County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division

NOTICE OF PUBLIC MEETING
MENTAL HEALTH ADVISORY BOARD
OCTOBER 17, 2024, 3:00 PM-5:00 PM
HEALTH SERVICES AGENCY, 1400 EMELINE, ROOMS 206-207, SANTA CRUZ, CA 95060
THE PUBLIC MAY JOIN THE MEETING BY CALLING (831)454-2222, CONFERENCE ID 900 607 988#

Xaloc Cabanes Chair 1st District	Valerie Webb Member 2nd District	Michael Neidig Co-Chair 3rd District	Antonio Rivas Member 4th District	Jennifer Wells Kaupp Member 5th District
Kaelin Wagnermarsh Member 1st District	Dean Shoji Kashino Member 2nd District	Hugh McCormick Member 3rd District	Celeste Gutierrez Member 4th District	Jeffrey Arlt Secretary 5th District

Felipe Hernandez Board of Supervisor Member	
Tiffany Cantrell-Warren Director, County Behavioral Health	Karen Kern Deputy Director, County Behavioral Health

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE
MENTAL HEALTH ADVISORY BOARD MEETING

The public may attend the meeting at the Health Services Agency, 1400 Emeline, Rooms 206-207, Santa Cruz. Individuals may click here to Join the meeting now or may participate by telephone by calling (831)454-2222, Conference ID 900 607 988#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Mental Health Advisory Board website.

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4611 (Hearing Impaired TDD/TTY: 711) at least 72 hours in advance of the meeting in order to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.
Si usted es una persona con una discapacidad o necesita servicios de interpretación (inglés/español o Lenguaje de señas), por favor llame al (831) 454-4611 (Personas con Discapacidad Auditiva TDD/TTY: 711) con 72 horas de anticipación a la junta para hacer arreglos. Personas con discapacidades pueden pedir una copia de la agenda en una forma alternativa.

MENTAL HEALTH ADVISORY BOARD AGENDA

Time	Regular Business
3:00 - 3:15	• Roll Call • Public Comment (No action or discussion will be undertaken today on any item raised during Public Comment period except that Mental Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each) • Board Member Announcements • *Approval of September 19, 2024 minutes** • Secretary's Report
	Standing Reports
3:15 - 3:25	September Patients' Rights Report – George Carvalho, Patients' Rights Advocate for Advocacy, Inc.
3:25 - 3:40	Board of Supervisors Report – Supervisor Felipe Hernandez
3:40 - 3:55	Behavioral Health Report: Tiffany Cantrell-Warren, Behavioral Health Director - Care Act Implementation – Brenda Campbell, BH Program Manager
	Presentation
3:55 – 4:15	Medication Use in Mental Health – Mike Neidig and Dean Kashino, MHAB Members
	New Agenda Items
4:15 - 4:25	*Discuss and vote on submitting the 2024 Data Notebook**
4:25 – 4:35	*Letter of Recommendation regarding Prop 36**
4:35 - 4:55	Formation of Committees -*Vote on Ad Hoc Committee HR8575**
4:55 - 5:00	**Future Agenda Items**
5:00	**Adjourn**

*Italicized items with * indicate action items for board approval.*

NEXT MENTAL HEALTH ADVISORY BOARD MEETING IS ON:
NOVEMBER 21, 2024, 3:00 PM – 5:00 PM
LOCATION TO BE ANNOUNCED

County of Santa Cruz

HEALTH SERVICES AGENCY

BEHAVIORAL HEALTH DIVISION

Salud Mental y
Tratamiento del Uso
de Sustancias

MINUTES – Draft

MENTAL HEALTH ADVISORY BOARD

SEPTEMBER 19, 2024, 3:00 PM - 5:00 PM
500 WESTRIDGE, COMMUNITY ROOM, WATSONVILLE
NO VIRTUAL OPTION AVAILABLE, IN-PERSON MEETING ONLY.

Present: Antonio Rivas, Celeste Gutierrez, Jeffrey Arlt, Jennifer Wells Kaupp, Michael Neidig, Valerie Webb, Xaloc Cabanes, Supervisor Felipe Hernandez, Stella Peuse
Absent: Dean Kashino, Hugh McCormick
Staff: Tiffany Cantrell-Warren, Andrea Turnbull, Jane Batoon-Kurovski

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I. Roll Call – Quorum present. Meeting called to order at 3:06p.m. by Chair Xaloc Cabanes.

II. Public Comments
- Three people addressed the MHAB: Diane Dutton, Becky Steinbruner, Tyler Starkman
- 1 written correspondence from Nancy Sondel was read aloud

III. Board Member Announcements
- New MHCAN Director - Tyler Starkman
- Becky Steinbruner hosts a radio program called Community Matters to discuss topics of interest to the Santa Cruz Community
- Chair received confirmation that the Sheriff's Office does not do sweeps, only done by the city police
- Saturday, September 28th – Santa Cruz County Out of the Darkness Community Walk at Skypark, Scotts Valley
- Laura Chatham no longer on the board
- Stella Peuse leaving the MHAB to attend college

IV. Business / Action Items
A. Approve August 15, 2024 Minutes
Motion/Second: Supervisor Hernandez / Antonio Rivas

Ayes: Antonio Rivas, Celeste Gutierrez, Jeffrey Arlt, Jennifer Wells Kaupp, Michael Neidig, Valerie Webb, Xaloc Cabanes, Supervisor Hernandez
Nays: None
Motion passed.

B. Approve August 16, 2024 Minutes with changes as discussed (one TAY from Districts 1, 2, 4 and one TAY from Districts 3, 5).
Motion/Second: Supervisor Hernandez / Antonio Rivas
Ayes: Antonio Rivas, Celeste Gutierrez, Jeffrey Arlt, Jennifer Wells Kaupp, Michael Neidig, Valerie Webb, Xaloc Cabanes, Supervisor Hernandez
Nays: None
Motion passed.

V. Reports

A. Secretary's Report

- Informed the board members that Celeste, Antonio and Jeffrey have completed their 2- hour training requirement for the year.
- Ethics training – Xaloc and Valerie upcoming due dates.
- CALBHBC has an October 18th meeting and October 19th training
- Crisis Jam 988 on YouTube every Wednesday morning for an hour
- NAMI online and in-person trainings

VI. Standing Reports

A. August Patients' Rights Report – George Carvalho, Patients' Rights Advocate
The August report was provided. George did not attend the meeting.

B. Board of Supervisors Report – Supervisor Felipe Hernandez

- Confirmed that the Sheriff's Office does not participate in any of the sweeps
- Announced that the Board of Supervisors adopted the resolution to address homelessness in a compassionate and comprehensive manner.

C. Behavioral Health Director's Report – Tiffany Cantrell-Warren, Director of Behavioral Health

- Update on the roll out of the 24/7/365 Mobile Crisis Response
    - Coverage has expanded to 7 days/week by the MERT team, 8am-6pm North and South County.
    - Family Services Agency (FSA) is providing triage and additional coverage for mobile crisis response up to 12am.
    - There are 15 counties in CA that have not been able to fully implement the 24/7/365 mandate.

- Suicide Prevention Strategic Plan, Andrea Turnbull, BH Program Manager
Andrea stated that the Suicide Prevention Strategic Plan Update is closing. They received 11 comments which will be taken to the Suicide

Awareness Team to discuss how to integrate comments and make changes. The plan will go to the Board of Supervisors in the month of October.

D. Crisis Now Academy Update
    - Innovation project funded by the state, MHSA and federal grants to improve BH crisis systems in Santa Cruz County, 3-year budget $5.2M, MHSA funding. Model focuses on crisis call centers, 24/7 mobile crisis teams and facility-based crisis centers that rely on evidence-based practices and peer support specialists. Ten 1.5-hour sessions. Participants included County BH, MHAB, Family Services, law enforcement, fire, NAMI, Monarch Services, Front Street, Encompass, Salud Para La Gente, Santa Cruz City Schools, Volunteer Center.
    - Meetings focused on 988 crisis call centers and mobile crisis response, facility-based crisis services, funding approaches, core principles and practices, stakeholder relationships and workforce training, key performance indicators, law enforcement collaboration.
    - MHAB requests quantifiable data of the mental health needs in Santa Cruz County for all populations, which will enable the MHAB to advocate to elected officials.

VII. New Agenda Items

A. Youth Report – Stella Peuse
- Scotts Valley High School and Scotts Valley Middle School Hope Squads kicked off the first 2 weeks of school this year.
- San Lorenzo Valley is bringing in a Hope Squad program or equivalent to their school this year.
- Recommendations for the MHAB:
    - Provide youth representatives an orientation before their first meeting
    - Allow youth to have more involvement with committees and site visits
    - Do outreach at high schools, presentations of what the MHAB does
    - Bonding retreats for the board members
    - Provide incentives for youth such as community services hours, stipend for gas

B. Formation of Committees (frequency, day, time) – To be discussed at the next meeting.

C. Discuss and vote on new day/time/frequency of regular meetings – to be discussed at the next meeting.

D. Letter of Recommendation – HR8575 Request to all Behavioral Health Boards
    - Intent is to contact each of the 58 counties of California with this letter. The bill is to expand the IMD’s from 16 beds to 36 beds.

