AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

ASSEMBLY BUDGET SUBCOMMITTEE NO. 2

ON EDUCATION FINANCE

ASSEMBLYMEMBER KEVIN MCCARTY, CHAIR

ASSEMBLY SELECT COMMITTEE

ON EARLY CHILDHOOD DEVELOPMENT

ASSEMBLYMEMBER RUDY SALAS, CHAIR

MONDAY, FEBRUARY 28, 2022

2:30 PM, STATE CAPITOL, ROOM 4202

Due to the regional stay-at-home order and guidance on physical distancing, seating for this hearing will be very limited for press and for the public. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted.

A moderated telephone line will be available to assist with public participation. The public may provide comment after all witnesses on all panels and issues have concluded, and after the conclusion of member questions. To provide comment, please toll-free:

877-692-8957 / Access Code: 131 54 202

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

6100 CALIFORNIA DEPARTMENT OF EDUCATION

ISSUE 1: CHILDREN AND YOUTH BEHAVIORAL HEALTH – PERSPECTIVES OF THE STATE SUPERINTENDENT OF PUBLIC INSTRUCTION

PANEL 1 - PRESENTERS

- **Tony Thurmond**, State Superintendent of Public Instruction

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 2: MENTAL HEALTH ISSUES: EARLY CHILDHOOD (0 – 5 YEARS OF AGE)

- **OVERSIGHT: CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI), AND MENTAL HEALTH PREVENTION AND EARLY INTERVENTION FOR YOUNG CHILDREN**

PANEL 2 - PRESENTERS

- **Jackie Wong**, Chief Deputy Director, First 5 California
- **Mary Ann Hansen**, Executive Director, First 5 Humboldt County
- **Angela M. Vázquez**, Policy Director - Mental Health, The Children's Partnership
- **Marni Sandoval,** Deputy Director of Behavioral Health, Child and Adolescent Services, Monterey County Health Department
- **Miren Algorri**, Child Care Providers United
- **Donna Sneeringer**, Chief Strategy Officer, Child Care Resource Center
- **Tena Sloan**, Vice President of Early Childhood Mental Health Consultation and Training, Kidango
- **Khieem Jackson**, Founding Member, Black Men for Education Equity
- **Deneen Gus**, Superintendent, Monterey County Office of Education
- **Melissa Stafford Jones**, Director, Children and Youth Behavioral Health Initiative, California Health and Human Services Agency

PANEL 2 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Autumn Boylan**, Deputy Director, Office of Strategic Partnerships, Department of Health Care Services
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
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- **Mark Newton**, Deputy Legislative Analyst: Health, Developmental Services and IT, Legislative Analyst's Office

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4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION
6100 CALIFORNIA DEPARTMENT OF EDUCATION

ISSUE 3: BEHAVIORAL HEALTH ISSUES: SCHOOL-AGE CHILDREN AND YOUTH (K-12)

- **CHHS, HCAI, DHCS: CYBHI OVERSIGHT AND 2022 PROPOSALS, AND CHILDREN AND YOUTH BH ISSUES IN MEDI-CAL**
- **OAC: PROGRAMING OVERSIGHT & 2022 PROPOSALS INCLUDING:**
  - CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE: EVIDENCE-BASED BEHAVIORAL HEALTH PROGRAMS REIMBURSEMENT BCP
  - MENTAL HEALTH STUDENT SERVICES ACT PARTNERSHIP GRANT PROGRAM AUGMENTATION BCP
  - STAKEHOLDER ADVOCACY CONTRACTS PROPOSAL
- **CDPH: OVERDOSE PUBLIC AWARENESS CAMPAIGN AND SURVEILLANCE BCP AND OFFICE OF SUICIDE PREVENTION OVERSIGHT**
- **CDE: K-12 BH OVERSIGHT**

PANEL 3 – PRESENTERS

- **Matthew Deip**, Youth Speaker, Assistant Program Manager, CA Youth Empowerment Network (CAYEN)
- **Melissa Stafford Jones**, Director, Children and Youth Behavioral Health Initiative, California Health and Human Services Agency
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
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- **Nghia Do**, Youth Speaker
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- **Almah Galan**, Youth Speaker, allcove San Jose YAG Member

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- **Tyler Sadwith**, Assistant Director, Behavioral Health, Department of Health Care Services
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- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch, Center for Healthy Communities, California Department of Public Health
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- **Mark Newton**, Deputy Legislative Analyst: Health, Developmental Services and IT, Legislative Analyst's Office

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 4: ALL CHILDREN THRIVE PROGRAM OVERVIEW AND REPORT

PANEL 4 – PRESENTERS

- **Maria Ochoa,** Assistant Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Harold Goldstein**, Executive Director, Public Health Advocates

PANEL 4 – Q&A ONLY

- **Terri Sue Canale**, Acting Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch, Center for Healthy Communities, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
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6440 UNIVERSITY OF CALIFORNIA
6610 CALIFORNIA STATE UNIVERSITY
6870 CALIFORNIA COMMUNITY COLLEGES

ISSUE 5: BEHAVIORAL HEALTH ISSUES: YOUNG ADULTS (18 – 25 YEARS OF AGE) OVERSIGHT: CYBHI, RECENT STATE FUNDING FOR BH, AND BH ISSUES IN CALIFORNIA UNIVERSITIES AND COLLEGES, AND FOR NON-STUDENTS

PANEL 5 – PRESENTERS

- **Briana Fernandez Diaz**, Youth Speaker, Central allcove Team YAG Member
- **Khoa-Nathan Ngo**, Youth Speaker, alcove San Jose YAG Member
- **Zofia Trexler**, Youth Speaker
- **Hugh Cook**, Youth Speaker, UCSB Student
- **Genie Kim**, Director of Student Mental Health and Well-being, Graduate, Undergraduate and Equity Affairs, University of California Office of the President
- **Joy Stewart-James,** Associate Vice President, Student Health & Counseling Services, CSU Sacramento
- **Rebecca Ruan-O'Shaughnessy,** Vice Chancellor for Educational Services and Support, California Community College Chancellor's Office
- **Melissa Stafford Jones**, Director, Children and Youth Behavioral Health Initiative, California Health and Human Services Agency
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
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AGENDA OVERVIEW

It has become widely accepted that American children and youth are in the midst of an unprecedented behavioral health crisis. Dire statistics and alarming trends existed before the pandemic, and since March of 2020, the data has only gotten worse. The United States Surgeon General issued an unprecedented advisory on December 7, 2021 highlighting the severity of the mental health crisis for youth. The advisory reports the following data:

- Before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the U.S. having a mental, emotional, developmental, or behavioral disorder.

- From 2009 to 2019, the share of high school students who reported persistent feelings of sadness or hopelessness increased by 40%, to more than 1 in 3 students.

- Suicidal behaviors among high school students also increased during the decade preceding COVID, with 19% seriously considering attempting suicide, a 36% increase from 2009 to 2019, and about 16% having made a suicide plan in the prior year, a 44% increase from 2009 to 2019.

- Between 2007 and 2018, suicide rates among youth ages 10-24 in the U.S. increased by 57%, and early estimates show more than 6,600 suicide deaths among this age group in 2020.

In October of 2021, a coalition of the nation's leading experts in pediatric health (the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association) declared a national emergency in child and adolescent mental health. The coalition stated that the "worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19 and the ongoing struggle for racial justice and represents an acceleration of trends observed prior to 2020." The following alarming statistics also have been reported:

- The suicide rate among Black youth in California doubled since 2014 (*California Department of Public Health, California Comprehensive Master Death File*).

- During the pandemic, 70% of LGBTQ youth report having poor mental health most or all of the time (*The Trevor Project, National Survey on LGBTQ Youth Mental Health 2021*).

The ACLU issued a 2022 report, "*State of Student Mental Wellness California*," which examines student wellness and access to school-based mental health support throughout multiple years of the pandemic. Findings from the surveys indicate students are experiencing a host of mental health issues, including but not limited to an increase in social anxiety, panic attacks, depressive symptoms, body image issues, self-harm, and suicidal ideation. According to the report: "California students were already among the most underserved in the country in terms of school-based mental health. This underprepared students and the public educational system to respond to the pandemic."

STUDENT-TO-STAFF RATIOS COMPARISON 2018[12]

RATIO	PROFESSIONALLY RECOMMENDED	NATIONAL AVERAGE	CALIFORNIA
Student-to-Counselor	250:1	444:1	682:1
Student-to-Social Worker	250:1	2,106:1	6,132:1
Student-to-Psychologist	700:1	1,526:1	998:1
Student-to-Nurse	750:1	936:1	1,482:1

According to this report:
Statewide surveys were administered to students in April 2020 and March 2021. The surveys were completed by over 1,200 California students, from 45 school districts in over 20 counties. 63 percent of students reported an emotional meltdown, 43 percent of students reported a panic or anxiety attack, 22 percent of students reported three or more days where they could not participate in school because of mental health, and 19 percent of students reported suicidal thoughts.

