to help reduce children and youth's risk of developing serious mental, emotional and developmental challenges. DHCS' Student Behavioral Health Incentive Program aims to improve access to preventive, early intervention and behavioral health services by school-affiliated providers for Medi-Cal enrolled children and adolescents in grades TK-12 in public schools. As noted in the "County Implementation Plans" subsection immediately below, counties will be required to describe their strategy for meeting these requirements at a local level.

County Implementation Plans

Before implementing demonstration activities, opt-in counties may be required to submit and secure DHCS approval of an implementation plan that outlines how each county will meet the requirements for securing IMD funding. County implementation plans are expected to address the following:

- **Access and Network Adequacy for CalBH-CBC Demonstration Services and Existing Services.** A description of the county's approach to ensuring that beneficiaries will have sufficient access to new and current SMHS benefits, informed by a review of community-based SMHS service utilization. As noted above, a key condition for participation will be the proven availability of community-based services covered as SMHS so that the expansion of Medi-Cal coverage for inpatient and residential treatment provided in IMDs under this waiver facilitates access to such care only when medically necessary and clinically appropriate and does not result in overutilization or inappropriate use of institutional care as a result of lack of access to community-based services.
- **New Benefits Schedule.** A proposed schedule for offering new Medi-Cal benefits required as part of the CalBH-CBC Demonstration for opt-in counties. The schedule must be consistent with DHCS-determined time frames. (See an initial description in Figure 4 below.)
- **CMS Requirements.** A description of how the county will meet certain CMS-specified requirements included in DHCS' implementation plan submitted to CMS, including the requirements described above regarding accreditation and ED strategy.
- **Community Engagement Strategies.** A county's proposed strategy for working with community stakeholders during the implementation of CalBH-CBC Demonstration activities, including, at a minimum, beneficiaries living with mental

health conditions, advocacy groups, behavioral health providers, MCPs, law enforcement, CARE Court, other counties and Tribal partners.

- **Outreach to Populations of Focus.** Equity-centered strategies for expanding services and supports for populations disproportionately affected by SMI/SED or for whom gaps in care are particularly notable, including children and youth, especially those involved in the child welfare system; individuals who are justice-involved; and individuals who are experiencing or at risk of homelessness (including individuals involved in CARE Court).
- **Housing and Homelessness Strategies.** Strategies for engaging with MCPs and continuums of care (CoC),[55] working collaboratively with ongoing initiatives to link beneficiaries to housing services, and ensuring that inpatient and residential treatment facilities address each beneficiary's housing needs at discharge.
- **Integration.** Strategies for working toward whole-person care through greater integration and collaboration with MCPs, DMC-ODS and other stakeholders.
- **Reporting.** Plans to meet reporting requirements on key measures related to CalBH-CBC Demonstration activities and goals (e.g., referrals to ECM and Community Supports, readmission rate following IMD stay, number of ACT teams, and beneficiaries receiving ACT services).
- **Financing Plan.** Strategies to reinvest the new resources associated with services and expenditure authority covered under the CalBH-CBC Demonstration, and an attestation that a county will maintain behavioral health funding efforts.

Demonstration Phasing

DHCS intends to phase in implementation of proposed CalBH-CBC Demonstration activities. While it is anticipated most statewide demonstration activities will launch in year one of implementation, select initiatives that require a longer lead-up period will be phased into the demonstration during year two of implementation (see Figure 4).

In addition, opt-in counties may join the CalBH-CBC Demonstration at any time during the demonstration period to allow them time to meet the enhanced expectations associated with using Medi-Cal funding for short-term stays in IMDs. Most demonstration activities specific to opt-in counties will be implemented upon a county's launch date, with others phased in within the first two years of county participation (see Figure 4).

DHCS will conduct stakeholder engagement throughout the demonstration design process.

[55] A CoC is a regional or local planning body that coordinates housing and services funding for homeless families and individuals on behalf of the U.S. Department of Housing and Urban Development.

