July 26, 2023

The Honorable Susan Eggman
California State Senate
1021 O St., Suite 8530
Sacramento, CA 95814

RE: **SB 326 (Eggman)**: **CONCERNS**

Dear Senator Eggman:

Mental Health America of California appreciates the Administration's goal of improving care for Californians living with behavioral health challenges. However, we have serious concerns that Behavioral Health Modernization, currently moving through the Legislature as SB 326 (Eggman), will not achieve the Administration's goals, and is likely to exacerbate California's mental health crisis. This letter is intended to supplement the proposed amendments we submitted to Assembly Health Committee on July 13, 2023.

Mental Health America of California (MHAC), an affiliate of Mental Health America, has five affiliate organizations and one associate organization in California. We are a peer run organization that has been leading the state in behavioral health public policy and advocacy since 1957. The mission of MHAC is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion, age or socioeconomic status who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. Along these lines, we support efforts which increase access to voluntary, culturally responsive, community-based behavioral health services.

Senate Bill 326 and the resulting ballot initiative, if passed, will result in significant changes to California's public behavioral health care system. An initiative of this magnitude should not be developed behind closed doors or rushed through the legislative process. Simple math can inform us that if (a) thirty percent of Mental Health Services Act (MHSA) funds are diverted to provide and support additional beds; (b) three percent of MHSA funds are diverted for a statewide workforce initiative; and (c) an unknown percentage of funds are diverted to provide substance use disorder (SUD) services for people without a mental health diagnosis, county mental health services will be reduced.

Our specific concerns are detailed below.

I. An initiative of this magnitude should not be rushed through the legislative process without significant stakeholder involvement and detailed analyses.

The Mental Health Services Act was drafted over several years, and included meaningful and substantial input from a broad variety of stakeholders, to ensure that the Act would meet the needs of Californians with mental health challenges who receive services in the public mental health care system. In contrast, SB 326 was drafted behind closed doors without input from the multitude of primary stakeholders who will be impacted, including peers, counties and providers. Furthermore, other than the recent report by the Legislative Analyst Office, there has been no analysis conducted by the Administration to examine the impacts of Behavioral Health Modernization on existing services.

SB 326, as currently written, would rename the MHSA to the Behavioral Health Services Act (BHSA) and divert 3% of county BHSA funds off the top for a statewide workforce initiative that is vaguely described in the bill. Additional funds would be diverted from local services for standalone SUD treatment and for residential beds. This will undoubtedly

impact local mental health services, but without detailed analysis and conversations with the multitude of local mental health stakeholders, it is impossible to know how many people will lose access to vital services, and which services will be reduced.

II. Changes to the MHSA should be designed after the current statewide mental health reforms have taken effect.

The MHSA was drafted and approved by voters to close gaps in California's public mental health system, and to provide funding for services that are not covered by existing funding streams. Yet California is currently undergoing drastic changes to its public mental health system, including California Advancing and Innovating Medi-Cal (CalAIM), the Children and Youth Behavioral Health Initiative (CYBHI), the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), Medi-Cal Mobile Crisis and 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP). With the exception of CYBHI, and certain aspects of CalAIM, the changes underway are intended to increase services for individuals with high needs.

With so many significant changes underway, it is virtually impossible to foretell where the gaps and needs of the system will be once all of these new programs are implemented. However, given the state's focus on the unhoused and those with high needs within SB 326, it is reasonable to assume that there will be gaps in upstream care. It is negligent and irresponsible for the state to move ahead with changes to the MHSA without allowing time for the current programs and initiatives to take effect, and for service needs in the public mental health care system to be exposed. Due to its role to fill unfunded system needs, the MHSA should not be reformed until California understands where the needs will be after system reforms are fully enacted.

III. California's high number of unhoused people is the direct result of a severe lack of affordable housing. We must address this issue prior to amending the MHSA.

Since 2018, California has poured at least 20 billion dollars into efforts to address homelessness[1], yet the number of people without homes has continued to climb. For example, between 2019 and 2022, the overall point in time count of people without homes in Sacramento rose 67%.[2]

The focus of the state's mostly one-time funding homelessness funding has been on temporary shelter/housing, with the development of very little permanent housing. Temporary housing, including shelters, does not result in long-term reductions in homelessness. As soon as the one-time funding is exhausted, individuals are once again on the streets.