By April 2021, Children's Hospital Colorado experienced a 90 percent increase in youth behavioral health visits in emergency departments compared to April 2019. Data from the University of California San Francisco (UCSF) Children's Hospital showed a 50 percent increase in suicidal ideation between January 2020 (14%) and January 2021 (21%). The UCSF Children's Hospital Oakland reported a 63 percent increase in patients experiencing mental health emergencies in 2020 compared to 2019.

The report includes the following recommendations to the state:

- Increase and sustain historic investments in mental health services for youth.
- Fund state-level, student-led initiatives to address student stigma
- Increase funding for school counselors, psychologists, social workers, and nurses to address high caseloads.
- Sustain and increase funds for Community Schools that are equipped to provide comprehensive school-based mental health support.
- Continue to invest in school-county partnerships for the delivery of mental health services to students and families.

- Support holistic education and wellness by funding the arts and music/art/dance therapists in schools.
- Increased oversight and accountability for districts and schools spending billions of dollars on mental health.

The California Department of Public Health (CDPH) reports that, in 2020, the most recent year for which full data are available, California experienced:

- 15,664 Emergency Department visits related to any opioid overdose – nearly double 2018 numbers.

- 5,502 opioid-related overdose deaths, over 70 percent of which involved fentanyl.

- 3,946 fentanyl-related overdose deaths, a 402 percent increase since 2018.

- 4,403 amphetamine-related overdose deaths, an 81 percent increase since 2018.

CDPH explains that recent trends in overdose show disparities by race, age, and gender. For example, Native Americans and Black/African Americans experience fentanyl-related overdose at rates that exceed those of Whites, Hispanics, and Asian/Pacific Islanders. Current research also points to disproportionate rates of overdose by social determinants, such as education, poverty, and access to safe and stable housing. Similarly, research demonstrates that instability increases overdose – individuals without health insurance, who were incarcerated, or living in poverty are at increased risk of fatal opioid overdose.

The purpose of this hearing is for the Legislature to conduct oversight on the 2021 Children and Youth Behavioral Health Initiative, consider 2022 proposals related to children and youth behavioral health, and consider the overall effectiveness of the state's response to the children and youth behavioral health crisis.

ITEMS TO BE HEARD

6100 CALIFORNIA DEPARTMENT OF EDUCATION

ISSUE 1: CHILDREN AND YOUTH BEHAVIORAL HEALTH – PERSPECTIVES OF THE STATE SUPERINTENDENT OF PUBLIC INSTRUCTION

PANEL 1 - PRESENTERS

- **Tony Thurmond**, State Superintendent of Public Instruction

OVERSIGHT

The State Superintendent of Public Instruction will provide an overview of the current state of behavioral health among California's children and youth, discuss how the California Department of Education is responding to this crisis, and how the state is supporting students and schools.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 2: MENTAL HEALTH ISSUES: EARLY CHILDHOOD (0 – 5 YEARS OF AGE)
- **OVERSIGHT: CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI), AND MENTAL HEALTH PREVENTION AND EARLY INTERVENTION FOR YOUNG CHILDREN**

OVERVIEW

This issue covers mental health issues and services affecting very young children, including: 1) the Children and Youth Behavioral Health Initiative; 2) mental health services and supports in child care and pre-school settings; and 3) mental health needs unique to children with intellectual disabilities.

PANEL 2 – PRESENTERS

- **Jackie Wong**, Chief Deputy Director, First 5 California
- **Mary Ann Hansen**, Executive Director, First 5 Humboldt County
- **Angela M. Vázquez**, Policy Director - Mental Health, The Children's Partnership
- **Marni Sandoval,** Deputy Director of Behavioral Health, Child and Adolescent Services, Monterey County Health Department
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BACKGROUND

Stakeholders and advocates point out that while young children have significant mental health needs, little to no funding in the state budget is dedicated to meeting the mental health needs of this population. Advocates report that 43 percent of young children have experienced at least one Adverse Childhood Experience (ACE).

The Children and Youth Behavioral Health Initiative includes $800 million to cover dyadic therapy in the Medi-Cal Program, which will benefit some young children. Dyadic therapy is a form of treatment that serves parents or caregivers and children together and is widely considered a very effective approach to pediatric care. Nevertheless, advocates point out that although dyadic treatment may have significant value (especially for children with complex needs), they believe that mental health prevention and early intervention services should be brought to early learning and care settings, similar to efforts to bring these services to schools for older children.

The state's most marginalized children come from low-income and immigrant communities where access to publicly funded early care opportunities with comprehensive whole child services are limited. In order to reach these families, advocates argue for bringing these services to where they are, including family child care settings and other family friendly places in the community. They believe that investments in additional evidence-based programs such as Infant and Early Childhood Mental Health Consultation, Triple P Positive Parenting Programs, and the Incredible Years, among other models, could lead to a large-scale expansion of two- generational approaches that can be tailored to fit the needs of families in diverse communities.

Stakeholders assert that community-based programs are uniquely positioned to help families overcome barriers to mental health care, and they can connect families and educators with more intensive health, mental health, or developmental support, consultation or referrals to early intervention services.

In October of 2021, The Children's Partnership and the First 5 Center for Children's Policy issued a report, "*Addressing infant and early childhood mental health needs: opportunities for community solutions*," which addresses this issue. The full report can be accessed here:

https://first5center.org/publications/addressing-infant-and-early-childhood-mental-health-needs-opportunities-for-community-solutions

From this report's executive summary:

"Using information gathered from program data of early-childhood and family serving programs, interviews with state leaders and program administrators and staff and relevant literature, this report seeks to describe the wide range of community-based promotion, prevention and early identification and intervention programs for California infants, toddlers and preschoolers.

"This paper focuses on community-based programs in California supporting infants, toddlers, and preschoolers' social-emotional health, as well as their goals, service models, and funding sources. In community-based programs, care and support are delivered in spaces children and their families frequent and allow families to play an active role in their delivery. Community-based services are distinct from clinical mental health services, such as the new dyadic care Medi-Cal benefit, which, in addition to community-based services, are an essential part of the mental health system for young children. Services at the community level might look like facilitated playgroups, parenting support classes or mental health consultation for early care and education providers, among others. These programs are uniquely positioned to help families overcome barriers to mental health care access, and they can connect families and educators with more intensive health, mental health, or early intervention services as needed. Community-based programs are also most likely to reach families from historically marginalized communities, including immigrant and low-income families of color.

"This report recommends a multilayered approach that builds on the work that has already been done to promote protective factors to reduce the effects of toxic stress and ACEs that were exacerbated by the pandemic. California must braid funding sources, create system-level coordination, and ensure every community offers broad prevention efforts to support caregivers and young children.

"Recommendations include:

- Expand Infant and Early Childhood Mental Health community-based services for Medi-Cal eligible children and families. The Children & Youth Behavioral Health Initiative offers the promise of transforming and vastly expanding children's mental health services. The strategies that make up that initiative should explicitly target young children in community-based settings in recognition of the special needs of this age group.

- County Mental Health Services Act funding should prioritize young children to effectively promote well-being and prevent mental health conditions. This paper recommends the State Mental Health Services Act Commission identify children ages 0 to 5 as a priority population, given the unique opportunities for positive development as well as the significant vulnerabilities faced by young children and their families.

- Expand early childhood education providers' access to Infant and Early Childhood Mental Health consultation, an evidence-based model, through state contracts with early childhood education providers and additional technical assistance.

- Expand and support the Infant and Early Childhood Mental Health workforce. There is a significant need for policies to increase the number of licensed and non-licensed professionals who are trained in infant and early childhood mental health and development, particularly professionals of color who are multilingual.

- Increase awareness of infant and early childhood mental health. Broad, accessible and informative public information campaigns can play a role in reducing stigma and opening doors to prevention and early intervention services."

STAFF COMMENTS/QUESTIONS

The committees request the stakeholders on the panel share their experiences and expertise with serving young children, make recommendations to the state for improving the state's support for this population, and respond to the following:

- Please provide some specific examples of evidence-based programs that improve the mental health of very young children?

- Please describe the unique needs and opportunities associated with children with intellectual disabilities.

The committees request the administration provide reactions to the information and recommendations shared by the other panelists, discuss the state's perspective on serving this population, and respond to the following:

- Would you agree that the CYBHI overlooks this population, and if so, what is the administration's current thinking on further developing support and services for young children?

Staff Recommendation: No action recommended at this time, as this is an oversight issue; however staff recommends that the Legislature consider increasing investments in strategies that support the mental health and emotional wellbeing of very young children.