Approve reaching out to other counties and send the letter to the 58 counties.

Motion/Second: Jeffrey Arlt / Mike Neidig

Ayes: Antonio Rivas, Celeste Gutierrez, Jeffrey Arlt, Jennifer Wells Kaupp, Michael Neidig, Valerie Webb, Xaloc Cabanes, Supervisor Hernandez

Nays: None

Motion passed.

Board members to disseminate letters – Jennifer, Celeste and Jeffrey.

VIII. Future Agenda Items

- Data Notebook 2024

IX. Adjournment

Meeting adjourned at 5:01 p.m.

CARE: A Pathway to Hope and Healing

Community Assistance, Recovery and Empowerment in Santa Cruz County

What is CARE?

The **Community Assistance, Recovery, and Empowerment (CARE) Act** creates a new pathway to deliver mental health and substance use disorder treatment and support services to eligible individuals who have untreated schizophrenia spectrum or other psychotic disorders.

The CARE Act allows the Court to order the County to provide behavioral health treatment in community-based settings.

The individual enters this pathway when a petitioner requests court-ordered treatment, services, supports, and housing resources under the CARE Act, for an eligible individual (or “respondent”).

CARE Act will be available to eligible Santa Cruz County residents starting **December 1, 2024**.

What CARE is NOT

CARE is not a conservatorship.

- Medications, treatment, and placement cannot be forced.
- The entire process is voluntary.

CARE is not a cure for homelessness.

- Housing is not guaranteed.

CARE is not for all people with mental illness.

- The CARE Act addresses only a very specific set of psychotic disorders.

Overview of CARE Act Roles

Participant/ Respondent

Petitioner

Santa Cruz County Behavioral Health

Community & Service Providers

Court Partners

"Respondent" is a legal term to refer to the person participating in the CARE Act Process. You'll hear this term being used in the court room and potentially other settings.

Respondent

Potential participants/respondents are adults with a diagnosis of Schizophrenia Spectrum or other psychotic disorders who:

- Have severe and persistent symptoms that interfere substantially with primary activities of daily living (ADLs),
- Are unable to maintain functioning,
- Are not stabilized,
- Are either
  - Unlikely to survive safely/independently and the condition is deteriorating OR
  - In need of services and support to prevent further deterioration,
- Are able to participate in a CARE agreement/plan as the least restrictive alternative to ensure their stability, and
- Will likely benefit from the CARE process.

Respondents will be represented by a lawyer from the Public Defender's Office.

For more information, visit the CARE Act Eligibility Criteria brief and Eligibility in Practice training materials.

CARE Eligible Diagnoses

Schizophrenia Spectrum Disorders

- Schizophrenia
- Schizoaffective Disorder
- Schizophreniform Disorder
- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Other Psychotic Disorders

- Brief Psychotic Disorder
- Delusional Disorder
- Schizotypal Personality Disorder
- Substance/Medication Induced Psychotic Disorder
- Catatonia Associated with Another Mental Disorder
- Unspecified Catatonia

Diagnoses Not Meeting Eligibility*

- Psychotic Disorder Due to A General Medical Condition
- Catatonia Associated with another Medical Condition
- Major Depression with Psychotic Features
- Bipolar Disorder with psychotic features
- Any Substance Related Disorder not listed above

*Unless accompanying another eligible diagnoses

For more information, visit the American Psychiatric Association (2022) DSM-5 TR.

Petitioner

A petitioner could include:

- Family members
  - Limited to a parent, spouse, sibling, child or grandparent
- A mental health professional or other service provider who is treating or has recently treated the client/respondent
- The director of a hospital in which the client/respondent was recently or is hospitalized
- County Behavioral Health agency
- First responders
- Homeless outreach worker
- A roommate/housemate
- The client/respondent

For more information, visit CARE Act Resources For Petitioners.

Santa Cruz County Behavioral Health

- Agency assigned to engage with the client/respondent as they enter into the different pathways of a CARE agreement
- Behavioral Health (BH) creates an initial report, conducts clinical evaluation, engages the client in the mental health treatment, and connects the client with other services and supports.
- CARE participants will be assigned to a BH coordinator who will ensure that they receive services to support unmet needs, either through the Specialty Mental Health Clinic or through community providers.

For more information, visit the CARE Act Fact Sheet and 2022 California Welfare and Institutions Code.

Community & Service Providers

- Santa Cruz County has different types of potential housing providers that may engage with CARE Act clients, including but not limited to:
  - Housing First Models, including
    - Bridge/Interim Housing Models
    - Rapid Rehousing
    - Permanent Supportive Housing
- Behavioral Health Bridge Housing (BHBH) funding

For more information, visit the CARE Act Fact Sheet and 2022 California Welfare and Institutions Code.

Role of First Responders and Other Professionals

1) As the Petitioner:

- Consult with your agency's counsel to complete court forms. Note: Self-help centers only assist individuals.
- First responders as petitioners are replaced by County Behavioral Health (BH) at the initial appearance.
- Original petitioner should be present and can make a statement at the initial hearing.

2) As a referral source:

- In some cases, you may refer to other organizations:
  - County Behavioral Health
  - Health care, hospitals, or emergency departments
  - Community services providers
- Consider identifying liaisons to support communication.

For more information, visit First Responders & the CARE Act - CARE Act Resource Center (care-act.org)

Key Considerations Before Filing a CARE Petition

CARE does not apply to people who are already voluntarily engaged in Behavioral Health services.

- Before filing a CARE petition, consider reaching out to Behavioral Health. They can help assess if someone meets the necessary criteria.

Petitions must include documentation of a qualifying disorder and one of the following:

- Affidavit of a Behavioral Health clinician OR
- Proof of two recent hospitalizations for intensive treatment ("5250" or "14-day hold").

How Does the CARE Process Work?

1. The CARE process begins with the filing of a **petition**.

   Petition may be filed by family members, healthcare or social services workers, first responders, or Santa Cruz County Behavioral Health.

2. The Court determines **eligibility**.
3. If eligible, the Court will work with the participant/respondent and their attorney to create a voluntary **CARE agreement** or a court-ordered CARE plan that connects them with **services**.
4. There will be regular status review hearings to **review** progress and challenges.
5. After 12 months, the respondent may **graduate** from the program or **continue** for another year.

After graduating from the CARE process, the respondent remains eligible for ongoing treatment, services, and housing to support long-term recovery.

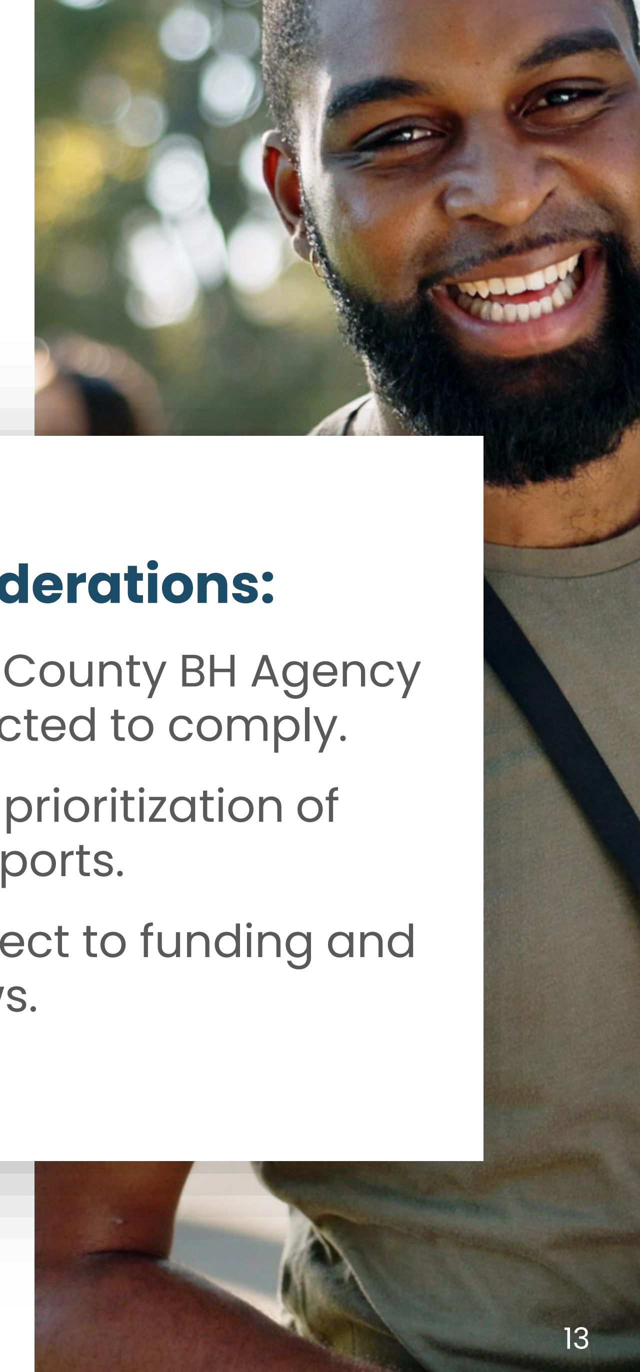
What's in a CARE Agreement or CARE Plan?