Figure 4: CalBH-CBC Demonstration Timeline

Demonstration Timeline	
Launch Statewide Activities	

Year One of Implementation	• Clarification of existing Children- and Family-Focused Benefits
	  ○ MST
	  ○ FFT
	  ○ PCIT
	  ○ Potentially Additional Therapeutic Modalities
	• Performance Supports
	  ○ Statewide COEs
	  ○ Statewide County Incentive Program
	• Meet County Accountability Requirements

Year Two of Implementation	• Performance Supports
	  ○ Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
	  ○ Promotion and Standardization of Quality of Care in Residential and Inpatient Settings
	• Supports for Youth in Child Welfare
	  ○ Cross-Sector Incentive Pool
	  ○ Activity Stipends
	  ○ Initial Child Welfare-Specialty Mental Health Assessment at Entry Point into Child Welfare

Launch County Option Benefits	

Rolling Basis	• County Option to Provide Enhanced Community-Based Services:
	  ○ ACT
	  ○ FACT
	  ○ CSC for FEP
	  ○ Supported Employment
	  ○ Community Health Worker Services
	  ○ Rent/Temporary Housing

Upon IMD Opt-In County Go-Live *(anticipated rolling basis)*	• County Option to Receive FFP for Short-Term Stays in IMDs
	• Meet Requirement to Provide Community-Based Services for Beneficiaries Living with SMI/SED:
	  ○ ACT
	  ○ Peer Support Services, Including Justice-Involved Specialization
	• Opt-In County Incentive Program (startup and capacity development milestones)
	• Meet County Accountability Requirements
	• Meet CMS Accreditation and ED Strategy Requirements

Demonstration Timeline	

Within Two Years of IMD Opt-In County Go-Live	• Meet Requirement to Provide Community-Based Services for Beneficiaries Living with SMI/SED:
	  ○ FACT
	  ○ Supported Employment
	  ○ Community Health Worker Services
	  ○ Rent/Temporary Housing
	• Opt-In County Incentive Program (process metrics (e.g., participating in COE training and meeting performance benchmarks for new Medi-Cal benefits))

Appendix 1: California's Major Behavioral Health Initiatives

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration was designed to complement and build on California's other major behavioral health initiatives. These initiatives include, but are not limited to, children- and youth-focused initiatives, enhanced supports for populations of focus, other initiatives to strengthen the continuum of care, and behavioral health delivery system reforms.

Children- and Youth-Focused Initiatives

- **Children and Youth Behavioral Health Initiative (CYBHI).**[56] CYBHI is a $4.4 billion investment to enhance, expand and redesign the systems that support behavioral health for children and youth. The goal of CYBHI is to reimagine mental health and emotional well-being for all children, youth and families in California by delivering equitable, appropriate, timely and accessible behavioral health services and supports.
- **Student Behavioral Health Incentive Program (SBHIP)**.[57] SBHIP includes a designated $389 million over a three-year period from January 1, 2022, to December 31, 2024, to increase the number of Medi-Cal enrolled children and adolescents receiving behavioral health services through schools and improve coordination of child and adolescent behavioral health services through increased coordination with schools, MCPs, counties and mental health providers. The programs will distribute incentives to MCPs that meet goals and metrics associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools.
- **Complex Care Capacity Building.**[58] Assembly Bill 153 provided $43.3 million in funding to both county welfare agencies and probation departments to support counties with establishing a high-quality continuum of care designed to support foster children and nonminor dependents in the least restrictive setting, consistent with the child's permanency plan.

[56] CalHHS, "Children and Youth Behavioral Health Initiative," May Revision 2021-22. Available at https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.

[57] DHCS, "Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics." Available at https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-Overview-and-Requirements-2-1LR.pdf.

[58] CDSS, All County Letter No. 21-143, November 2021. Available at https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2021/21-143.pdf?ver=2021-11-17-115026-727.

Enhanced Supports for Populations of Focus

- **CalAIM Justice-Involved Initiatives.**[59] CalAIM Justice-Involved Initiatives support justice-involved individuals by enrolling individuals in prisons, jails and youth correctional facilities in Medi-Cal coverage, providing key services pre-release, and connecting them with behavioral health, Enhanced Care Management, social services and other providers that can support their reentry.
- **Behavioral Health Bridge Housing.**[60] The 2022-23 California State Budget includes $1.5 billion in general fund spending over two years to provide short-term housing and treatment supports intended to transition individuals living with significant behavioral health needs out of unsheltered homelessness into a stable living environment in advance of further placement into permanent housing.
- **Felony Incompetent to Stand Trial (IST) Waitlist Solutions.**[61] The 2022-23 California State Budget includes $535.5 million in general fund spending in 2022-23, increasing to $638 million per year in 2025-26 and ongoing at the Department of State Hospitals for solutions focusing on Early Stabilization and Community Care Coordination and Expanding Diversion and Community-Based Restoration Capacity for the IST population.
- **Housing and Homelessness Incentive Program.**[62] As a means of addressing social determinants of health and health disparities, the Housing and Homelessness Incentive Program allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. MCPs and the local homeless continuum of care, in partnership with local public health jurisdictions, county behavioral health, public hospitals, county social services and local housing departments, must submit a homelessness plan to the Department of Health Care Services (DHCS).
- **Community Assistance, Recovery and Empowerment (CARE) Court.**[63] CARE Court will provide mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need. CARE Court is not for everyone experiencing homelessness or mental illness; rather, it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity – to serve these