According to the California Legislative Analyst Office[3], the following is the result, in terms of ***permanent housing***, of some of the state's homelessness funding:

- Project Homekey: $798 Million spent with 6,467 Permanent units
- Encampment Resolution Funding: $50 million spent with 53 people placed directly into permanent housing, and 365 exiting encampments directly into emergency shelters or transitional housing
- No Place Like Home: $1.9 billion. Since 2018, 498 units have been completed

A recent groundbreaking study by Dr. Margot Kushel at the University of California San Francisco found that the majority of unhoused people in California become unhoused simply because they cannot afford housing. Seventy percent of people surveyed for the study indicated that a monthly rental subsidy of $300-$500 would have prevented their

[1] https://lao.ca.gov/handouts/socservices/2023/2023-24-Budget-Housing-Homelessness-Proposed-Budget-Changes-032923.pdf
[2] https://www.saccounty.gov/news/latest-news/Pages/2022-Point-in-Time-Count-Report-Released.aspx#:~:text=Point%20in%20Time%20Count%20by,over%20the%20last%20three%20years
[3] https://lao.ca.gov/handouts/socservices/2023/2023-24-Budget-Housing-Homelessness-Proposed-Budget-Changes-032923.pdf

homelessness.[4] Although a high percentage of unhoused people reported symptoms of mental health challenges, these challenges were not the cause of individuals becoming unhoused. In fact, the trauma of becoming unhoused and the traumas associated with being unhoused can cause new mental health challenges or worsen existing mental health challenges.

A review of data from the Housing and Community Development dashboard reveals that statewide Regional Housing Needs Projections (RHNA) estimate that, in order to meet local housing needs, 40% of housing must be for people with low and very low incomes. Yet between 2013 and 2024, 76% of the housing permitted by local Continuums of Care (CoC) was for people ***above moderate incomes***, with only 12% of permits for people with low and very low incomes.[5] The most recent census data reveals that between 2017 and 2021, the median household income in California was $84,097.[6] Thus, the vast majority of housing being built in California is only affordable to households who make more than $84,000 per year.

Homelessness in California is an affordable housing issue. Recently, the Legislature approved a large-scale audit of California's homelessness spending, with the goal of learning why the state's $20 billion investment towards housing and homelessness has not reduced the number of people without homes. We believe it is imperative that the Legislature wait for the results of this audit before approving a broad diversion of mental health funds for beds and other housing in California.

IV. Behavioral Health Modernization, if passed by voters, will result in decreased community mental health services.

SB 326 would reduce community mental health services in several ways. First, the proposal would allow the state to take 3% of county BHSA funds off the top to fund an ill-defined statewide workforce program. While we recognize the severity of California's workforce shortages, we believe that sources other than MHSA should fund these programs. The MHSA was written to provide funding to counties for local mental health services, and already allows five percent of funds for statewide activities. Furthermore, the department of Health Care Access and Information is currently charged with the state's primary workforce initiatives. We question whether it is wise to provide funding for a separate state agency to begin parallel efforts.

The MHSA currently allows counties to provide housing and housing services to FSP clients, and we support this use of MHSA funds. However, SB 326 would require counties to shift 30% of their BHSA funds away from mental health services to housing, beds, and housing services. While we strongly support efforts to ensure that every Californian has a safe and stable home, additional funding for this should not come at the expense of community mental health services. As noted previously in this document, homelessness in California is an affordable housing issue, not a mental health issue.

In addition to diversion of mental health funds, the bill would also add a new population to be served by BHSA funds—people with substance use treatment needs who do not have mental health challenges. This, too, will reduce the community mental health services currently provided by counties. Again, we believe that people with substance use treatment needs should receive the care that they need, but this funding should not reduce community mental health services.

Under the new BHSA funding formula, the services that will be most impacted are those that fall within the third bucket (Behavioral Health Services and Supports), which would require counties to spend 15% of BHSA funds on early

[4] https://homelessness.ucsf.edu/our-impact/our-studies/california-statewide-study-people-experiencing-homelessness
[5] https://www.mhac.org/wp-content/uploads/2023/06/Data-Shows-Serious-Mental-Illness-is-not-the-cause-of-Unhoused-Population-Increase-in-California.pdf
[6] https://www.census.gov/quickfacts/fact/table/CA/BZA210221

intervention activities and 15% of BHSA funds on non-FSP Community Services and Supports (CSS), Workforce, Education and Training (WET), Innovations (INN), Capital Facilities and Technological Needs (CFTN) and Prudent Reserve (PR). According to the recent analysis by the Legislative Analyst Office, these categories including Prevention and Early Intervention currently comprise around 60% of MHSA dollars. We can assume then that these categories without Prevention and Early Intervention would currently comprise 41% of MHSA dollars. If we compare this with SB 326 as currently drafted, funding for these vital services would be reduced by 26%. Programs and services currently funded under this category include mental health outpatient services, outreach and engagement services, workforce efforts, crisis and urgent care services, and homeless outreach, among many others. These are vital services that should not be reduced.