CARE Agreement/Plan

- Each Participant/respondent will have an individualized CARE Plan specific to their needs.
- Services may include the following:
  - Behavioral health services
  - Medically necessary stabilization medications
  - Housing resources & supports
  - Funded social services, including those available to indigent California residents

Additional considerations:

- Respondent and County BH Agency will both be expected to comply.
- Judge can order prioritization of services and supports.
- Services are subject to funding and federal/state laws.



For more information, visit the training Overview of CARE Agreement & CARE Plan and California Welfare and Institutions Code (W&I Code) section 5982.

How to Learn More about CARE Eligibility

For individuals in our community:

- Contact the **Santa Cruz County Law Library** in Santa Cruz or the **Santa Cruz Superior Court Self Help Center** in Watsonville.
- Both locations provide guidance on CARE eligibility, the CARE process, and support with completing and reviewing the CARE Petition.
- Services can be provided in-person or remotely.
- Visit lawlibrary.org and santacruz.courts.ca.gov/self-help for contact information and hours.
- Or call 831-420-2205 (Law Library) or 831-786-7200 option 4 (Self Help Center).

For more information, visit the CARE Act Fact Sheet and 2022 California Welfare and Institutions Code.

How to File a CARE Petition in Santa Cruz County

Individuals can visit either:

- Santa Cruz Law Library (basement of 701 Ocean Street, Santa Cruz)
- **or** Watsonville Self Help Center (1 Second Street, Room 301, Watsonville) to:
  - Learn about eligibility
  - Obtain court forms
  - Get help completing and reviewing the forms

File completed court forms:

- In person in Room 110, Civil Clerk Office (701 Ocean Street)
- **or** Online using efile

- After filing, most respondents will be represented through the Public Defender's office.
- *Remember: CARE is a completely voluntary and confidential process.*

Court Partners

The following legal partners will help ensure that CARE is legally followed in the best interest of each respondent:

The Judge:

- Is neutral arbiter and
- Will strive to conduct CARE proceedings in informal, non-adversarial atmosphere.

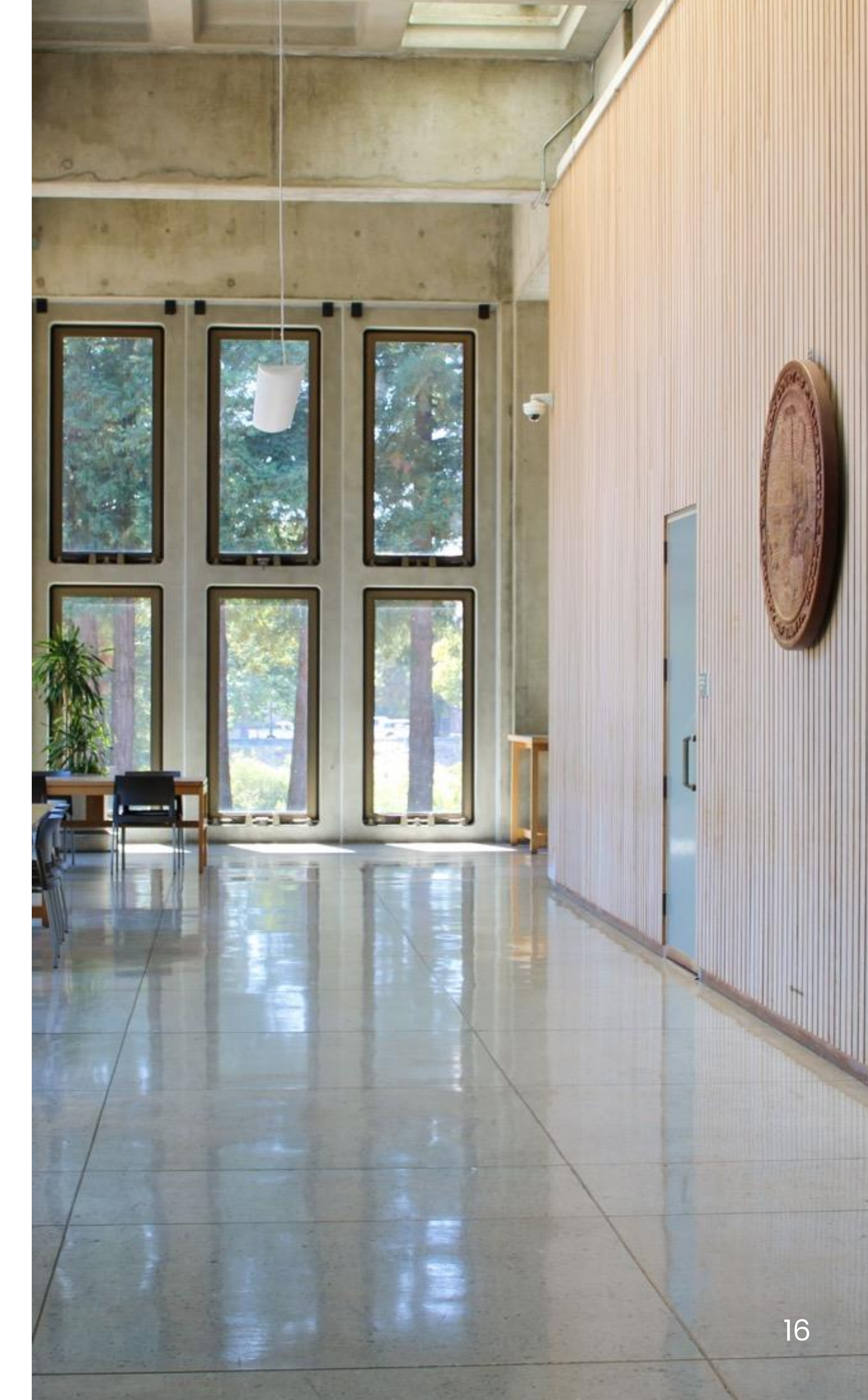
County Counsel (attorney):

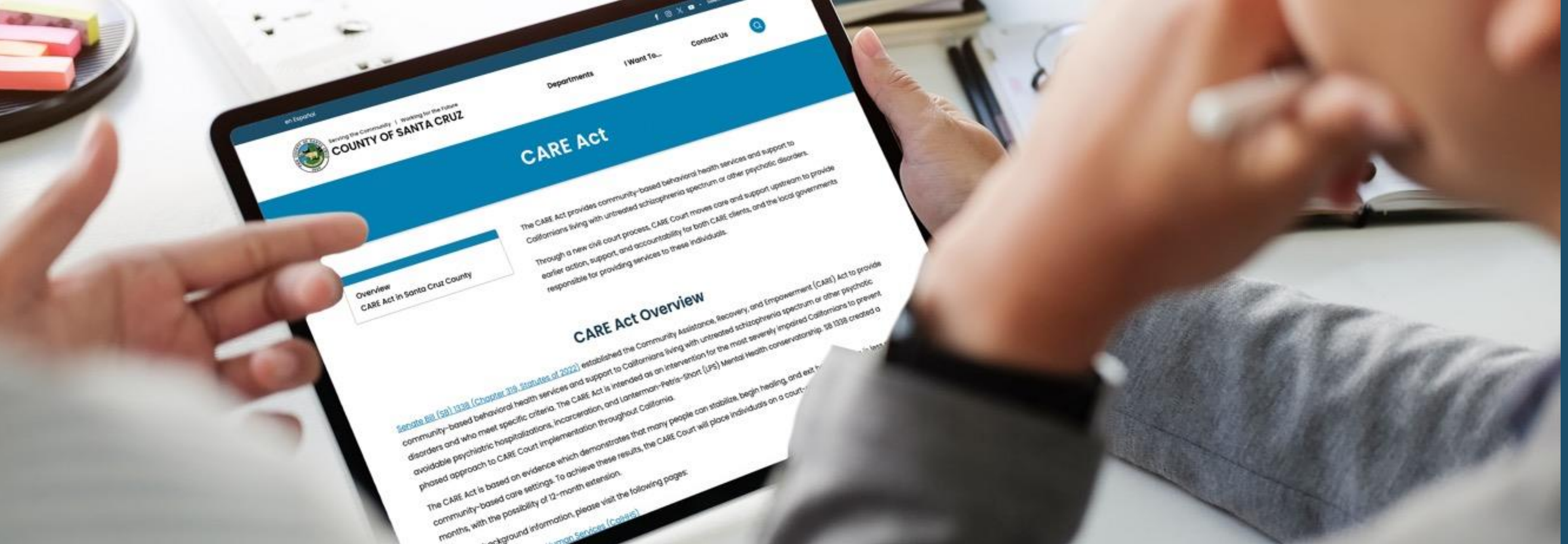
- Will advise and represent County Behavioral Health and
- Ensure that all legal forms & documents are properly filed.