[59] DHCS, "CalAIM Justice-Involved Advisory Group Kickoff Meeting," October 2021. Available at https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-Justice-Involved-Advisory-Group-Kickoff-Deck10272021.pdf.

[60] "California State Budget Summary – 2022-23," Health and Human Services. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

[61] Ibid.

[62] DHCS, "Housing and Homelessness Incentive Program," March 2022. Available at https://www.dhcs.ca.gov/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx.

[63] "Governor Newsom's New Plan to Get Californians in Crisis Off the Streets and into Housing, Treatment, and Care," March 2022. Available at https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf.

Californians before they enter the criminal justice system or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. It connects a person in crisis with a court-ordered CARE Plan for up to 12 months, with the possibility of extending for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services, including a housing plan.

Other Initiatives to Strengthen the Continuum of Care

- **CalAIM Enhanced Care Management (ECM).**[64] As a key part of CalAIM, ECM is a new statewide Medi-Cal benefit available to select populations of focus that will address clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor's office or at home. Beneficiaries will have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental and social services delivery systems, making it easier for them to get the right care at the right time.

  Effective July 1, 2023, the ECM benefit will launch statewide for the Children and Youth Involved in Child Welfare population of focus. The Children and Youth Involved in Child Welfare population of focus includes children and youth who meet one or more of the following conditions:

  - Are under age 21 and are currently receiving foster care in California
  - Are under age 21 and previously received foster care in California or another state within the past 12 months
  - Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
  - Are under age 18 and are eligible for and/or in California's Adoption Assistance Program
  - Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months

- **CalAIM Community Supports.**[65] Community Supports are new services provided by Medi-Cal MCPs as cost-effective alternatives to traditional medical services or settings. Community supports are designed to address social drivers of health (factors in people's lives that influence their health). All Medi-Cal MCPs are encouraged to offer as many of the 14 preapproved Community Supports as

[64] DHCS, "CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program." Available at https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices.
[65] Ibid.

possible, which are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.

- **Recovery Incentives: California's Contingency Management (CM) Program.**[66] CM is an evidence-based treatment that provides incentives to treat people living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests negative for stimulants. While CM has been tested using other sources of funding, California is the first state in the country to receive federal approval to offer CM as a Medicaid benefit through the Recovery Incentives Program.
- **Medication-Assisted Treatment (MAT) Expansion Program.**[67] The California MAT Expansion Project aims to increase access to MAT, reduce unmet treatment need, and reduce opioid overdose-related deaths through the provision of prevention, treatment and recovery activities. The California MAT Expansion Project focuses on populations with limited MAT access, including those in rural areas and American Indian and Alaska Native Tribal communities.
- **Behavioral Health Continuum Infrastructure Program (BHCIP).**[68] BHCIP awards competitive grants ($2.2 billion in total) to qualified entities to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. A portion of the funding is available for increased infrastructure targeted to children and youth aged 25 and younger.
- **CalBridge Behavioral Health Navigator Pilot Program.**[69] The CalBridge Behavioral Health Navigator Pilot Program provides grants and technical assistance totaling $40 million to acute care hospitals to support hiring trained behavioral health navigators in EDs to screen patients and, if appropriate, offer intervention and referral to mental health or SUD programs. Training and technical assistance are provided by California Bridge, a program that supports screening and treatment of SUD in EDs, including MAT for opioid use disorder. The program is funded by California's Home- and Community-Based Services (HCBS) Spending Plan.

---

[66] DHCS, "DMC-ODS Contingency Management." Available at https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx.