V. SB 326 removes existing MHSA priorities for children and youth.

Currently, the MHSA categories of prevention and early intervention, full-service partnerships, and community services and supports prioritize children and youth. Current PEI regulation (9 CCR § 3706) requires counties use at least 51% of PEI funding for children, youth and transition age youth ages 25 and younger. Similarly, regulations for CSS (9 CCR § 3610) also require counties to provide FSP and non-FSP services to children and youth. Yet, there is no language within SB 326 requiring that services be provided to children and youth. Given the Administration's stated priority of focusing BHSA dollars on adults without homes, we are concerned that the proposal authorizes counties to significantly reduce, or possibly eliminate, spending on children and youth.

Furthermore, the proposal would require that children and youth who receive BHSA services must have a serious emotional disturbance diagnosis. This is contrary to recent state efforts including the former Surgeon General's Adverse Childhood Experiences (ACEs) report and statewide efforts in CalAIM. California has long recognized that childhood trauma results in increased risk for a behavioral health disorder, and that interventions provided before the emergence of symptoms can dramatically improve outcomes. In 2021, the Department of Health Care Services (DHCS) released Behavioral Health Information Notice (BHIN) 21-073 which includes criteria for beneficiaries under age 21 to access specialty mental health services. Under these criteria, people under age 21 need only be at high risk for a mental health challenge to access services. ***We recommend that SB 326 incorporate the SMHS access criteria to ensure that all children and youth in need of services can access those services.***

VI. State level governance and oversight of the BHSA would continue to be diffuse and likely ineffective.

When Proposition 63 was presented to voters in 2004, the informational flyer stated that the measure "Requires strict accountability for funds. An oversight panel of independent, unpaid members supervises expenditures. They can cut off funding for programs that are not effective." This strict accountability has never materialized. Furthermore, oversight of the MHSA has declined since 2004, with AB 100 (2011)[7] eliminating the duty of the Department of Mental Health to approve county three-year plans, and eliminating the duty of the Mental Health Services Oversight and Accountability Commission (MHSOAC) to approve Prevention programs and to review and comment on county three-year plans. These duties were never re-assigned to DHCS. It is important to note that, in removing this oversight of the MHSA, AB 100 stated in Section 1(b):

> *Further, it is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act**. In eliminating state approval of county mental health programs, the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act**.*

The state has never established a means to effectively oversee the MHSA. Oversight of the MHSA was further eroded in 2012 with the dissolution of the Department of Mental Health.

[7] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB100

State level governance and oversight of the BHSA would remain diffuse and limited under SB 326. The bill would eliminate all oversight responsibilities from the MHSOAC/BHSOAC, and only slightly increases the oversight responsibilities of DHCS. It remains unclear within SB 326 who would be responsible for state leadership and oversight. There continue to be multiple entities with partial leadership responsibilities, including the Health and Human Services Agency (HHS), DHCS, MHSOAC/BHSOAC, and the California Behavioral Health Planning Council (CBHPC). However, clear and distinct responsibilities for these agencies have not been delineated.

Strong oversight and accountability of the BHSA will be necessary to the long-term success of the measure. ***We recommend that the Legislature make a concerted effort to clearly define oversight of the measure including clear designation of entity roles and responsibilities.***

We appreciate the opportunity to provide these comments on SB 326 (Eggman), and the Administration's Behavioral Health Modernization proposal. Our recommendations are intended to ensure that people with mental health challenges can access the services and supports that will be most effective for each individual.

If you have any questions or would like more information, please do not hesitate to contact me (hstrunk@mhac.org) or our Interim Director of Public Policy, Karen Vicari (kvicari@mhaofca.org).

In Community,

Heidi L. Strunk
President & CEO

cc: Assembly Health Committee