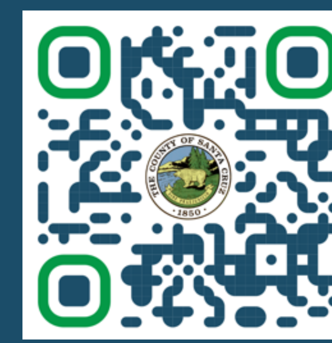
Public Defender (attorney):

- Is a Court-appointed lawyer, regardless of ability to pay and
- Will represent the Respondent's interests and rights in the courtroom and provide other supportive services.

For more information, visit the CARE Act Fact Sheet and the Legal Roles in the CARE Act brief.







santacruzcountyca.gov/CARE

Where Can I Learn More About CARE?

If you think the CARE Act could help someone you care about, find additional information and resources at:

Santa Cruz County CARE Act:

- Website: santacruzcountyca.gov/CARE
- Email: CAREact@santacruzcountyca.gov

Other CARE Act Resources:

- CARE Act Resource Center
- Frequently Asked Questions

Medication Use in Mental Health

October 17, 2024

Voluntary and Involuntary Treatment is Driven by Safety Risk and Symptom Acuity

- Grave risk for suicide
- A threat to harm others
- Gravely disabled and unable to care for themselves
- Aggressive and violent behavior
- Agitation especially with acute psychosis or the loss of contact with reality. This can include delusions or false beliefs and/or hallucinations or false sensory perceptions.
- Delirium involves confusion and a lack of awareness of someone’s surrounding. If associated with agitation (hyperactive delirium), it can be viewed as an acute mental health crisis.

Basic Guidelines for Acute Mental Health Crisis Treatment

- Treat the patient in the least restrictive environment possible under the circumstances.
- Try nonmedicinal de-escalation techniques first.
- Try to determine the underlying cause of the problem. What are the patient’s known medical conditions, especially any known mental health conditions and/or substance abuse disorders?
- If medication is needed, choose the most appropriate treatment.
- In general, behavioral health medications are felt to work at the synapse or the communication link between to neurons or nerve cells. They affect the neurotransmitters, such as serotonin, norepinephrine, dopamine, and GABA or gamma-aminobutyric acid. Most of this is theoretical.

Nonpsychiatric Medical Conditions that can appear as an Acute Mental Health Crisis (CITMAN)

- Genetic and Developmental Disorders, such as Autism Spectrum Disorders and Inborn Errors in Metabolism (porphyria, Wilson's Disease).
- Infections, such as meningitis and encephalitis. Fever can also cause delirium.
- Trauma, including post-traumatic pain, post-traumatic concussion.
- Medication intoxication, side effects, and withdrawal.
- Metabolic derangement due to various conditions, such as diabetes, Addison's Disease, thyroid disorders, SIADH, and Nutritional Deficiencies (B12, Wernicke's Encephalopathy).
- Malignant and nonmalignant tumors.
- Neurologic events, such as transient ischemic attacks, stroke, and seizures.

Medications Used in an Acute Mental Health Crisis

- Generally, antipsychotic medications are used.
- Exceptions include using anti-anxiety agents (Anxiolytics) like benzodiazepines (Valium, Ativan) for catatonic states, alcohol withdrawal, or agitation due to drug/medication effects. For example, anticholinergic medications, such as antihistamines (i.e. Benadryl and Dramamine, which are used to prevent motion sickness), scopolamine (the ear patch used to prevent motion sickness), Donnatal (prescribed for intestinal cramping and diarrhea), and Vesicare (prescribed for overactive bladders) can cause delirium. A catatonic state generally involves immobility and withdrawal, but benzodiazepines have a paradoxical effect in this condition and is the medication of choice.

Antipsychotic Medications

- Can be administered by mouth or by injection (intramuscularly or IM and sometimes intravenously or IV)
- Generally, medications take effect faster by injection and can be administered, if a patient is refusing medication treatment. IV administration is difficult in an agitated patient.
- First generation medications, such as droperidol (Inapsine) and haloperidol (Haldol), tend to more sedating and are preferred in acutely agitated patients. They are felt to inhibit dopamine action. They can be safely mixed with anxiolytics, such as lorazepam (Ativan). However, they have more extrapyramidal(EPS) or Parkinson-like side effects, such as involuntary muscle movements, like facial contortions, lip smacking, and tremor.
- Second generation medications or “atypical” antipsychotics have less EPS. They are felt to change the synapse or nerve cell connection. However, risperidone (Risperdal) has a slow onset when administered IM. Olanzapine (Zyprexa) acts more quickly, but it can cause respiratory depression when administered with anxiolytics. Quetiapine (Seroquel) is best for known Parkinson patients.

Antidepressants

- Less likely to be needed in an acute mental health crisis.
- In general, they work at the synapse or the communication link between to neurons or nerve cells. They affect the neurotransmitters, such as serotonin, norepinephrine, and dopamine.
- Selective Serotonin Reuptake Inhibitors or SSRIs, such as Prozac, Paxil, Zoloft, Celexa, and Lexapro.
- Selective Norepinephrine Reuptake Inhibitors or SNRIs, such as venlafaxine (Effexor), desvenlafaxine (Pristiq), and duloxetine (Cymbalta). Since they have some SSRI effects, they are also known as “Dual Pathway” antidepressants.
- Serotonin Modulators, such as trazodone (Desyrel). These have some SSRI properties, can stimulate serotonin release, and can also bind to some serotonin receptors.
- Norepinephrine-Dopamine Reuptake Inhibitors, such as bupropion (Wellbutrin).

Antidepressants continued…

- Tricyclics, such as amitriptyline (Elavil), nortriptyline (Pamelor), imipramine (Tofranil), and doxepin (Sinequan). They increase both serotonin and norepinephrine in the brain. They have anticholinergic side effects, such as dry mouth, dilated pupils, blurred vision, urinary retention, and constipation.
- Monoamine Oxidase Inhibitors (MAO-Inhibitors), such as selegiline (Emsam) and phenelzine (Nardil), block MAO which degrades serotonin and norepinephrine. However, it can trigger serotonin syndrome, which includes anxiety, agitation, sweating, and confusion. Also, in conjunction with certain foods, it can trigger extreme high blood pressure.
- Adjunctive Medications for Major Depression: aripiprazole (Abilify) and brexipiprazole (Rexulti). Both are second generation anti-psychotic medications. Mechanism of action is unknown.

Mood Stabilizers

- Unlikely to be needed during an acute mental health crisis, but they can prevent a relapse.
- Used for bipolar disorders, especially Type I, which has more profound manic episodes than Type II.
- First line medications for control of acute manic episodes include lithium, which is associated with a reduced risk of suicide, valproate and divalproex (Depakote), and quetiapine (Seroquel).
- Second line agents are better for maintenance therapy. These include the above first line agents and lamotrigine (Lamictal).

Antianxiety Medications or Anxiolytics

- SSRIs are the medications of choice, since they are nonaddictive. However, they can sometimes cause agitation and insomnia. If this happens, hydroxyzine (an antihistamine) or gabapentin can be added for a few weeks.
- Alternatives to SSRIs include:

a) Buspirone, which stimulates the serotonin receptor.

b) Tricyclic antidepressants, such as imipramine or mirtazapine. These are sedating and may help those with panic disorder.

- Benzodiazepines should be used with caution due to their addictive potential. Diazepam (Valium) and clonazepam (Klonopin) are preferred due to rapid onset of action and long duration of action. Felt to enhance the neurotransmitter GABA or gamma-aminobutyric acid. GABA A receptors cause a sedative hypnotic effect.

DATA NOTEBOOK 2024

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness and/or substance use disorders.

For general information, you may contact the following email address or telephone number:
DataNotebook@CBHPC.dhcs.ca.gov
(916) 701-8211

Or you may contact us by postal mail at:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413 Sacramento, CA 95899-7413

For questions regarding the SurveyMonkey online survey, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2024 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2024 Data Notebook, please use the following link and fill out the survey online by **November 30, 2024**:

https://www.surveymonkey.com/r/MFGJBYT

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CBHPC 2024 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. Planning Council staff analyze these responses to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify successes, unmet needs and make recommendations.

In 2019, we developed a section of the survey ("Part I") with standard questions that helped us detect any trends in critical areas affecting our most vulnerable populations. These included foster youth, individuals experiencing homelessness, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assisted in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy. The Part I questions were used from 2019-2023. In addition to these standardized questions, each Data Notebook focused on a different topic of interest. Survey questions for these topics have been referred to as "Part II."

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

What's New This Year?

For the 2024 Data Notebook, the Planning Council will no longer include the standardized Part I questions in the survey. This change will give us the opportunity to develop a new set of important and timely performance outcomes measures that can be tracked over time. We also aim to shorten the overall length of the survey to make it more accessible for participating counties. A complete analysis of the data collected over that five-year period is forthcoming, but some of the data regarding housing and homelessness are discussed later in this document.