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ISSUE 3: BEHAVIORAL HEALTH ISSUES: SCHOOL-AGE CHILDREN AND YOUTH (K-12)

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- **CDE: K-12 BH OVERSIGHT**

OVERVIEW

This issue covers behavioral health issues, departments, programs, and services affecting school-age children and youth. The committees plan to provide oversight on existing and recent budget investments, including: 1) the Children and Youth Behavioral Health Initiative; 2) the Mental Health Student Services Act; 3) various youth-focused projects at the Mental Health Services Oversight & Accountability Commission; and 4) the new State Office of Suicide Prevention. The committees also will consider relevant 2022 budget proposals. Finally, the committees will more generally explore the behavioral health needs of kids, and the state's response to those needs, within the context of the current behavioral health crisis.

PANEL 3 – PRESENTERS

- **Matthew Deip**, Youth Speaker, Assistant Program Manager, CA Youth Empowerment Network (CAYEN)
- **Melissa Stafford Jones**, Director, Children and Youth Behavioral Health Initiative, California Health and Human Services Agency
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
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PROPOSALS AND OVERSIGHT ISSUES

The Children and Youth Behavioral Health Initiative (CYBHI)

The CYBHI is a $4+ billion initiative included in the 2021 budget to build a significant new behavioral health infrastructure for children and youth (ages 0 – 25) in California over five years. As agreed to in last year's budget, the initiative includes the following major components:

Children and Youth Behavioral Health Initiative COMPONENTS	Department	$$ AMOUNT (In Millions)
Mental Health Student Services Act Partnerships	MHSOAC	$205
Increased Access to Student BH Services	DHCS	$400
School-Linked Behavioral Health Partnerships and Capacity	DHCS	$400 (K-12) $150 (Higher Ed)
Evidence-Based Behavioral Health	DHCS, MHSOAC	$386.1 (DHCS) $42.9 (MHSOAC)
Behavioral Health Workforce Capacity	HCAI	$448
Behavioral Health Counselors and Coaches	HCAI	$352
Behavioral Health Services and Supports Platform and Pediatric, Primary Care and Other Healthcare Provider e-Consult	DHCS	$749.7
Pediatric, Primary Care and Other Healthcare Provider: Training	DHCS	$50
Behavioral Health Infrastructure	DHCS	$310
CalHOPE Student Support Program	DHCS	$45
New Medi-Cal Benefit – Dyadic Services	DHCS	$800
Subject Matter Expertise and Evaluation	CHHS	$50
Public Education and Change Campaign	CDPH	$100
State Operations	DHCS	$70
Public Education on ACEs and Trauma	OSG	$25.5
TOTAL FUNDING		**$4.584 billion**

The CYBHI includes the following components administered by DHCS:

- *Medi-Cal Managed Care Plan Student Behavioral Health Incentives*. $400 million ($200 million General Fund and $200 million federal funds) for DHCS to support incentives for Medi-Cal managed care plans to provide mild-to-moderate behavioral health services to students in partnership with schools and county behavioral health departments.

- *School-Linked Behavioral Health Partnerships*. $100 million CFRF in 2021-22 and $450 million in 2022-23 for the Department of Health Care Services (DHCS) to support school-linked behavioral health partnerships. Of the two year funding, $400 million would support county behavioral health department partnerships with schools and $150 million would support behavioral health services in higher education.

- *Evidence-Based Behavioral Health Programs*. $429 million CFRF in 2022-23 for DHCS to develop and expand evidence-based behavioral health programs addressing early psychosis, disproportionately impacted communities and communities of color, youth drop-in wellness centers, intensive outpatient programs for youth, and prevention and early intervention services for youth. DHCS will coordinate with MHSOAC to implement these programs and allocate 10 percent of the funding to the Commission.

- *Planning for Behavioral Health Services and Supports Platform*. $10 million General Fund in 2021-22 for DHCS to support initial planning for implementation of a behavioral health services and supports platform to expand CalHOPE.

- *Dyadic Services Benefit in Medi-Cal*. $200 million ($100 million General Fund and $100 million federal funds) annually beginning in 2022-23 for DHCS to add dyadic services as a Medi-Cal benefit.

- *Continuation of CalHOPE*. $45 million General Fund in 2021-22 for DHCS to continue CalHOPE, a crisis counseling program that includes a media campaign, web-based resources and services, a 24-hour warm line, and student support for social and emotional learning.

- *State Operations and Administration*. $44 million ($22 million General Fund and $22 million federal funds) in 2021-22, $48 million ($24 million General Fund and $24 million federal funds) in 2022-23, $12 million ($6 million General Fund and $6 million federal funds) in 2024-25, and $12 million ($6 million General Fund and $6 million federal funds) in 2025-26, for DHCS to support state operations and administration of the various components of the initiative.

The Legislature also approved trailer bill language to implement the components of the initiative, including requiring DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a school site. A health care service plan, including a Medi-Cal managed care plan, or an insurer will, commencing January 1, 2024, be required to reimburse school-based services provided to one of its members according to the fee schedule, regardless of whether the provider is within the plan's or insurer's contracted provider network.

In a February 7, 2022 CYBHI implementation update, the administration describes the CYBHI as follows:

> "California's Children and Youth Behavioral Health Initiative is reimagining the way we provide behavioral health support to ALL our children and youth ages 0-25, by bringing together the existing support systems to create an ecosystem that fosters social and emotional well-being, addresses behavioral health challenges, and provides equitable, appropriate, timely, and accessible services for emerging and existing behavioral health needs (mental health and substance use). The ecosystem will include the entire continuum of care and have a particular focus on prevention efforts to provide support before behavioral health issues emerge, build capacity and conditions for wellness, promote social and emotional well-being, and ensure early intervention."

Please see the full February 7, 2022 CYBHI implementation update that is an attachment to this agenda and can also be accessed: here .

CYBHI 2022 Proposals

Consistent with the agreements in the 2021 budget, DHCS requests expenditure authority of $185.8 million ($153.4 million General Fund and $32.4 million federal funds) in 2021-22 and $1.3 billion ($1.2 billion General Fund and $111.5 million federal funds) in 2022-23. The proposed budget includes the following 2022-23 components of the Initiative:

- $87 million total funds ($41 million General Fund) to implement Dyadic Services effective January 1, 2023.
- $429 million General Fund for evidence-based behavioral health practices.
- $450 million General Fund for school behavioral health partnerships and capacity (on top of the $100 million provided for FY 2021-22).
- $230 million General Fund for the Behavioral Health Services and Supports Platform and related e-Consult service and provider training (on top of the $10 million provided in FY 2021-22).

Medi-Cal Managed Care Plan Student Behavioral Health Incentives. DHCS requests expenditure authority of $64.8 million ($32.4 million General Fund and $32.4 million federal funds) in 2021-22 and $129.7 million ($64.8 million General Fund and $64.8 million federal funds) in 2022-23 to support incentive payments to Medi-Cal managed

care plans to, in coordination with county behavioral health departments and schools, build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention behavioral health services for students. The 2021 Budget Act investment of $400 million for this program is being spread out over several fiscal years as the program phases in.

School-Linked Behavioral Health Partnerships. DHCS requests General Fund expenditure authority of $100 million in 2021-22 and $450 million in 2022-23 to support direct grants to local educational agencies (LEAs), institutions of higher education, publicly funded childcare and preschools, health care services plans, community-based organizations (CBOs), tribal entities, behavioral health providers, city mental health authorities, or counties to build infrastructure, partnerships, and capacity statewide to increase the number of children and youth receiving preventive and early intervention behavioral health services from schools, providers in school, school affiliated CBOs, or school-based health centers. Of the $550 million investment over two years, $400 million is targeted to children pre-school through 12th grade, while $150 million is targeted to higher education. DHCS reports it is still developing the timeline for this grant program. DHCS hired a consultant in January 2022 and is developing a work plan.

Evidence-Based Behavioral Health Programs. DHCS requests General Fund expenditure authority of $429 million in 2022-23 to support scaling and spreading of evidence-based interventions statewide to improve outcomes for children and youth. These resources would support a grant program for counties, tribal entities, commercial plans, managed care plans, CBOs, and behavioral health providers to implement evidence-based practices and programs, including early psychosis intervention and treatment, prevention and early intervention, youth drop-in centers, and other programs. DHCS is partnering with the Mental Health Services Oversight and Accountability Commission to develop this program, with 10 percent of the funding allocated to the Commission. The program was originally authorized for the 2022-23 fiscal year and included funding from the CFRF. DHCS is requesting to use General Fund for this grant program and redirect the CFRF funding for other purposes.

Behavioral Health Services and Supports Platform. DHCS requests General Fund expenditure authority of $10 million in 2021-22 and $230 million in 2022-23 to procuring a business services vendor to implement a statewide, all-payer behavioral health direct services and supports platform. The platform would support regular automated age appropriate assessments, screenings, and self-monitoring tools, and would develop tools to help families navigate how to access help, regardless of payer source. The platform would provide interactive education, app-based games, videos, book suggestions, automated cognitive behavioral therapy and mindfulness exercises. Those whose interactions demonstrate a need for clinical services would be guided to their health plan to set up assessment visits, allowing ongoing, continuous relationships with licensed clinicians through telehealth or in person. The platform would also include e-consult and e-referrals, as well as being accessible by telephone.