[67] DHCS, "The California MAT Expansion Project Overview." Available at https://www.dhcs.ca.gov/individuals/Pages/MAT-Expansion-Project.aspx.

[68] DHCS, "The Behavioral Health Continuum Infrastructure Program." Available at https://www.dhcs.ca.gov/services/MH/Pages/BHCIP-Home.aspx#:~:text=The%20Behavioral%20Health%20Continuum%20Infrastructure%20Program%20(BHCIP)%20provides%20the%20Department,expand%20the%20community%20continuum%20of.

[69] DHCS, "Medicaid Home- and Community-Based Services (HCBS) Spending Plan: Quarterly Reporting for Federal Fiscal Year 2021-2022," October 2021. Available at https://www.dhcs.ca.gov/Documents/HCBS-Spending-Plan-Q2-Final-Report.pdf.

- **988 Crisis Call Hotline.**[70] DHCS invested $20 million in California's network of emergency call centers to support the launch of the new national 988 hotline for people seeking help during a behavioral health crisis.
- **Medi-Cal Community-Based Mobile Crisis Intervention Services.**[71] The 2022-23 California State Budget designated $1.4 billion ($335 million in general funds) to add qualifying community-based mobile crisis intervention services as a Medi-Cal covered benefit through the Medi-Cal behavioral health delivery system.
- **CalHOPE.**[72] CalHOPE delivers crisis support for Californians experiencing stress and trauma. Services include individual and group crisis counseling and support, individual and public education through media, community networking and support, connection to resources, and media and public service announcements. Expanding CalHOPE to support children and youth access to virtual behavioral health services and interactive tools is a key component of CYBHI.[73]

Behavioral Health Delivery System Reforms

- **CalAIM Behavioral Health Payment Reform.**[74] DHCS plans to transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. This shift will enable counties to participate in broader delivery system transformation, engage in value-based payment arrangements with other delivery system partners, and make long-term investments in mental health and SUD delivery systems at the local level.
- **CalAIM No Wrong Door.**[75] DHCS is adopting a "no wrong door" approach to help enrollees more easily and quickly access mental health and SUD services. Beneficiaries will receive clinically appropriate and covered services regardless of the delivery system through which they seek care. Services rendered in good faith will be reimbursed by the provider's contracted plan during assessment.
- **CalAIM Screening and Transition Tools.**[76] DHCS worked with stakeholders to develop standardized screening and transition tools that are specific to

[70] DHCS, "California Dedicates $20 Million to Support New Mental Health '988' Crisis Hotline," September 2021. Available at https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2021/21-06-988-Line.pdf.
[71] "California State Budget Summary – 2022-23," Health and Human Services. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.
[72] "CalHOPE." Available at https://www.calhope.org/Pages/default.aspx.
[73] CalHHS, "Children and Youth Behavioral Health Initiative," May Revision 2021-22. Available at https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.
[74] DHCS, "CalAIM Behavioral Health Workgroup." Available at https://www.dhcs.ca.gov/provgovpart/Pages/bhworkgroup.aspx.
[75] DHCS, "Behavioral Health Stakeholder Advisory Committee (BH-SAC) meeting," October 21, 2021. Available at https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf.
[76] Ibid.

individuals under the age of 21 for use by county mental health plans (MHPs) and MCPs across the state.[77]

- **CalAIM Updated Specialty Mental Health Services (SMHS)[78] and DMC/DMC-ODS Criteria.** DHCS updated criteria for accessing SMHS and DMC/DMC-ODS services to streamline beneficiaries' access to care. The updated criteria will cover services during the assessment period, allow treatment without confirmed diagnosis, and expand specialty mental health access criteria to include experience of trauma, such as homelessness, child welfare or juvenile justice involvement.
- **CalAIM Documentation Redesign.**[79] DHCS updated and modernized SMHS and DMC/DMC-ODS documentation requirements to focus on appropriate oversight, reduce administrative burden on clinicians and maximize resources for direct client care. Key updates include replacing the static, point-in-time treatment plan with the dynamic problem list, using standardized domain-driven assessments, requiring overall leaner documentation, and determining disallowances based on fraud, waste and abuse.
- **Behavioral Health Integration (BHI) Incentives Program.**[80] As authorized under Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care, the objective of the BHI Incentives Program is to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in an MCP network.

[77] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California," January 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.
[78] Ibid.
[79] Ibid.
[80] DHCS, "Behavioral Health Integration Incentive Program Application." Available at https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx.