The topic selected for the 2024 Data Notebook is "homelessness within the public behavioral health system." The Planning Council recognizes that this complex issue is the subject of much discussion, advocacy, and policy across the state. Our goal is to gather information about how counties address the issue of homelessness and housing among people served in their behavioral health systems and identify what data counties collect on this topic. There are also several questions at the end of the survey asking for your input on what topics or performance outcomes you would like us to focus on next year.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health (BH) boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify critical issues in their community. This work informs county and state leadership about local behavioral health programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report,' which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions (CALBHBC). The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Behavioral Health Boards and Commissions website.

[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.

What are Performance Outcomes?

While local behavioral health boards and commissions are required to review performance outcomes data for their counties, there is some ambiguity about what constitutes a "performance outcome measure." Outcome measures are one of several kinds of measures used to evaluate the quality of health care organizations and services. According to the Agency for Healthcare Research and Quality, a common classification of quality measures[4] includes:

- **Structural Measures** provide data on the capacity, systems, and infrastructure of a health care provider to gauge their ability to provide care. Examples of structural measures would be the ratio of providers to patients, or whether the organization uses electronic medical records.
- **Process Measures** indicate that a provider is using evidence-based best practices and processes to achieve a positive impact on people's health or reduce harmful outcomes. Examples of process measures are the number of patients who receive recommended health screenings, appointment wait times, or frequency of follow-up appointments.
- **Outcome Measures** evaluate the impact a service or intervention has on an individual's health status and recovery, whether positive or negative. Examples of outcome measures include evaluations of symptom severity, rates of hospital readmissions, and quality of life.

Of these three kinds of quality measures, outcome measures are arguably the most valuable for assessing the effectiveness of a health care service or intervention. However, they are also the hardest to evaluate. A big challenge with outcome measures is that there are many factors that influence health outcomes besides the treatment or services that an individual receives. It is beneficial to evaluate outcome measures in the context of structural and process measures, as they are closely related. Improving processes and system capacity within a health care organization can result in improved outcomes.

Patient-reported outcomes are important for assessing the quality of care that patients receive. These are outcome measures of an individual's health, quality of life, and their experiences regarding the care they receive, using information gathered directly from the patient and/or their caregivers. Examples include patient reports of how well they feel their provider listens to them during appointments, or how effective they feel their treatment has been over the past 6 months.

A **performance indicator** is a specific measure, whether quantitative or qualitative, that is used to determine if a service or program is achieving their desired outcomes. During the evaluation process, the organization reviews their indicators to assess the

[4] Types of Health care Quality Measures, by the Agency for Healthcare Research and Quality.

effectiveness of their processes, policies, and services. It is important to also review the indicators themselves at regular intervals to determine if those indicators are working as intended, or whether the indicators need to be modified to better serve the evaluation plan. Note that it may be difficult to draw sound conclusions from qualitative indicators.

In behavioral health care, there are many potential outcome indicators that can be used to evaluate the impact of programs and services. The California Association of Local Behavioral Health Boards and Commissions published an issue brief[5] on the topic of performance outcome data that includes suggested data points for county behavioral health agencies. The Agency for Healthcare Research and Quality also has publicly available resources on how to choose health care quality measures.[6] We recommend that local behavioral health boards and commissions and behavioral health agencies familiarize themselves with these resources when considering what data to collect or use.

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[5] Performance Outcome Data Issue Brief, published by the California Association of Local Behavioral Health Boards and Commissions.
[6] Key Questions When Choosing Health Care Quality Measures, by the Agency for Healthcare Research and Quality.

CBHPC 2024 Data Notebook: Homelessness in the Public Behavioral Health System

Homelessness is a multifaceted and longstanding phenomenon in United States, and California in particular. The state of California is home to the largest number of individuals experiencing homelessness in the nation. Our state makes up about 12% of the total population of the United States, yet accounts for 31% of the nation's homeless population and 49% of the unsheltered population as of 2023. The combination of low income and a lack of affordable housing continues to be the largest contributing factors for homelessness. However, there are many other factors that play a role in this issue including incarceration, racial disparities, physical and mental health, and domestic violence.

The intersection of homelessness and behavioral health is a complex topic, and has been the subject of increasing public discussion, political debate, and legislation. Rates of homelessness have continued to increase at alarming rates, exacerbated by the effects of the COVID-19 pandemic. As public concerns about homelessness have grown, so have statewide efforts to reform behavioral health services in California. While the Planning Council does not share or endorse the view that mental illness is the primary cause of homelessness, the public behavioral health system does play a vital role in serving individuals experiencing homelessness.

The California Behavioral Health Planning Council has a long history of advocacy regarding housing and homelessness within the public mental health system. In 2016, the Planning Council published a report[7] highlighting programs and policies that looked promising for ending homelessness for those with severe mental illness and substance use disorders. This report was the result of multiple panel presentations in 2015 involving people with lived experience, providers, advocates, and other stakeholders. More recently, our Housing and Homelessness Committee published an issue brief[8] in 2020 highlighting services available to prepare persons experiencing homelessness for successful transitions to housing.

For the past 5 years, the Data Notebook survey has included an item asking counties to report on new or expanded services for homeless behavioral health clients. We have also included data from the federal Department of Housing and Urban Development (HUD) Point-In-Time counts for California. By making this topic the primary focus of the

[7] Hope for the Hopeless: Effective Programs that Promote Real Change. Published January 2016 by the California Behavioral Health Planning Council.
[8] The Crisis of Housing and Homelessness: Effective Programs to Bridge the Gap from Homelessness to Housing. Published May 2020 by the California Behavioral Health Planning Council.

2024 Data Notebook, we aim to learn more about how individuals experiencing homelessness are served within the public behavioral health system. The survey questions for this year have been written to identify the types of data being collected at the county level, as well as some basic information on county-level programs, needs, and goals regarding homelessness.

Defining Homelessness

The federal government finalized an official definition of homelessness in 2011[9] for the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. This definition states that a person or family is homeless if they fall into one of four categories:

- **Currently homeless** (lacking a fixed, regular, nighttime residence, which includes living in a car or temporary shelter program).
- **Imminent risk of homelessness** (those who will lose their nighttime residence within 14 days).
- **Homeless under other federal statutes or programs**. This includes those who have not had a permanent residence in the last 60 days.
- **Fleeing or attempting to flee domestic violence**, dating violence, or other threatening situations.

Additionally, the definition of “chronic homelessness” was clarified in 2015[10]. This definition covers individuals or families who have been homeless for at least 12 months, or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

Because these definitions are the ones used by the Department of Housing and Urban Development, they are the ones that we will be using for the purposes of the 2024 Data Notebook. However, we understand that many organizations and programs have different working definitions for these terms and are interested to learn how your county behavioral health agency defines homelessness in practice.

A Recent History: Housing and Homelessness Data presented in 5 years of California Data Notebook Overview Reports, 2019-2023.

Every year, the states, counties, and many cities perform a “Point-in-Time” Count[11] of the individuals experiencing homelessness in their counties, usually on a specific date

[9] The final ruling on the definition of homelessness for the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, on the HUD Exchange website.
[10] Federal definition of chronic homelessness, on the HUD Exchange website.
[11] 2023 Point-in-Time Homeless Populations and Subpopulations Reports are available on the HUD Exchange website.

in January. Such data are key to state and federal policy and funding decisions. **Table 1** provides data from the 2023 Point-in-Time Count. This data is publicly available, provided by the U.S. Department of Housing and Urban Development.

Table 1. State of California Estimates of Homeless Individuals Point in Time[12] Count 2023

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL 2023	Percent Change from 2022
Persons in households without children	38,230	117,020	155,028	+ 6.6%
Persons in households with children	19,484	5,999	25,483	- 0.2%
Unaccompanied homeless youth	3,239	6,934	10,173	+ 6.1%
Veterans	3,153	7,436	10,589	+ 1.9%
Chronically homeless individuals	16,621	54,529	71,150	+ 16.8%
Total (2023) Homeless Persons in CA	57,976	123,423	181,399	+ 5.8%
Total (2023) Homeless Persons, USA	396,494	256,610	653,104	+ 12.1%

We have presented California data from the federal HUD Point-in-Time Count in each data notebook to inform the local behavioral health boards and for a basis for their discussion and responses.

The data from the past 5 years, displayed below in **Figure 1**, show increasing trends during this time span for nearly all the groups selected, including total homeless persons, those unsheltered, the chronically homeless, those served by emergency shelters, those persons with severe mental illness, and those who experienced chronic

[12] PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development (www.HUD.gov). Sheltered persons include those who were in homeless shelters and distinct types of transitional or emergency housing.

substance abuse. The groups which did not show any major increases during this time span include those served in transitional housing at the selected point-in-time counts, and the numbers for unaccompanied youth aged 18-24, and for unaccompanied children under 18. We do not know the reason why numbers for those specific groups did not exhibit significant changes over this 5-year time span. Note the data gaps for January 2021, when COVID-19 health protocols precluded counting unsheltered individuals, and therefore impacted any data which normally would include those numbers in aggregated totals. Table 2 contains the numerical data used to construct Figure 1.

Figure 1. California Homeless Point-in-Time Counts for Several Vulnerable Populations, 2019-2023.