Dyadic Services. DHCS requests expenditure authority of $87.4 million ($40.8 million General Fund and $46.7 million federal funds) in 2022-23 to add dyadic services as a Medi-Cal benefit for children under 21 years old and their parents or guardians, beginning January 1, 2023. Dyadic services are based on the Healthy Steps model of care, an integrated behavioral health care model in which health care is delivered in the context of the caregiver and family, so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability.

CalHOPE Student Support. DHCS requests General Fund expenditure authority of $11 million in 2021-22 and $17 million in 2022-23 to provide training, technical assistance, technology, and tools to build and enhance positive social-emotional learning environments in schools through administration of the CalHOPE Student Support Program. The program was launched during the COVID-19 pandemic with support from the Federal Emergency Management Agency (FEMA) and the Substance Use and Mental Health Services Administration (SAMHSA) to address the challenges and stressors experienced by children, youth and families including social isolation, lack of school structure, and the need to adapt to distance learning. The CalHOPE Student Support Program is designed to give teachers and staff the skills to prepare a healthy learning environment for children, to be able to easily identify signs of stress and poor functioning, provide support for children and youth, and refer to more intensive services where needed.

Mental Health Services Oversight and Accountability Commission (Commission) Proposals and Oversight Issues

Children and Youth Behavioral Health Initiative: Evidence-Based Behavioral Health Programs Reimbursement Budget Change Proposal

The Commission requests $42.9 million one-time in reimbursement authority in 2022-23 to reflect an interagency agreement with DHCS to support the statewide expansion of evidence-based behavioral health programs as part of the CYBHI. This funding for the Commission resulted from negotiations between the Legislature and administration as part of the 2021 budget process and was included in the CYBHI in the final 2021 budget. This BCP provides additional detail on the planned expenditure of these funds.

Consistent with the CYBHI in the 2021 budget, the 2022 Governor's Budget includes $429 million one-time General Fund in 2022-23, available over three years, for DHCS to support statewide development and expansion of evidence-based and community-defined promising interventions proven to improve outcomes for children and youth with, or at high risk for, mental health conditions.

Entities eligible to receive grants may include Medi-Cal behavioral health systems, tribal entities, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers. Pursuant to WIC 5961.6, prior to selecting the evidence-based interventions, DHCS shall establish a workgroup comprised of subject matter experts and affected stakeholders to consider evidence-based

interventions based on robust evidence for effectiveness, impact on racial equity, sustainability. DHCS will determine the eligibility criteria, grant application process, and methodology for the distribution of grants to those entities it deems qualified. Grant awardees would be required to share standardized data as determined by DHCS.

Pursuant to the 2021 budget agreement, DHCS will enter into an interagency agreement (IAA) with the Commission to provide $42.9 million, or 10 percent of the total proposed allocation for this part of the initiative, to support this work. Although DHCS funding to the OAC must be expended in accordance with a pending IAA, funds could support the following:

- Participation in the statutorily-required workgroup that will recommend evidence-based programs for DHCS support statewide expansion;
- A statewide expansion of existing Commission grant programs (state operations and local assistance);
- Reporting requirements to DHCS for grant awardees, as determined by DHCS.

Mental Health Student Services Act Partnership Grant Program Augmentation BCP

The Commission requests 2 permanent positions and $16,646,000 one-time Mental Health Services Fund (MHSF) in 2022-23, available over five years, and a net-zero shift of $1,224,000 MHSF from local assistance to state operations in 2023- 24 and annually thereafter to support the administration and evaluation of the Mental Health Student Services Act (MHSSA) Partnership Grant Program.

SB 75 (Senate Budget and Fiscal Review, Chapter 51, Statutes of 2019), established the Mental Health Student Services Act (MHSSA), to further support partnerships between county behavioral health departments and educational entities. The 2019 Budget Act (Chapter 363, Statutes of 2019) included $50 million onetime MHSF in 2019-20 and $10 million MHSF in 2020-21 and ongoing to support the MHSSA Partnership Grant program. Of the $10 million MHSF ongoing, $1.2 million is for state operations and the remaining $8.8 million is for local assistance grants. The 2021 Budget Act (Senate Bill 129, Ch. 69 Stats. 2021) included a $205 million one-time augmentation to the program.

The MHSSA Partnership Grant program provides competitive grants to counties for partnerships between county behavioral health departments and local education entities for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. These grants are intended to provide support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, placement assistance and service plans for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ+, and youth who have been expelled or suspended from school. In addition to the Commission's responsibility to award school-county collaborative grants, the MHSSA also requires the Commission to "develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants"

The Commission will issue the MHSSA Partnership Grant program grants in five phases as funds are made available (See Table below). A total of 58 county programs will be funded for four years, with phase 1 grants having an optional fifth year of funding.

MHSA Grant Award Phases - Totaling 58 Grant Programs to be Funded by 2022

Phase I (2020)	Phase II (Early 2021)	Phase III (Mid 2021)	Phase IV (Late 2021)	Phase V 2022
18 grants awarded totaling $75 million	6 grants awarded totaling $25 million	6 grants to be awarded totaling $25 million	8 grants to be awarded totaling $30 million	20 grants to be awarded totaling $95 million

The Commission is charged with developing metrics and a system to measure and publicly report on the performance outcomes of services provided under the grants (WIC section 5886 (k) (1)). In addition, the Commission will need to conduct engagement with the public to ensure that the "perspectives and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members …" (WIC section 5846 (d)) are factored into its decisions and recommendations for the development of MHSSA performance metrics.

To create and collect the data for the above requirements the Commission will not only need to develop metrics and a system to measure performance outcomes but will also need to assess student outcomes through linkages with statewide data (WIC § 5886 (k) (2) (A) (iv-v)), engage with the 58 MHSSA Partnership Grant program grantees (generally, county behavioral health departments) and their partners (schools, school districts, and/or county offices of education), and develop public reports of service impact and outcomes.

This request proposes to augment the existing 2.0 authorized positions with an additional 2.0 additional permanent positions: 1) 1.0 Research Scientist Supervisor I; and 2) 1.0 Research Scientist III.

The Commission is responsible for reporting the performance outcomes of services provided using the MHSSA partnership grants. Of the total, the Commission requests, $15,694,000 one-time MHSF and $758,000 in 2023-24 and ongoing is to meet the statutory MHSSA evaluation requirements. The requested level of funding is based on a similar contract for the Triage Personnel Grant Program with similar activities and deliverables.

Existing law requires the Commission to do the following:

- Develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

- Provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022. The report shall address, at a minimum, all of the following:

    - Successful strategies.
    - Identified needs for additional services.
    - Lessons learned.
    - Numbers of, and demographic information for, the school-age children and youth served.
    - Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the program goals.

- The contract resources will support the following:

    - Developing a performance outcome monitoring system;
    - Providing consultation to grantees, Commission staff, and others;
    - Conducting an evaluation.

OAC Proposal to Expand Stakeholder Advocacy Contracts

The Mental Health Services Act (MHSA) calls for ensuring that consumers, families, and people facing disparities are engaged in decision-making. The Commission provides $5.4 million annually to support the voice of community members through eight stakeholder contracts. Contracts are established through a competitive procurement process and focused on community outreach, education and training, and advocacy.

The populations targeted with these funds include:

- clients and consumers
- diverse racial and ethnic communities
- families
- immigrants and refugees
- LGBTQ+ populations
- parents and caregivers
- transition age youth
- veterans

Six stakeholder advocacy contracts are scheduled to expire in 2023. Two are on an alternate schedule, including funding for immigrant and refugee stakeholders, which will expire this fiscal year. While all other contracts are focused on supporting a single organization that is asked to do outreach, education and training statewide, funding for immigrants and refugees in distributed among seven small contracts. The Commission elected to allocate these funds to seven organizations to recognize the diversity of issues facing immigrant and refugee communities and the racial, ethnic, cultural and language diversity of these populations.

The Commission is requesting increased stakeholder advocacy funding for two purposes:

- Increased funding of $670,000 ongoing for additional immigrants and refugee advocacy contracts; and

- $670,000 ongoing for contracts focused on supporting K-12 students to inform school mental health policies and programs.

OAC Oversight Issues

Over the past several years, the Legislature has substantially increased funding, and related authority, to expand the role of the MHSOAC beyond oversight to include various aspects of program development. The following describes key components of this expansion that relate most directly to children and youth.

Mental Health Student Services Act (MHSSA)

The MHSSA is the subject of one of the BCPs described above, and additional background on the program is provided here.