Appendix 2: CMS Implementation Plan Milestones

The Centers for Medicare & Medicaid Services' (CMS) approval of Section 1115 demonstrations to support individuals living with serious mental illness (SMI)/serious emotional disturbance (SED) is contingent on states meeting a series of milestones. The milestones are listed below.

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity, including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving federal financial participation (FFP) for services provided to beneficiaries.
- Establishment of an oversight and auditing process that includes unannounced visits to ensure participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements, as well as a national accrediting entity's accreditation requirements.
- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities.
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues).
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for comorbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address comorbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine and/or partnerships with local physical health providers).

Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive predischarge care coordination services to

help transition beneficiaries out of these settings and into appropriate community-based outpatient services as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment).

- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings, and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available.
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to.
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries living with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers).
- Implementation of strategies to develop and enhance interoperability and data sharing among physical, SUD and mental health providers, with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries living with SMI or SED.

Increasing Access to Continuum of Care, Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability.
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of nonhospital, nonresidential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers, as well as ongoing community-based services.
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.
- Implementation of a requirement that providers, plans and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., Level of Care

Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)) to help determine appropriate level of care and length of stay.

Earlier Identification and Engagement in Treatment, Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions in treatment sooner, including through Supported Employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers.
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

Main Focus of the 44 page Concept Paper: Use the guidance provided in in the extensive November, 13, 2018 State Medicaid Director Letter (SMDL) letter from the Center for Medicaid & Medicare Services (CMS) to:

- Further build out its continuum of community-based care and ensure that the care provided in institutional settings is high-quality and time-limited,
- Especially for the needs of Medi-Cal beneficiaries living with Serious Mental Illness (SMI) or Serious Emotional Disturbances (SED), including children in state welfare programs, across the state.

Page 7: Federal Demonstration Opportunity and Requirements

- November, 2018 State Medicaid Director Letter (SMDL)
  1. Adults 18 & above: Max. of 60 days/yr. in an Institute of Mental Diseases (IMD) facility. If LOS exceeds 60 days max., FFP waiver excluded.
  2. Must meet statewide avg. length of stay (ALOS) of 30 days.
  3. Children & Adolescents: Short-Term Residential Therapeutic Programs (STRTP) exemption from max. 6 mo. Length of Stay (LOS) requirement to allow a stay of up to 2 years for person is STRTPs that are also considered IMDs. Purpose is to transfer all persons in IMD licensed STRTPS out of such facilities w/in the 2 year period.
  4. **QUESTION:** Are any of the STRTP facilities under contract with Contra Costa Behavioral Health Services (CCBHS) also considered an Institute of Mental Diseases (IMD) facility?

Proposed CalBH-CBC Demonstration Approach: Pages 8 -10

- Strengthen the statewide continuum of community based services and evidenced based practices
- Support statewide practice transformations and improvements
- Improve statewide county accountability
- Establish a county “Opt-In” option to enhance community-based services
- Establish a county “Opt-In” option to receive Federal Financial Participation (FFP) reimbursement for services provided during short-term stays in Institute of Mental Diseases (IMD) licensed facilities.

Page 11—Figure 1: Building out the Continuum of Care for Persons Living with SMI/SED

Page 12—Figure 2: Populations of Focus

Pages 13 & 14—Figure 3: Key Components of the CalBH-CBC Demonstration Proposal

Strengthening the Stateside Continuum of Community Based Services: Pages 15-17

CA Children & Youth

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Parent-Child Interaction Therapy (PCIT)

CA Children & Youth in the Child Welfare System

- Cross-Sector Incentive Pool
- Activity Stipends
- Initial Child Welfare/Specialty Mental Health Assessment at Entry Point into Child Welfare

Supporting Statewide Practice Transformations: Pages 18-21

- Statewide COEs (Centers of Excellence)
- Statewide Incentive Program
- Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
  1. Patient Assessment Tool
  2. Treatment Bed Availability Platform
- Promotion and Standardization of Quality of Care in Residential and Inpatient Settings

Improving Statewide Accountability: Pages 21-22

"DHCS anticipates amending the county Mental Health Plan (MHP) to:

- Establish key performance expectations and accountability standards
- Build on goals and standards included in the state's Medi-Cal Comprehensive Quality Strategy and other
  quality and evaluation initiatives
- Outline incentive payment opportunities

County "Opt-In" Option-Reimbursement to provide Enhanced Community Based Services: Pages 22-25

- ACT (Assertive Community Treatment)
- FACT (Forensic Assertive Community Treatment)—county "Opt-In" employing persons w/lived exp.
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Supported Employment
- Rent/Temporary Housing for certain qualifying high-need beneficiaries
- Community Health Worker Services: Optional Services. Counties can "opt-in" to cover.