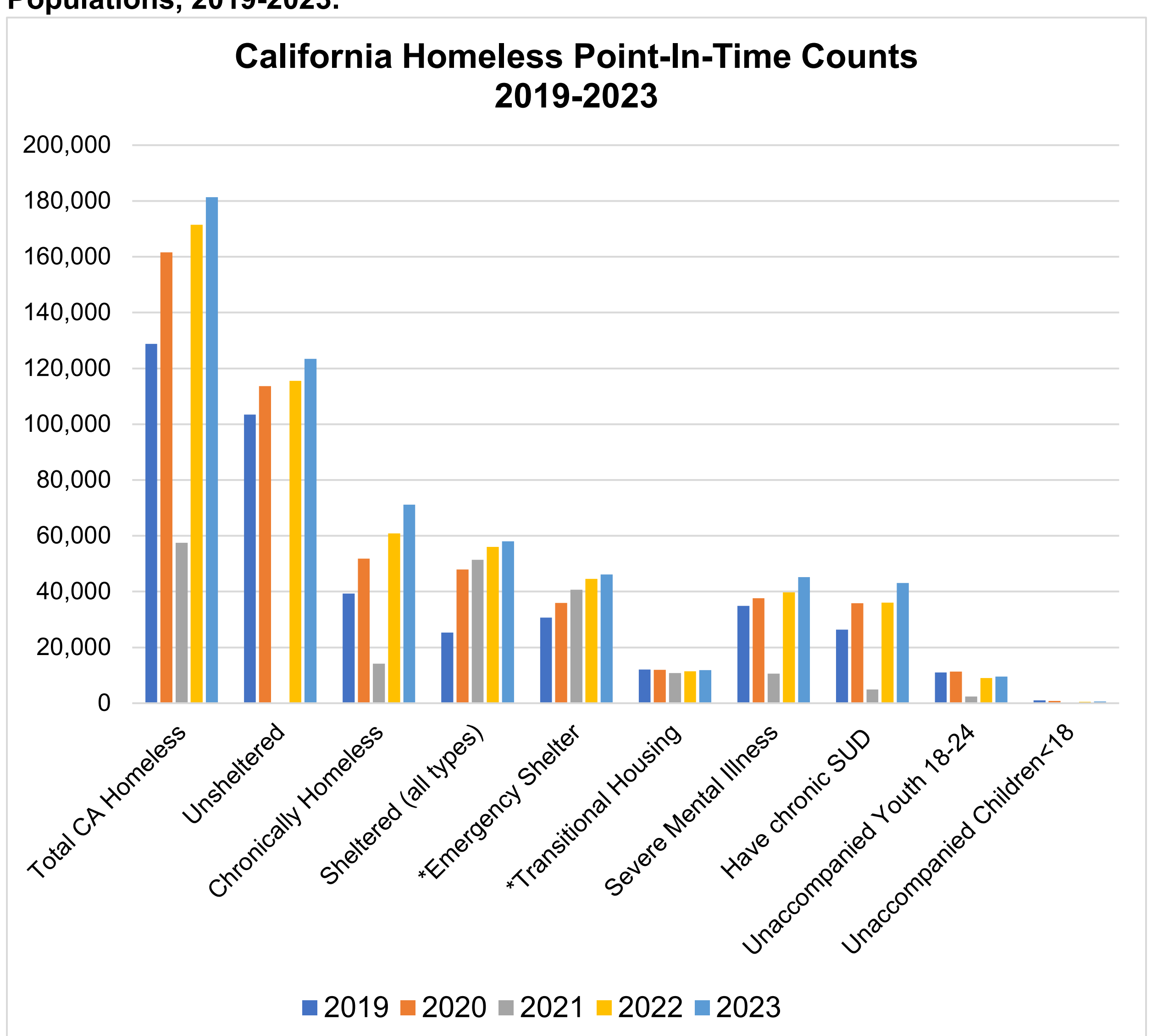


Table 2. CA Homeless Data from Annual P.I.T. Counts, 2019 – 2023.

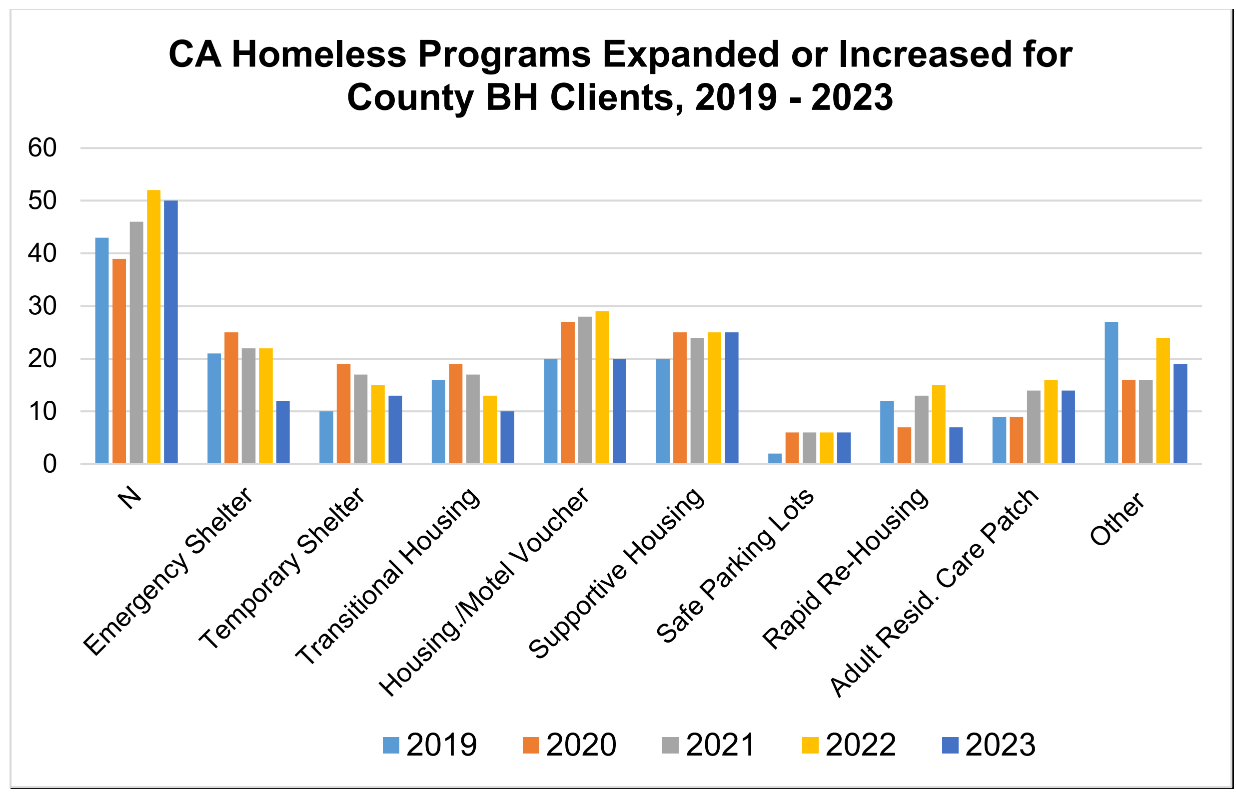
	2019	2020	2021	2022	2023
Total CA Homeless	128,777	161,548	57,468	171,521	181,399
Unsheltered	103,454	113,660	*	115,491	123,423
Chronically Homeless	39,275	51,785	14,168	60,905	71,150
Sheltered (all types)	25,323	47,918	51,429	56,030	57,976
***Emergency Shelter**	30,723	35,996	40,662	44,553	46,111
***Transitional Housing**	12,123	11,922	10,767	11,477	11,865
Severe Mental Illness	34,942	37,599	10,607	39,721	45,222
Have chronic SUD	26,410	35,821	4,970	36,096	43,047
Unaccompanied Youth 18-24	11,002	11,370	2,354	9,046	9,519
Unaccompanied Children<18	991	802	172	544	654

In addition to the HUD Point-In-Time data, previous Data Notebooks included the following survey question:

“During the most recent fiscal year, what new programs were implemented, or what existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?”

Figure 2 shows a summary of the responses to this question from the past 5 years. The Data group labeled ‘N’ shows the number of counties which submitted responses to this question in that year’s Data Notebook. The category of ‘Other’ includes some programs which were developed with special funding (such as Project Home Key, etc.) in response to the pandemic and the economic dislocation experienced by many individuals.

Figure 2. California Homeless Programs Added or Expanded for County Behavioral health Clients, 2019-2023.



~~#10) County BH used local data to develop a new FSP team with a population of focus of individuals with SMI who are experiencing~~

2024 Data Notebook Survey Questions

Please respond by means of the Survey Monkey link provided with this Data Notebook.