During the last round of Triage funding, the Commission dedicated $20 million to support partnerships between county behavioral health agencies and local schools. The Commission's goal in this opportunity was to incentivize robust partnerships between local education agencies and local behavioral health programs. The Commission supported this strategy in recognition that fiscal policies often create conflict between schools and county mental health programs. The Commission was able to fund four projects in response to more than 20 applications. In response, the Legislature passed the Mental Health Student Services Act (MHSSA) in 2018 and provided $40 million in one-time funds and $10 million in ongoing funds.

In 2020, the Commission dedicated $80 million in MHSSA funds - $40 million one time, and $10 million from four consecutive fiscal years – to offer $75 million in county grants with $5 million set aside for evaluation and implementation. The Commission received 38 grant applications and was able to fund 20 county programs. In the 2021-22, the Legislature provided an additional $100 million to expand the funding opportunity to all counties.

The Commission's current commitment to the MHSSA is $270 million and they are supporting projects in 55 of California's 59 local mental health agencies. Four local agencies have elected not to participate in the program. After three rounds of funding, additional funding remains and the Commission is working to release a final round of funding to all counties. The Commission also is working with local partners to develop an evaluation strategy and a plan for technical assistance. A report is due to the Legislature on March 1, 2022.

Strengthening Suicide Prevention Strategies for Youth.
The Commission has invested $880,000 to strengthen school mental health strategies targeting social emotional learning and suicide prevention. The Commission entered into contracts with three non-profit providers to enhance the support they provide for schools.

Allcove – Youth Drop-In Centers
In 2016 the Commission was approached by faculty at Stanford University to explore whether a globally recognized youth drop-in model would support transition age youth in California. Known as Headspace in Australia, where the model was developed, the program has expanded to several countries. The Commission sponsored a visit to California by experts from a Canadian-based program called the Foundry to meet with county behavioral health leaders to assess their interest in the program. The Commission visited the Foundry programs in Vancouver as part of this process.

Following several meetings with representatives from Stanford and the Foundry, the Commission approved an Innovation proposal from Santa Clara County to invest approximately $15 million in county innovation funds to launch two allcove youth drop-in centers. The allcove name and brand was developed by a Youth Advisory Group convened by Stanford. A robust youth advisory group is a key component of the Headspace model, as is the authority of the youth to rename the program in each country. The model also calls for brand consistency across sites, integrated services that include primary physical health, mental health, social, education and related employment support or referrals. The other countries that operate the model – Australia, Canada, Ireland, South Korea – each are single health care payer nations and thus the model stipulates that it must be available to all youth with minimal financial barriers to care. Services also are focused on vulnerable and marginalized youth and disparity populations, including but not limited to LGBTQ, homeless and indigenous youth.

Following the Commission's approval of the Santa Clara innovation project, the Legislature provided $15 million in state funds to expand the model. The Commission conducted a competitive procurement process and has awarded grants to support allcove sites in Los Angeles, Orange, San Mateo and Sacramento Counties. The Commission also provided funding to Stanford to provide technical assistance to participating counties and to support a healthcare learning network with training, data and evaluation support and community outreach. The Commission currently holds the Trademark for the allcove brand and makes it available at no cost to participating partners.

A number of local partners are struggling to implement the model because it requires integrated care, must serve all youth and requires use of the allcove brand and materials as developed by the Youth Advisory Group. At the core of these challenges is concern that traditional reimbursement funding may not cover the full costs of the model. The Commission is working with consultants to explore how best to cover the cost of this model and ensure that the program will serve all youth, regardless of payer responsible for their care.

Anti-Bullying Project

The 2021 Budget Act allocated $5 million to the Commission to launch a youth-focused anti-bulling initiative that leveraged social media to support youth. The focus of the work is on bullying that is focused on race, ethnicity, language, country of origin and related themes. The project is part of a broader initiative targeting Anti-Asian hate. The Commission formed an advisory committee as directed in the budget to support this project.

The Commission formed an advisory committee which provided guidance on best uses of the funding and the Commission is currently finalizing a contract with an array of partners to develop a social media strategy, informed by youth, that focuses on anti-bullying and guides youth to access mental health services and anti-bullying support when needed.

California Department of Public Health (CDPH) Budget Change Proposal (BCP) and Oversight Issue

Overdose Public Awareness Campaign and Surveillance BCP

CDPH Center for Healthy Communities (CHC), Substance and Addiction Prevention Branch (SAPB), requests one-time funding in the amount of $55 million from the new Opioid Settlement Fund to be established in 2022-23, with provisional language for the funds to be available until June 30, 2025. This proposal supports the formation of two new strategies to prevent and respond to opioid overdose in California: 1) media and health communications campaigns targeted towards youth opioids education and awareness, and fentanyl risk education; and 2) syndromic (rapid) surveillance using the BioSense Platform to collect and analyze data on opioid overdose trends.

This proposal seeks to bolster the State's response to the complex and evolving overdose epidemic through two key strategies:

1. Raise awareness of drug misuse, overdose risks, and treatment options through statewide media and health communications campaigns.
2. Improve statewide syndromic surveillance (BioSense) and reporting of overdose to inform substance abuse prevention and treatment.

This proposal creates dedicated state funding to support evidence-based media and health communications campaigns designed to reduce risky substance use behaviors and dedicated state funds for syndromic surveillance and rapid reporting of overdose. Fully funding this proposal will create specific authority for CDPH to hire staff to support the media campaigns and improve reporting and analytics through the administration and expansion of the BioSense Platform, thereby filling unmet gaps in existing prevention, health communications programming, and surveillance, including using real-time data to strengthen early intervention and treatment options. The rapid data dashboard resulting from Strategy 2 will be publicly available to stakeholders, including local health jurisdictions, other CalHHS departments, and the Governor's Office.

Strategy 1 – Raise Awareness through Media and Health Communications Campaigns

This proposal seeks to support a comprehensive media and health communications strategy with three campaigns to educate the public about risks and consequences of drug use and to influence attitudes, social norms, and stigma around seeking support and treatment for substance use.

CDPH-SAPB will release an RFP to solicit proposals from bidders who possess strong skills, knowledge, and experience in developing and implementing strategic, statewide media campaigns; experience in effective media buy and optimal placement of messages; and experience working with health educators and subject matter experts to develop comprehensive and effective health education tool kits.

The RFP will support three separate campaigns to be implemented over three years:

1. Youth Opioid Use Prevention and Awareness
   This campaign will target youth ages 16-20 to promote behavior change, reduce opioid misuse, and decrease stigma associated with seeking treatment among youth and young adults. Building upon lessons learned from the California Tobacco Control Program, the youth opioid use prevention and awareness campaign will provide clear, science-based, and judgment-free messaging to prevent youth experimentation and use. Objectives of this media campaign include educating youth about the risks and consequences of opioid use; influencing youth attitudes, social norms, and perception of opioids; and developing health education resources that can be utilized by families, educators, and local governmental and non-governmental organizations.

2. Fentanyl Education and Awareness
   This campaign will target adults, ages 21-40, with messaging and educational information specific to the risks of fentanyl use and prevalence of fentanyl in other drugs. This campaign will include education and awareness of evidence-based harm reduction strategies that can reduce the risk of a fentanyl-related overdose, including the use of fentanyl test strips and use of opioid antagonists (naloxone). Objectives of this media campaign include educating Californians about the risks and consequences of intentional and unintentional fentanyl use; educating Californians on evidence-based harm reduction strategies that may decrease the risk of a fentanyl-related overdose; and developing health communication and educational resources that can be utilized by local governmental and non-governmental organizations.
3. Shatterproof Atlas
   The purpose of this campaign is to raise awareness of the Shatterproof Atlas service, implemented by DHCS. The Shatterproof Atlas is a web-based, consumer-oriented resource for those in need of SUD treatment services to help locate service providers, with information on services provided, locations, quality information, and user feedback. The Atlas is in operation in several other states and DHCS is currently using federal grant funding to support its implementation in

California. The media campaign would inform the public about the Atlas service and substance use treatment options available in California.

Strategy 2 – Improve Syndromic Surveillance and Reporting of Overdose

There is currently no rapid statewide syndromic surveillance system to monitor for fentanyl and other drug-related overdoses in California. Such a system, if connected to a public-facing dashboard, will provide near real-time data on drug-related overdose to stakeholders at the state and local level to support prevention, early intervention, and linkages to treatment.

California is one of only seven states that does not use the BioSense Platform for statewide syndromic surveillance. BioSense, created and maintained by the Centers for Disease Control and Prevention (CDC)—National Syndromic Surveillance Program, is a free, secure, cloud-based computing environment available to public health agencies to conduct syndromic surveillance and analyze data on a common platform. Data are rapid and accurate; for example, emergency department data are uploaded to BioSense within 24 hours of patient encounter. In the United States, 73 percent of all emergency department visits were reported to the BioSense Platform. The platform is designed with a point-and-click interface, meaning that data within BioSense are available and accessible to a broad range of data users.