NOTE: In this Sec. 1115 Demonstration application, the CA Dept. of Health Care Services (DHCS) will seek the ability to maximize the "Dollar for Dollar Medi-Cal match" and, thus, maximize the use of Mental Health Services Act (MHSA) dollars in the expanded provision of services to the Seriously Emotionally Disturbed (SED) and Seriously Mentally Ill (SMI) population throughout the state.

County "Opt-In" Option to Receive Federal Financial Participation (FFP) Reimbursement for Short-Term Stays in in Institute of Mental Diseases (IMD) facilities: Pages 25-27

- FFP for Short-Term Stays in IMDs
- Requirement to Provide All Community-Based Services for Beneficiaries Living with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)
- Incentive Program for Opt-In Counties
- Meeting Other CMS Requirements

NOTE 1: In order to "Opt-In," the county MUST agree to:

- Cover the enhanced set of community-based services described above
- Reinvest dollars generated by the demonstration into community-based care
- Meet robust accountability requirements to ensure that IMDs are used when medically necessary and provide high-quality care
- Cover Peer Services, including persons who are Justice involved through the Peer Support Specialist Certification Program with a forensic (i.e., justice-involved) area of specialization.
- Demonstrate that beneficiaries have sufficient access to current Specialty Mental Health Service (SMHS) benefits. "A key condition for participation will be the proven availability of community-based services covered as SMHS so that the expansion of Medi-Cal coverage for inpatient and residential treatment provided in IMDs under this waiver facilitates access to such care only when medically necessary and clinically appropriate, and does not result in overutilization or inappropriate use of institutional care as a result of lack of access to community-based services."

NOTE 2: DHCS also intends to request authority in the CalBH-CBC Demonstration to establish an incentive program for opt-in counties that can be used to help counties and providers prepare for and sustain the implementation of demonstration features.

NOTE 3—FFP for Short-Term IMD Stays:

- Centers for Medicare & Medicaid Services (CMS) will not cover the cost of room and board associated with the stay unless the setting qualifies as an inpatient facility under section 1905(a) of the Social Security Act.
- FFP not available for services provided in nursing homes that qualify as an IMD.
- Nor for services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in an Institute of Mental Diseases (IMD) facility by operation of criminal law.

Demonstration Financing and Reinvestment: Pages 28-30

- Demonstration Financing: Page 28
- Continuing Investments in Behavioral Health
- Leverage MHSA Funding

NOTE 1: Under this Demonstration**, s**ervices listed above will be "bundled" under Medi-Cal, thus, allowing counties to use MHSA funding for the nonfederal state share of these newly covered Medi-Cal services and , thus, directly drawing down Federal Financial Participation (FFP) ("Dollar for Dollar Medi-Cal match").

- Requirement to Reinvest in Behavioral Health: Pages 29-30

NOTE 2: DHCS proposes to require opt-in counties to submit an implementation plan to that will include a "financing plan" section to prompt the county to describe its proposed plan for reinvesting the equivalent amount of new Medi-Cal funding associated with its participation in the CalBH-CBC Demonstration into the provision or capacity expansion of behavioral health services.

Demonstration Plan and Phasing: Pages 30-35

- CMS Implementation Plan

Note 1: DHCS envisions applying many Centers of Medicare & Medicaid Services (CMS) MS requirements to opt-in counties and qualifying facilities and may require a select number of changes statewide. See Appendix 22: Pages 42-44

- Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
- Improving Care Coordination and Transitions to Community-Based Care
- Increasing Access to Continuum of Care, Including Crisis Stabilization Services
- Increasing Availability of Community-Based Crisis Services
  1. Treatment Bed Availability Platform
  2. Patient Assessment Tool
- Earlier Identification and Engagement in Treatment, Including Through Increased Integration

County Implementation Plans for securing Institute of Mental Diseases (IMD) Funding: Pages 32-33

- Access and Network Adequacy for CalBH-CBC Demonstration Services and Existing Services
- New Benefits Schedule
- Centers for Medicare & Medicaid Services (CMS) Requirements
- Community Engagement Strategies
- Outreach to Populations of Focus
- Housing and Homelessness Strategies
- Integration
- Reporting
- Financing Plan

Demonstration Phasing: Pages 33-35

- Pages 34-35: Figure 4: CalBH-CBC Demonstration Timeline

NOTE 1: Per Figure 4, the Demonstration will be a multi-year (likely 3-4 year) phase in process.