Section 1: Homelessness in the Public Behavioral Health System

~~#10) County BH used local data to develop a new FSP team with a population of focus of individuals with SMI who are experiencing ho~~

1. **Please identify your County / Local Board or Commission.** *(dropdown menu)*
2. **Which of the following definitions of homelessness does your county use to identify individuals experiencing homelessness within your behavioral health system?** *(select all that apply)*
   a. The U.S. Housing and Urban Development (HUD) definition of *homelessness*, as used in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.
   b. The U.S. Department of Health and Human Services definition of *homeless youth* established by the Runaway and Homeless Youth Act (RHYA).
   c. The U.S. Department of Education definition of *homeless children and youths* as defined in the McKinney-Vento Homeless Assistance Act.
   d. Substance Abuse and Mental Health Services Administration (SAMHSA) definition of those who are *experiencing homelessness*.
   e. The Social Security Administration (SSA) definition of *homelessness*.
   f. Other (written response)

3. **Does your county enter data on homelessness and housing services into a Homeless Management Information System (HMIS)?**
   a. Yes
   b. No

4. **Concerning individuals currently receiving services in your county behavioral health system, is your county actively collecting data on the housing status of any of the groups listed?** *(Please check all that apply)*
   a. Foster youth
   b. Youth 18 years of age or younger
   c. Youth ages 19-24
   d. Adults ages 25-65
   e. Adults 66 years of age or older
   f. Consumers receiving mental health services
   g. Consumers receiving substance use treatment
   h. Veterans
   i. Individuals exiting incarceration from county jail
   j. Individuals exiting incarceration from prison
   k. Individuals in Institutions of Mental Disease (IMDs)
   l. Individuals in psychiatric hospitals
   m. Other (please specify)

n. None/Not Applicable

5. **What supports are necessary to provide housing to people served in your county behavioral health system for more than 6 months?** *(Please check all that apply)*
   a. Case management services
   b. Intensive case management services
   c. Health or social services access/navigation services
   d. Medication-Assisted Treatment
   e. Enhanced Care Management (ECM) and Community Supports
   f. Rental subsidies
   g. Housing vouchers
   h. Transitional and temporary housing
   i. Peer support
   j. Community health worker
   k. Supported employment services
   l. Wellness centers
   m. Full-Service Partnerships (FSPs)
   n. Other (written response)

6. **Does your county behavioral health system participate in a county-wide interagency continuum of care that meets regularly to address housing for your county residents?**
   a. Yes
   b. No

7. **For people currently receiving services from your county behavioral health system, are you actively collecting any data on whether they are homeless/unsheltered at every point of service? For example, do you check for homeless status every time you provide individuals with any service?**
   a. Yes
   b. No

8. **Please list the organizations/agencies you work with to provide housing support and services for individuals served by your county behavioral health system.** *(Written Response: please use bullet points for this list)*

9. **Is your county behavioral health system able to use local data when making program decisions and financial investments in existing or new homelessness/housing programs?**
   a. Yes
   b. No

#8) Front Street, Encompass Community Services, Community Connection, Housing Matters County Housing for Health Division of the Human Services Department, HPHP, Volunteer Center, Housing for Health

#10) County BH used local data to develop a new FSP team with a population of focus of individuals with SMI who are experiencing homelessness-IHART (Integrated Housing and Recovery Team). This FSP work closely with mental health Connectors supported by Front St to provide connection to the Housing CoC and Coordinated Entry system and provide housing navigation services.

10. **If you answered "Yes" to the previous question, can you give an example of a program your county initiated based on data you collect or track?** *(Written response)*

11. **Does your county behavioral health department have a housing services unit or housing coordinator?**
    a. Yes
    b. No

Section 2: Performance Outcomes Data

12. **Does your behavioral health agency currently collect data for the performance indicators listed below for all adult beneficiaries?** *(Please check all that apply)*
    a. Employment status
    b. Criminal justice involvement
    c. Housing status
    d. Visits to the emergency room (ER)
    e. Psychiatric Hospitalizations
    f. Lanterman-Petris-Short (LPS) Conservatorship
    g. Rates of self-harm
    h. Rates of suicide
    i. Social functioning and community connectedness
    j. Self-reported wellness
    k. Overall patient satisfaction
    l. Other (Please Specify)

13. **Does your behavioral health agency currently collect data for the performance indicators listed below for all child and youth beneficiaries?** *(Please check all that apply)*
    a. Criminal justice involvement
    b. Housing status
    c. Visits to the emergency room (ER)
    d. Psychiatric Hospitalizations
    e. Rates of self-harm
    f. Rates of suicide
    g. School attendance/absenteeism
    h. Academic engagement
    i. Classroom behavior
    j. Social functioning and community connectedness
    k. Self-reported wellness
    l. Overall patient satisfaction
    m. Other (Please Specify)

14. Do you utilize the performance indicators previously identified in any of the following ways? *(Please check all that apply)*

a. Evaluate the effectiveness of programs
b. Make changes in spending
c. Make changes in program planning
d. Inform partners and stakeholders
e. Advocate for policy changes
f. Engage in community outreach
g. Other (written response)

15. Overall, do you have adequate data to evaluate and comment on performance outcomes in your county behavioral health system?

a. Yes
b. No

16. Which of the following topics or areas of interest would your county like to see future Data Notebooks focus on? *(Please select up to 5).*

a. Employment Status
b. Criminal Justice Involvement
c. Housing Status
d. Visits to the emergency room (ER)
e. Psychiatric Hospitalizations
f. Lanterman-Petris-Short (LPS) Conservatorship
g. Rates of Self-Harm and Suicide
h. School-Based Wellness for Children/Youth
i. Social Functioning and Community Connectedness
j. Self-reported wellness
k. Overall Patient Satisfaction
l. Other (Please Specify)

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. The questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

17. What process was used to complete this Data Notebook? (Please select all that apply)

a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
b. MH board completed majority of the Data Notebook.
c. Data Notebook placed on agenda and discussed at board meeting.
d. MH board work group or temporary ad hoc committee worked on it.
e. MH board partnered with county staff or director.
f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
g. Other (please specify)

18. Does your board have designated staff to support your activities?

h. Yes (if yes, please provide their job classification)
i. No

Administrative Aide

19. Please provide contact information for this staff member or board liaison.

Jane Batoon-Kurovski, Jane.Batoon-Kurovski@santacruzcountyca.gov; 831-454-4611

20. Please provide contact information for your board's presiding officer (chair, etc.)

Xaloc Cabanes, Xaloc@aol.com; 831-239-4505

21. Do you have any feedback or recommendations to improve the Data Notebook for next year?

118TH CONGRESS
2D SESSION

H. R. 8575

To amend title XIX of the Social Security Act to revise the definition of institution for mental diseases under the Medicaid program to exclude from such definition institutions having 36 beds or less if such institutions meet certain standards.

IN THE HOUSE OF REPRESENTATIVES

MAY 28, 2024

Mr. GOLDMAN of New York (for himself, Ms. MALLIOTAKIS, Mr. CÁRDENAS, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XIX of the Social Security Act to revise the definition of institution for mental diseases under the Medicaid program to exclude from such definition institutions having 36 beds or less if such institutions meet certain standards.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Michelle Alyssa Go
5 Act".

1 **SEC. 2. REVISING THE DEFINITION OF INSTITUTION FOR**
2 **MENTAL DISEASES UNDER THE MEDICAID**
3 **PROGRAM TO EXCLUDE FROM SUCH DEFINI-**
4 **TION INSTITUTIONS HAVING 36 BEDS OR**
5 **LESS IF SUCH INSTITUTIONS MEET CERTAIN**
6 **STANDARDS.**

7 Section 1905(i) of the Social Security Act (42 U.S.C.
8 1396d(i)) is amended to read as follows:
9 "(i) INSTITUTION FOR MENTAL DISEASES.—The
10 term 'institution for mental diseases' means a hospital,
11 nursing facility, or other institution that is primarily en-
12 gaged in providing diagnosis, treatment, or care of persons
13 with mental diseases, including medical attention, nursing
14 care, and related services, unless such hospital, facility,
15 or other institution—
16 "(1) has 36 beds or less; and
17 "(2) meets nationally recognized, evidence-
18 based standards for mental health programs (and, in
19 the case of an institution for mental diseases that
20 provides treatment for substance use disorders,
21 meets nationally recognized, evidence-based stand-
22 ards for substance use disorder programs, such as
23 the latest standards set forth by the American Soci-
24 ety of Addiction Medicine) approved by the Sec-
25 retary, including standards that establish the types
26 of services offered, hours of clinical care, and staff-

1 ing credentials for such an institution, and any other
2 standards as the Secretary may require.''.

3 **SEC. 3. EFFECTIVE DATE.**

4 The amendments made by this Act shall take effect
5 180 days after the date of enactment of this Act and shall
6 apply to State plans beginning on such date.

○

08-JUN-2024

Santa Cruz County Board of Supervisors
701 Ocean Street, Room 500
Santa Cruz, CA 95060
831 4543 2200

Re: Letter of recommendation in support of Congressional Bill HR 8575 the Michelle Alyssa Go Act .

To: Santa Cruz County Board of Supervisors

The Santa Cruz County Mental Health Advisory Board recommends that the BOS send a letter urging our congressional representatives to actively support and or cosponsor HR 8575, the Michelle Alyssa Go Act which expands the Medicaid program's reimbursement to Institutions for Mental Diseases (IMD) from 16 to 36 beds and for patients between the ages of 22 and 64.