To improve overall overdose surveillance, respond more rapidly to overdose spikes, and to inform prevention and treatment, this proposal intends to establish BioSense in California specifically for non-fatal overdose and drug misuse surveillance and for overdose spike identification at the local level. Additional benefits to CalHHS include opportunities to conduct rapid, real-time surveillance of other illnesses and environmental exposures (e.g., COVID-19, influenza-like illness, hazardous algal blooms, etc.), thereby benefiting a broad range of CDPH and CalHHS programs.

CDPH-CHSI will adopt, maintain, and administer the BioSense syndromic surveillance system. CDPH-CHSI will serve as state administrator of BioSense and will work to onboard counties and facilities who are not currently using the platform. There are currently 17 counties in California that have at least one facility contributing data to BioSense. During the 3-year time period, the goal will be to onboard 10-15 new counties and increase participation in 11 counties with partial participation in BioSense.

In addition to BioSense implementation, CDPH-CHSI will work with CDPH- ITSD to conduct a feasibility study to examine the possibility of integrating the BioSense data into the CDPH Ecosystem of Data Sharing (EODS).

CDPH-SAPB, as part of its Overdose Prevention Initiative, will develop a syndromic surveillance data dashboard that will disseminate BioSense data to overdose prevention stakeholders, including local health jurisdictions, local overdose response coalitions, and other state agencies such as DHCS.

Current data on the existing California Overdose Surveillance Dashboard are provided quarterly and bi-annually and currently have a data lag of approximately 5-9 months for fatal and non-fatal overdose data, depending on the data source.

Office of Suicide Prevention (OSP) Oversight

The OSP was established through AB 2112 (Ramos, Chapter 142, Statutes of 2020) and subsequently funded through the 2021 Budget Act with $780,235 General Fund ongoing to support five positions within the OSP.

AB 2112 included the following responsibilities for the office, which aligns with Commission's recommendations from "*Striving for Zero: Strategic Plan for Suicide Prevention 2020-2025:"*

- Providing information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs.
- Conducting state level assessment of regional and statewide suicide prevention policies and practices, including those from other states, and including specific metrics and domains as appropriate. Focusing activities on groups with the highest risk, including youth, Native American youth, older adults, veterans, and LGBTQ people.
- Monitoring, tracking (surveillance) and dissemination of data to inform prevention efforts at the state and local levels.
- Convening experts and stakeholders, including, but not limited to, stakeholders representing populations with high rates of suicide, to encourage collaboration and coordination of resources for suicide prevention.
- Reporting on progress to reduce rates of suicide.
- Sharing and receiving data from other state entities relevant to the responsibilities and objectives of the office.
- Consulting with the Mental Health Services Oversight and Accountability Commission to implement suicide prevention efforts consistent with the Mental Health Services Oversight and Accountability Commission's Suicide Prevention Report "Striving for Zero."

TK-12 Student Mental Health

Mental Health on Campus. Learning loss is quantifiable with local academic assessment data, but the COVID-19 pandemic's impact on student emotional and mental health is also widely reported despite not being measured consistently across the state.

According to a 2021 American Academy of Child & Adolescent Psychiatry journal article,[1] children and adolescents are probably more likely to experience high rates of depression and anxiety during and after COVID-19 isolation ends. These mental health impacts may increase as enforced isolation continues intermittently, and mental health interventions may be required for up to nine years.

Adults on school campuses are also reporting record stressors, while school leaders are reporting great difficulty in hiring. According to RAND[2]: "Stress was the most common reason teachers cited for leaving the profession before and during the pandemic. In fact, teachers cited stress nearly twice as often as insufficient pay as a reason for quitting. COVID-19 appears to have exacerbated teachers' stress. Almost half of all public-school teachers who left the profession early and voluntarily since March 2020 listed COVID-19 as the main reason for their departure."

Despite billions in one-time and on-going funding dedicated to human resources and pandemic response in the 2021-22 Budget Act, school leaders report great difficulty in hiring, and meeting public health demands on campus.

Federal Relief & 2021-22 Budget Act Support for Pandemic Response

Education Funding. The 2021-22 Budget Act reflected historic levels of growth to the Proposition 98 guarantee for school funding. The final per-student funding average, from all funding sources added up to over $21,000 per student, and the guarantee grew by over $20 billion from the 2019-20 Budget Act.

[1] Journal of the American Academy of Child & Adolescent Psychiatry. "Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19." Maria Elizabeth Loades, DClinPsy, et al.

[2] Diliberti, Melissa Kay, Heather L. Schwartz, and David Grant, Stress Topped the Reasons Why Public School Teachers Quit, Even Before COVID-19. Santa Monica, CA: RAND Corporation, 2021. https://www.rand.org/pubs/research_reports/RRA1121-2.html.

State and federal early action allocated over $22 billion in one-time pandemic response funds to local schools, including support for public health and learning recovery efforts:

Budget Also Includes $22.3 Billion One-Time Federal Relief Funding

(In Millions)

Program	Description	Amount
Grants to schools[a]	Provides $19.6 billion directly to schools for broad array of activities, including those related to COVID-19. Also includes $302 million to support students with disabilities and $99 million for homeless students.	$20,002
Instruction and expanded learning grants	Covers a portion of costs associated with In-Person Instruction and Expanded Learning Opportunities Grants, adopted in Chapter 10 of 2021 (AB 86, Committee on Budget).	2,015
Expanded learning	Provides temporary rate and slot increases for the After School Education and Safety Program and 21st Century Community Learning Centers.	301
State operations	Funds California Department of Education to allocate and monitor federal COVID-19 relief funding.	15
Total		**$22,334**

[a] Includes funding provided directly to public K-12 schools from CRRSAA and ARPA. Excludes federal funds from the CARES Act, which were allocated in the 2020-21 budget.

Note: Reflects federal funding included in the 2021-22 budget package and mid-year appropriations made during 2020-21.

COVID-19 = coronavirus disease 2019; CRRSAA = Coronavirus Response and Relief Supplemental Appropriations Act; ARPA = American Rescue Plan Act; and CARES = Coronavirus Aid, Relief, and Economic Security.

Source: LAO

Many of the new investments in the 2021-22 Budget Act were intended to support pandemic response, including $1.7 billion for afterschool and summer programs in the 2021-22 school year, $3 billion for Community Schools over a seven-year period, and $550 million in Special Education learning recovery supports.

Budget Includes $30.5 Billion in New K-12 Proposition 98 Spending

(In Millions)

Ongoing	
Local Control Funding Formula	$4,367
Expanded Learning Opportunities Program	1,753[a]
Special education	397
Other	1,048
Subtotal	($7,565)
One Time	
Deferral paydowns	$11,042
COVID-19-related actions	5,258
Community schools	3,002
Education workforce	2,567
Curriculum and instruction	120
Other	950
Subtotal	($22,939)
Total	**$30,504**

[a] Of the total, $753 million is one-time 2020-21 Proposition 98 funding.

COVID-19 = coronavirus disease 2019.

Source: LAO

Student Mental Health Funding. As was covered in a prior Assembly Education Committee joint information hearing[3], the 2021-22 Budget package contained enormous investments, multi-year, in student mental health infrastructure:

- The package enacted a Children and Youth Behavioral Health Initiative Act (CYBHI Act) which requires private health plans and insurers, Medi-Cal Managed Care (MCMC) health plans, and county behavioral health delivery systems to provide coverage for school-based mental health and substance abuse disorder (SUD) services, irrespective of the network status of the health care provider, and additional requirements to increase school site reimbursements, including over $1.2 billion allocated for these purposes.

- The Budget Act appropriated $429 million in one-time funds to permit the DHCS, or its contracted vendor, to award competitive grants to entities it deems qualified for the following purposes: (a) To build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services for children and youth 25 years of age and younger; (b) To expand access to licensed medical and behavioral health professionals, counselors, peer support specialists, community health workers, and behavioral health coaches serving children and youth; (c) To build a statewide, community-based organization provider network for behavioral health prevention and treatment services for children and youth, including those attending institutions of higher education; and, (d) To enhance coordination and partnerships with respect to behavioral health prevention and treatment services for children and youth via appropriate data sharing systems.

- The Budget Act appropriated $250 million in one-time funds to the Mental Health Services Oversight and Accountability Commission to provide additional Mental Health Student Services Act grants to support partnerships between county mental health and LEAs.

- The Budget also authorized the Department of Health Care Information and Access (previously the Office of Statewide Health Planning and Development), as a component of the Children and Youth Behavioral Health Initiative, to award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites.

Finally, the Budget package made significant changes to School-Based Services in the Education Budget Trailer Bill, AB 130 (Committee on Budget):

- Requires the California Department of Education (CDE), no later than January 1, 2022, to establish an Office of School-Based Health Programs (Office) for the purpose of assisting LEAs regarding the current health-related programs under the

[3] California Assembly Education Joint Information Hearing 10/27/2021

purview of the CDE, including collaborating with the DHCS and other departments and offices involved in the provision of school-based health services, and assisting LEAs with information on, and participation in, the specified school-based health programs, including School-Based Medi-Cal Administrative Activities (SMAA), LEA Billing Option Program (BOP), and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

- Requires the CDE, by January 1, 2022, to appoint a state school nurse consultant to be housed within the Office, with responsibilities as specified.