Appendix 1: California's Major Behavioral Health Initiatives: Pages 36-41

Children and Youth-Focused Initiatives: Page 36

- Children and Youth Behavioral Health Initiative (CYBHI): $4.4B investment to enhance, expand and redesign the systems that support behavioral health for children and youth.
  Student Behavioral Health Incentive Program (SBHIP): $389M from 2022 through 2024 to increase the number of Medi-Cal enrolled children and adolescents receiving behavioral health services through schools and improve coordination of child and adolescent behavioral health services through
- Complex Care Capacity Building

Enhanced Supports for Populations of Focus: Pages 37-38

- CalAIM Justice-Involved Initiatives
- Behavioral Health Bridge Housing: $1.5B in fiscal Year 2022 through fiscal year 2024 to provide "bridge housing" for persons with major mental health challenges.
- Felony Incompetent to Stand Trial (IST) Waitlist Solutions: $535M in 2022-2023 increasing to $635M in 2025-2026 to help counties care for their IST population.
- Housing and Homelessness Incentive Program
- Community Assistance, Recovery and Empowerment (CARE) Court: Court ordered CARE plan for 12 months with the possibility of extending for another 12 months.

Other Initiatives to Strengthen the Continuum of Care: Pages 38-39

- CalAIM Enhanced Care Management (ECM): Effective July, 2023 Focus—Children & Youth involved in Child Welfare.
- CalAIM Community Supports
- Recovery Incentives: California's Contingency Management (CM) Program: An evidence-based treatment that provides incentives to treat people living with stimulant use disorder and support their path to recovery.
- Medication-Assisted Treatment (MAT) Expansion Program: Focus—reduce Opioid use and related deaths.
- Behavioral Health Continuum Infrastructure Program (BHCIP): $2.2B statewide in 6 rounds of competitive funding to refurbish or build facilities to help children, adolescents, and adults living with major Mental Health (MHD) and Substance Use Disorder (SUD) challenges.
- CalBridge Behavioral Health Navigator Pilot Program: $0M to acute care hospitals to screen for referral to Mental Health/SUD facilities.
- 988 Crisis Call Hotline: $20M in initial state funding to help establish call centers to handle crisis calls in lieu of police crisis involvement, whenever possible.
- Medi-Cal Community-Based Mobile Crisis Intervention Service: $1.4B designated in the 2022-2023 state budget to add mobile crisis intervention as a covered Medi-Cal benefit.
- CalHOPE: Delivers crisis support for Californians experiencing stress and trauma, esp. children and adolescents.

Behavioral Health Delivery System Reforms: Pages 40-41

- CalAIM Behavioral Health Payment Reform
- CalAIM No Wrong Door
- CalAIM Screening and Transition Tools
- CalAIM Updated Specialty Mental Health Services (SMHS)78 and DMC/DMCODS Criteria
- CalAIM Documentation Redesign
- Behavioral Health Integration (BHI) Incentives Program

Appendix 2: CMS Implementation Plant Milestones: Pages 42-44

- Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings: Page 42
- Improving Care Coordination and Transitions to Community-Based Care: Pages 42-43
- Increasing Access to Continuum of Care, Including Crisis Stabilization Services: Pages 43-44
- Earlier Identification and Engagement in Treatment, Including Through Increased Integration: p. 44

FINAL NOTE and Comment: This state Dept. of Health Care Services (DHCS) California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration concept paper makes many references (footnotes and otherwise) to California's new Community Assistance, Empowerment & Recovery (CARE) Court. From my perspective, this Dept. of Health Care Services (DHCS) concept paper was written to focus on CARE Court, not on counties (like Contra Costa) who have previously opted-in to use 1991 State Realignment funding to pay for its citizens involved with an LPS Temporary or 1-year Renewable Conservatorship.