Santa Cruz county currently has only 16 out of the 153 acute care inpatient psychiatric beds recommended by the California Department of Health Care Access and Information. Santa Cruz also has a large population of individuals over the age of 22 without health insurance needing mental health and substance use treatment.

HR8575 amends title XIX of the Social Security Act to revise the definition of Institution for Mental Diseases (IMD) under the Medicaid program allowing mental health institutions to be reimbursed by Medicaid if they have more than 16 beds designated for mental health treatment. This bill would also remove the age limitation for medical reimbursement, so that IMD patients between the ages of 22 and 64 are eligible for Medicaid reimbursement.

This legislation will increase the number of beds from 16 to 36 allowing for the expansion of existing facilities.

Again, Santa Cruz County Mental Health Advisory Board recommends that the BOS send a letter urging our congressional representatives to actively support and or cosponsor HR 8575, the Michelle Alyssa Go Act which expands the Medicaid program's reimbursement to Institutions for Mental Diseases (IMD) from 16 to 36 beds and for patients between the ages of 22 and 64.

Please do not hesitate to contact Xaloc Cabanes, chair of MHAB, should you have any questions.

Santa Cruz County Mental Health Advisory Board

10-SEP-2024 DRAFT

(Local Behavioral Health Board or Commission)
Address
Phone

To: (Local Behavioral Health Board or Commission)

Re: Request to support bill HR8575 to expand IMD beds

We, the Santa Cruz County Mental Health Advisory Board are contacting all California Mental Health Advisory boards requesting that they send a letter of recommendation to their BOS requesting that the BOS send a letter to their local congressional representatives requesting that they cosponsor HR8575, the Michelle Go Act, authored by Representative Dan Goldman of New York.

This act expands the Medicaid program's reimbursement to Institutions for Mental Diseases (IMD) from 16 beds to 36 beds and for patients between the ages of 22-64. We have successfully done this in Santa Cruz and we are awaiting to hear back from our congressional representatives.

We have attached our letter of recommendation that you may use as your template as well as a copy of the HR8575 text. HR 8575 currently has 11 cosponsors (there is no limit to the number of cosponsors), including 3 from California: Rep. Tony Cardenas D-CA29, Rep. Grace Napolitano D-CA 31, and Rep. Julia Brownley D-CA26.

Thank you for your service.

Please do not hesitate to contact me, Jeffrey Arlt, should you have any questions.

Santa Cruz County Mental Health Advisory Board

Santa Cruz County Mental Health Advisory Board

10-SEP-2024 DRAFT

Local Behavioral Health Boards and Commissions Contact Info

1. Alameda Mental Health Advisory Board ACBH.MHBCommunications@acgov.org3rd Mon, 3 - 5pm In-person & Online
2. Alpine Mental Health Advisory Board (530) 694-1816 4th Wednesday, 12pm - 1pm In-person
3. Amador Behavioral Health Advisory Board (209) 223-6412 3rd Wed, 3:30pm - 5pm In-person
4. Berkeley (City) Mental Health Commission 4th Thurs, 7pm - 9pm In-person
   Jamie Works-Wright Health,Housing, and Community Services (510) 981-7721 BAMHC@berkeleyca.gov
5. Butte Behavioral Health Advisory Board 530-891-2850 3rd Wed, 3pm - 5pm In-person & Online
6. Calaveras Mental Health Advisory Board 1st Tues, 3:30pm - 5pm In-person
7. Colusa Behavioral Health Board 2nd Tues, 3pm In-person & Online
8. Contra Costa Mental Health Commission 1st Wed, 4:30pm - 6:30pm In-person & Online
9. Del Norte Local Behavioral Health Board 1st Mon (Every 2 Months), 12pm In-person & Online
10. El Dorado Behavioral Health Commission 3rd Wed, 5 pm In-person & Online
11. Fresno Behavioral Health Board 3rd Wed, 3:30pm - 5:30pm In-person
12. Glenn Behavioral Health Advisory Board 2nd Tues, 3pm In-person & Online
13. Humboldt Behavioral Health Board 4th Thurs, 12:15pm In-person & Online
14. Imperial Behavioral Health Advisory Board 3rd Tues, (Time Varies) In-person & Online
15. Inyo Behavioral Health Advisory Board 2nd Wednesday, 2:30pm In-person & Online
16. Kern Behavioral Health Board 4th Mon, 5:30pm - 7:00pm In-person
17. Kings Behavioral Health Advisory Board 4th Mon, 12pm - 1:30pm In-person & Online
18. Lake Mental Health Board 2nd Thurs (every other month), 4pm - 5pm In-person & Online
19. Lassen Behavioral Health Advisory Board 2nd or 3rd Mon (Varies), 5:30pm In-person
20. Los Angeles Mental Health Commission 4th Thurs, 11am - 1:30pm In-person & Online
21. Madera Behavioral Health Advisory Board 3rd Wed, 11:30am ~ 1pm In-person

22. Marin Behavioral Health Board 2nd Tues, 6pm - 7:30pm In-person & Online
23. Mariposa Behavioral Health Board 1st Wed, 12:30 pm - 2 pm In-person & Online
24. Mendocino Behavioral Health Board 4th Wed, 10am (Varies) In-person
25. Merced Behavioral Health Advisory Board 1st Tues, 4pm - 6 pm In-person & Online
26. Modoc Behavioral Health Advisory Board 3rd Thurs, 3:30pm In-person & Online
27. Mono Behavioral Health Advisory Board Varies, usually 2nd Monday (Every 2 Months), 3pm - 4:30pm In-person & Online
28. Monterey Behavioral Health Commission Last Thurs, 5:30pm In-person & Online
29. Napa Behavioral Health Board 2nd Mon, 4pm - 6 pm In-person
30. Nevada Mental Health & Substance Use Advisory Board 1st Fri, 10 - 12pm (No meeting in July) In-person
31. Orange Behavioral Health Advisory Board 4th Wed, 10am - 11:45am In-person & Online
32. Placer Mental Health, Alcohol and Drug Advisory Board 4th Mon, 6:15pm (Times may vary) In-person & Online
33. Plumas Behavioral Health Commission 1st Wed, 1pm - 3 pm In-person & Online
34. Riverside Behavioral Health Commission 1st Wed, 12pm - 2pm In-person & Online
35. Sacramento Mental Health Board 1st Wed, 6pm - 8pm In-person & Online
36. Sacramento Youth Behavioral Health Youth Advisory Board 1st & 3rd Tues, 5pm - 7pm In-person & Online
37. San Benito Behavioral Health Board 3rd Thurs, 12pm-1:30pm In-person
38. San Bernardino Behavioral Health Commission 3rd Thurs, 12pm - 2pm In-person & Online
39. San Diego Behavioral Health Advisory Board 1st Thurs, 2:30pm - 5pm In-person & Online
40. San Francisco Behavioral Health Commission 3rd Thurs, 6pm - 8pm In-person & Online
41. San Joaquin Behavioral Health Advisory Board 3rd Wed, 5pm In-person
42. San Luis Obispo Behavioral Health Board 3rd Wed, 3pm In-person

43. San Mateo Behavioral Health Commission 1st Wed, 3pm - 5pm (No meeting in August) In-person & Online
44. Santa Barbara Behavioral Wellness Commission 3rd Wed, 3pm - 5pm In-person & Online
45. Santa Clara Behavioral Health Board 2nd Mon, 12pm In-person
46. Santa Cruz Mental Health Advisory Board 3rd Thurs, 3pm-5pm In-person & Online
47. Shasta Mental Health, Alcohol and Drug Advisory Board 2st Wed (Every other month), 5:30pm In-person & Online
48. Sierra Behavioral Health Advisory Board 1st Thurs, 9:30am - 11am In-person & Online
49. Siskiyou Behavioral Health Board 3rd Mon, 3:30pm In-person & Online
50. Solano Behavioral Health Advisory Board 3rd Tues, 3:30pm - 5pm In-person
51. Sonoma Mental Health Board 3rd Tues (Every other month), 5pm - 7pm In-person & Online
52. Stanislaus Behavioral Health Board 4th Thurs, 5pm In-person
53. Sutter-Yuba Behavioral Health Advisory Board 2nd Thurs, 5pm In-person & Online
54. Tehama Behavioral Health Advisory Board 3rd Wed, 12:15pm-1:30pm In-person & Online
55. Tri-City Mental Health Commission 2nd Tues, 3:30pm In-person & Online
56. Trinity Behavioral Health Services Board 3rd Wed, 12 pm In-person & Online
57. Tulare Mental Health Board 1st or 2nd Tues (Varies), 3pm In-person & Online
58. Tuolumne Behavioral Health Advisory Board 1st Wed, 4pm In-person
59. Ventura Behavioral Health Advisory Board 3rd Mon, 1pm - 3:30pm In-person & Online
60. Yolo Local Mental Health Board 1st Wed, 6pm - 8pm In-person & Online