- Establishes the School Health Demonstration Project in the Office as a pilot project to expand comprehensive health and mental health services to public school pupils by providing LEAs with intensive assistance and support to build the capacity for long-term sustainability by leveraging multiple revenue sources, with the purpose being to provide training and technical assistance on the requirements for health care provider participation in the Medi-Cal program to enable LEAs to participate in, contract with, and conduct billing and claiming in the Medi-Cal program through all of the following: (a) The LEA BOP; (b) SMAA; (c) Contracting or entering into a memorandum of understanding (MOU) with MCMC plans as a participating MCMC plan contracting provider; (d) Contracting with or entering into a MOU with county MHPs for specialty mental health services (SMHS), such as through EPSDT, and contracting with community-based providers to deliver health and mental health services to pupils in school through contracts with MCMC plans or county MHPs.

- Requires the State Superintendent of Public Instruction (SSPI), on or before June 30, 2022, in consultation with the executive director of the State Board of Education (state board) and the DHCS, to select up to three organizations to serve as technical assistance teams for purposes of the pilot project. Requires, on or before September 1, 2022, the CDE, in consultation with the DHCS, to select up to 25 LEAs to serve as pilot participants for a period of two years. The Budget Act appropriated $5 million in onetime funds for this purpose.

- Requires the CDE to establish a process to select, with approval from the executive director of the state board, a LEA to provide guidance around Medi-Cal billing and increase LEAs' capacity to successfully submit claims through the LEA BOP. The Budget Act appropriated $250,000 in on-going funds for this purpose.

STAFF COMMENTS/QUESTIONS

CHHS:
The committees request Agency provide an overview and implementation update of the CYBHI, and respond to the following:

- Please describe the "California Healthy Minds, Thriving Kids Project." Did the state contract with the Child Mind Institute for this work? If so, how much funding was included in the contract, and what are the contract deliverables?

DHCS:
The committees request DHCS provide implementation updates on the CYBHI, present significant changes and budget issues associated with Medi-Cal behavioral health services for children and youth (0 – 25 years of age), and respond to the following:

- Could you provide technical assistance on how the allcove youth drop-in model can most easily bill the Medi-Cal program?
- Have you begun discussions to develop the details of the CYBHI interagency agreement between DHCS and the Commission? Can you share any preliminary planning and thinking about this contract and funding?

MHSOAC:
The committees request the Commission briefly present the two MHSOAC BCPs contained in this agenda, present the Commission's stakeholder advocacy proposal, provide an overview and updates on the Commission's work related to children and youth, and make any recommendations the Commission has for the state to more effectively meet the behavioral health needs of children and youth.

CDPH:
The committees request CDPH present the Overdose Public Awareness Campaign and Surveillance BCP, provide an implementation update on the Office of Suicide Prevention (OSP), and respond to the following:

- Please describe how CDPH will evaluate the overdose public awareness campaign for effectiveness.

- Please explain how the OSP is prioritizing the youth mental health crisis, and what, if any, immediate and urgent prevention activities have been launched?

- Is the OSP directly involved in the CYBHI? If so, how?

CDE:
The committees request CDE provide an overview of behavioral health issues, programs, and challenges in California's K-12 schools, and respond to the following:

- What are the goals and scope for the Office of School-Based Health?

- How will CDE and CHHS facilitate the necessary partnerships between Public Health and school agencies for the CYBHI?

- What barriers do local school leaders believe remain to facilitate student mental health services in the near-term?

- What is the state of adult/educator stress and trauma at this point in the pandemic? How does this impact school climate and student mental health?

Staff Recommendation: No action at this time to allow for additional discussion and consideration of the various proposals and issues discussed.

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 4: ALL CHILDREN THRIVE PROGRAM OVERVIEW AND REPORT

PANEL 4 – PRESENTERS

- **Maria Ochoa,** Assistant Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Harold Goldstein**, Executive Director, Public Health Advocates

PANEL 4 – Q&A ONLY

- **Terri Sue Canale**, Acting Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch, Center for Healthy Communities, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst: Health, Developmental Services and IT, Legislative Analyst's Office

OVERSIGHT ISSUE

The 2018 Budget Act appropriated $10 million (Mental Health Services Fund) to CDPH for implementation of the All Children Thrive Program (ACT) over three years. The 2021 Budget Act includes $25 million to extend and expand the Program. This issue is to provide oversight over the program, including to receive a report on the first three years of the program. CDPH has a contract with Public Health Advocates to implement the Program.

BACKGROUND

ACT is an equity-focused, community-driven initiative to support California communities in conducting local campaigns to prevent adverse childhood experiences (ACEs), counter their effects, promote healing, and foster individual and community resilience, thereby giving California children the opportunity to thrive. Project coordinators state that they have gathered the most promising policy interventions from around the world and, together with community leaders, residents from low-income California cities and counties, and leaders from 17 communities, have begun designing systems change interventions. ACT supports transformative innovation and improvement to prioritize children's health and development. Project leaders committed to demonstrate

measurable outcomes in these pilot communities and to have evidence-based models ready to scale throughout the state.

ACT works with cities to focus on solutions that prevent and heal ACEs and promote child and family wellbeing. ACT focuses on the following five main priorities, known as Community Action Areas:

1. Promoting healthy child development;
2. Creating protective environments;
3. Youth development and civic engagement;
4. Strengthening economic supports for children and families; and
5. Access to safe and stable housing.

Community Engagement Awardees

The following cities have received ACT grant awards:

- Antioch – Family Justice Center
- Bakersfield – Visión y Compromiso (VyC)
- Boyle Heights – Social Media
- Coachella – Raices Cultura
- Fresno – The Children's Movement of Fresno (United Way of Fresno and Madera)
- Lakeport – Hope Rising Lake County
- Maywood – YMCA
- Mendocino Rancheria and Reservations – Weaving Wellness and Diversity
- Modesto – Tuolumne River Trust
- Oxnard – Reality Improv Connection, Inc BRITE Program
- Pomona – Pomona Community Foundation
- Sacramento – Youth Forward
- Santa Ana – Charitable Ventures A fiscal sponsor for Santa Ana Early Learning Imitative
- Santa Paula – Kids and Families
- Ukiah – Drug Free Communities
- Vallejo – Children's Network
- Yuba County – Camptonville Community Partnership

Learning Communities

The ACT Learning Community is a peer learning network where ACT cities come together and work on community-level issues facing children and families by meeting regularly to discuss experiences, ideas and offer feedback. Cities can move at the pace that works best for them to achieve progress in their Community Action Areas.

STAFF COMMENTS/QUESTIONS

The committees request CDPH provide an overview of ACT, and that Public Health Advocates present the final report on the first three years of funding and implementation of the ACT, provide an implementation update on the new 2021 funding, and respond to the following:

- How many more cities are expected to participate as a result of the new 2021 funding?

- Please provide examples of the evaluation metrics being used to measure the effectiveness of the individual projects.

- How are you working with others to coordinate ACT with other major efforts like the MHSA and CYBHI?

Staff Recommendation: No action is recommended as this is an oversight issue.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION
6440 UNIVERSITY OF CALIFORNIA
6610 CALIFORNIA STATE UNIVERSITY
6870 CALIFORNIA COMMUNITY COLLEGES

ISSUE 5: BEHAVIORAL HEALTH ISSUES: YOUNG ADULTS (18 – 25 YEARS OF AGE) OVERSIGHT: CYBHI, RECENT STATE FUNDING FOR BH, AND BH ISSUES IN CALIFORNIA UNIVERSITIES AND COLLEGES, AND FOR NON-STUDENTS

OVERVIEW

This issue covers behavioral health issues, departments, programs and services affecting young adults. Specifically, the committees will conduct oversight on recent budget investments including the Children and Youth Behavioral Health Initiative and Proposition 63 funding. The committees also will explore the quality and accessibility of behavioral health services and supports for college and university students and for non-student young adults. Finally, the committees would like to better understand recent trends in behavioral health in this age group, and how the state can improve its response to the current BH crisis for this age group.

PANEL 5 – PRESENTERS

- **Briana Fernandez Diaz**, Youth Speaker, Central allcove Team YAG Member
- **Khoa-Nathan Ngo**, Youth Speaker, alcove San Jose YAG Member
- **Zofia Trexler**, Youth Speaker
- **Hugh Cook**, Youth Speaker, UCSB Student
- **Genie Kim**, Director of Student Mental Health and Well-being, Graduate, Undergraduate and Equity Affairs, University of California Office of the President
- **Joy Stewart-James,** Associate Vice President, Student Health & Counseling Services, CSU Sacramento
- **Rebecca Ruan-O'Shaughnessy,** Vice Chancellor for Educational Services and Support, California Community College Chancellor's Office
- **Melissa Stafford Jones**, Director, Children and Youth Behavioral Health Initiative, California Health and Human Services Agency
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Elizabeth Landsberg**, Director, Department of Health Care Access and Information
- **Caryn Rizell**, Deputy Director, Healthcare Workforce Development Division, Department of Health Care Access and Information

- **Maria Ochoa,** Assistant Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Marni Sandoval,** Deputy Director of Behavioral Health, Child and Adolescent Services, Monterey County Health Department
- **Christine Stoner-Mertz**, Chief Executive Officer, California Alliance of Child and Family Services
- **Jeannette Zanipatin**, California State Director, Drug Policy Alliance
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives

PANEL 5 – Q&A ONLY

- **Autumn Boylan**, Deputy Director, Office of Strategic Partnerships, Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director, Behavioral Health, Department of Health Care Services
- **Tyler Sadwith**, Assistant Director, Behavioral Health, Department of Health Care Services
- **James Regan,** Assistant Deputy Director, Healthcare Workforce Development Division, Department of Health Care Access and Information
- **Terri Sue Canale**, Acting Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Robin Christensen**, Chief, Substance And Addiction Prevention Branch, Center for Healthy Communities, California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch, Center for Healthy Communities, California Department of Public Health
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst: Health, Developmental Services and IT, Legislative Analyst's Office

OVERSIGHT ISSUES

Most California campuses offer some mental health services, supported by a mix of student fees and other funds. Among college students, the COVID-19 pandemic has exacerbated a longstanding rise in mental health issues. For example, a study from the Healthy Minds Network (a research organization focused on the mental health of young adults) indicates that the prevalence of depression among college students nationally increased from 36 percent in fall 2019 to 41 percent in spring 2021, while the prevalence of anxiety increased from 31 percent to 34 percent.

Most public campuses in the state offer some services: All 10 University of California (UC) campuses, all 23 California State University (CSU) campuses, and at least 90 out of 116 California Community Colleges (CCC) campuses provide student mental health services, according to a report published in December by the Legislative Analyst's Office (LAO). The LAO noted that campuses primarily provide short-term counseling in individual and sometimes group settings. Campus policies vary on the exact number of counseling sessions students may receive, with some campuses setting a limit (commonly between six to twelve sessions per year) and others leaving this to the discretion of counselors. Beyond counseling, other typical campus-provided services include crisis intervention (such as a hotline) for students experiencing urgent mental health concerns, as well as case management to connect students to other campus and community resources. In addition, campuses often provide various kinds of outreach on mental health issues, including trainings and workshops, peer support programs, and online resources. Because campus mental health services are generally intended to be short term, students seeking or requiring long-term treatment tend to be referred to community providers.

Most of these services are supported by students, with campuses charging a health fee along with tuition. Student health costs range from $44 per year at many community colleges, $150 to $740 per year at CSU campuses, and $85 to $549 per year at UC. (UC also charges a $1,128 Student Services Fee at all campuses, and some campuses use some of this funding for mental health services.)

In addition, according to the LAO, 11 community colleges currently participate in the Local Education Agency Medi-Cal Billing Option Program (LEA BOP), which allows public K-12 and higher education institutions to receive federal reimbursement through Medi-Cal, the state's Medicaid program. (Though eligible, no CSU or UC campus currently participates in the program.) Other fund sources for student mental health vary by campus and may include core campus operating funds, certain categorical programs (such as the CCC Student Equity and Achievement Program), external competitive grants, and federal COVID-19 relief funds.

At UC, university-sponsored health insurance also is beginning to cover more student mental health costs. Nearly half of UC students are enrolled in the UC Student Health Insurance Plan (SHIP). (CSU and CCC do not have comparable student health insurance

plans.) UC SHIP historically has been limited to psychiatry and other medical services, but two campuses recently started billing UC SHIP for student counseling services.

State has recently begun supporting services. Even before the pandemic, the state had begun to support increased mental health services for students, using various funding sources, including General Fund, Proposition 98 General Fund, and the MHSA. The 2021-22 Budget Act marked the first time the state began providing ongoing General Fund or Proposition 98 General Fund support at all three segments to boost these services. The chart below was prepared by the LAO and indicates state mental health services funding for the segments during the past five years.

State Has Significantly Increased Funding for Campus-Provided Student Mental Health Services

General Fund, Unless Otherwise Noted (In Millions)

	2017-18	2018-19	2019-20	2020-21	2021-22
UC	—	—[a]	$5.3	$5.3	$20.3
CSU	—	—	3.0[b]	—	15.0
CCC[c]	$4.5	$10.0	7.0[b]	—	30.0
Total	**$4.5**	**$10.0**	**$15.3**	**$5.3**	**$65.3**

[a]UC indicates it spent $5.3 million on student mental health services in 2018-19 using part of a one-time state allocation for general university needs.

[b]Mental Health Services Fund (MHSF).

[c]Unless otherwise noted, reflects Proposition 98 General Fund. Chart excludes about $100,000 ongoing MHSF to CCC for state operations provided since 2008-09.

The new ongoing funding includes provisional language requiring CCC to report every three years and CSU and UC to report annually on these funds, including how the funds were distributed among and used by campuses.

In addition, the Children and Youth Behavioral Health Initiative provided $30 million one-time General Fund in 2021-22 and $120 million one-time General Fund in 2022-23 to DHCS for grants to build partnerships, capacity, and infrastructure supporting behavioral health services for CCC, CSU, and UC students. DHCS is to award the grants through a competitive process to higher education institutions and other eligible entities (such as counties, community-based organizations, and health insurance plans).

Mental Health Services Oversight and Accountability Commission (OAC) Early Psychosis Intervention In approximately 2014, the OAC sponsored a research project to document the availability of early psychosis services and whether those services are aligned with best or evidence-based practices. In 2015 a nationally recognized study found that an array of integrated services, known as Coordinated Specialty Care, when provided within 18 months of the onset of psychotic symptoms, can dramatically improve outcomes, lower costs and support the independence of mental health consumers. Psychosis typically starts in the late teen years to the early 20s, although there are exceptions.

In response, the OAC provided $100,000 to the University of California, Davis, in partnership with several county behavioral health departments, to design a health care learning collaborative focused on expanding access to best available care through the Coordinated Specialty Care model. Generally, Medi-Cal will pay for some 80 percent of services under the model. Private insurance pays for far less care.

Five counties agreed to co-invest county innovation funds in the proposed learning collaborative and the state later invested $20 million to support the project allowing the project to be expanded to include 12 counties with interest from others. This work also has raised $5 million in federal funding, $1.5 million in philanthropy, and includes a small research project with Kaiser to explore the potential return on investment if Kaiser covered the cost of Coordinated Specialty Care for its commercially insured members. Additionally, in partnership with DHCS, the OAC is promoting adoption of the Coordinated Specialty Care model with federal funded block grant funds that are set aside for early psychosis care. Approximately $1.5 million remains in the early psychosis intervention account to support this work.

As part of an aggressive prevention and early intervention strategy, the OAC urges the state to establish a clear and compelling goal to screen for and respond to psychosis within the targeted 18 months following onset. The OAC states that this strategy should include determining an estimate of the number of Californians who will develop psychosis each year, the number of individuals served with Coordinated Specialty Care programs, and a strategy to match access to care to the need for care.

STAFF COMMENTS/QUESTIONS

UC, CSU, CCC:

- How has the COVID-19 pandemic impacted student mental health? How have campuses sought to address emerging mental health issues among students?

- Can the segments charge students' health insurance providers for some mental health services? Are there policy or budget actions the state could take to help better connect insurance providers and campus mental health services?

- What are the segments' goals for student mental health services? Are there staffing ratios, specific services, or other metrics that the segments hope to achieve?

- What is the typical wait time for students seeking mental health services?

- How has ongoing state support impacted these services?

CHHS, DHCS:
Please describe how the CYBHI addresses the BH needs of this population, describe any other state programs, including Medi-Cal, that seek to serve and support young adults and their BH needs, and respond to the following:

- How is DHCS working with UC, CSU, and CCC to make Medi-Cal more accessible to higher education students?

HCAI:
The committees request HCAI discuss the BH workforce issues unique to serving this population, as well as the role of California colleges and universities in addressing BH workforce shortages.

CDPH:
The committees request CDPH share data on behavioral health rates and trends in this age group in California, with a focus on suicide and overdose deaths. Please also detail any other work of the department specific to BH issues of this age group.

MHSOAC:
The committees request the OAC discuss its work on early psychosis and any other work targeted to addressing the BH needs of young adults. Please also provide any recommendations to the state for better addressing the BH needs of young adults.

Staff Recommendation: No action at this time to allow for additional discussion and consideration of the various proposals and issues discussed.