AGENDA - PUBLISHED

CONTRA COSTA COUNTY Mental Health Commission

Wednesday, November 6, 2024 **4:30 PM** **1025 Escobar Street, Martinez**

https://zoom.us/j/5437776481
Meeting number: 543 777 6481 | Call in: 1 669 900 6833 | Access code: 543 777 6481

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at 1025 Escobar Street, Martinez, during normal business hours. Staff reports related to items on the agenda are also accessible online at www.contracosta.ca.gov. If the Zoom connection malfunctions for any reason, the meeting may be paused while a fix is attempted. If the connection is not reestablished, the committee will continue the meeting in person without remote access. Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

I. Call to Order, Roll Call and Introductions

II. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).

In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion, or action on the item will occur, except for the purpose of clarification.

III. Commissioner comments on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).

IV. Chair Comments / Announcements

V. APPROVE September 4, 2024 Mental Health Commission (MHC) Meeting Minutes **24-3230**

Attachments: 09-04-2024 Mental Health Commission Minutes DRAFT

VI. UPDATE on Care Court and the Children's Crisis Stabilization Unit (CCSU) – Dr. Suzanne Tavano, Director, Behavioral Health Services

VII. DISCUSSION continued from the October 23, 2024, joint meeting of the Mental Health Commission / Alcohol and Other Drugs Advisory Board (MHC/AOD AB) on Proposition 1/Senate Bill 326 Changes **24-3646**

Attachments: AttA _ SB326 _ 2023-2024

The next meeting is currently scheduled for December 4, 2024 @ 4:30pm

For Additional Information Contact: Angela Beck @ (925) 313-9553

VIII. Adjourn

File #: 24-3230 **Agenda Date:** 10/2/2024 **Agenda #:** V.

Advisory Board: Mental Health Commission
Subject: September 4, 2024 Meeting Minutes
Presenter: Cmsr. Laura Griffin

ATTACHMENT:
September 4, 2024 Mental Health Commission (MHC) Meeting Minutes

MONTHLY MEETING MINUTES
MENTAL HEALTH COMMISSION (MHC)
September 4th, 2024 – DRAFT

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. L. Griffin, MHC Chair, called the meeting to order @ 4:35 pm. Members Present (In-Person): Chair, Cmsr. Laura Griffin, District V Vice-Chair, Cmsr. Tavane Payne, District IV Cmsr. Y'Anad Burrell, District I Cmsr. Ken Carlson, District IV Cmsr. Gerthy Loveday Cohen, District III *JC Cmsr. Sani Momoh, District III Cmsr. Vanessa Rogers, District IV Cmsr. Barbara Serwin, District II *EC Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Cmsr. Contesa Tate, District V Cmsr. Jenelle Towle, District IV Speakers Dr. Suzanne Tavano, Director Behavioral Health Services Other Attendees (*in Person): Phil Arnold, NAMI CC Colleen Awad (Supv Carlson's Ofc)* Guita Bahramipour* Angela Beck* Jennifer Bruggeman Elaine Cortez-Schroth, Contra Costa Crisis Center* Paul Cumming, Sr. Associate Outreach, Everwell* Alejandra Escobedo Dr. Stephen Field, Medical Director John Gallagher, Hope Solutions Nicole Green, Vice Chair, Alcohol and Other Drugs Advisory Board Fatima Matal Sol, Alcohol and Other Drugs Program Chief* Audrey Montana* Jennifer Quallick (Supv. Andersen's ofc) **Motion:** L. Griffin request approval for Cmsr. B. Serwin to participate remotely based on 'emergency circumstances" for this September 4, 2024 MHC meeting (in accordance with AB2449 – Teleconferencing options allowed under the Brown Act, dated March 1, 2023). Seconded by T. Payne **Vote: 11-0-0** **Ayes**: L. Griffin (Chair), T. Payne (VC), Y. Burrell, K. Carlson, G. Loveday Cohen, S. Momoh, V. Rogers, G. Stern, G. Swirsding, C. Tate, J. Towle Abstain: N/A	Meeting was held at: 1025 Escobar Street, Martinez, CA 94553 and via Zoom platform
II. PUBLIC COMMENT: • (Elaine Cortez-Schroth) Suicide Prevention Awareness Month announcement. Also the first ever annual '988-day' raising awareness to the 988 suicide/crisis lifeline and emphasize the importance of mental health support. Since its launch nationwide two years ago, more than 10 million calls, including 1.7mil texts and chat of people looking for help with suicidal thoughts, mental health and substance use related crisis. In California, 988 is currently routed to 12 call centers. In California alone, received over 350k calls and responded to over 40k texts/chats last year	

alone. Expansion of the text/chat compacity has doubled in more than a year, so the crisis center here in Contra Costa will launch their new platform starting in October to further expand our crisis response capabilities. For the Contra Costa Crisis Center, this is a dramatic increase in the lifeline calls, with nearly 22k 988 calls alone this past year, which is 79% increase over the first year and have managed over 70k calls on 19 crisis lines (including 211). We are set to receive over 80k in the upcoming year. Geo-routing will start next month and could potentially further increase our call volume.

- (Phil Arnold) 61 years ago, Dr. King gave his 'I have a dream' speech in Washington, D.C. 18 days later, on September 15, 1963, the 16th Street Church was bombed where four innocent girls were murdered. As we approach 9/11 and remembering that date, I am mindful of what my dear friend, Joe Ovick (County Office of Education Superintendent) promoted, at that was to "Practice Civility" as we must set the example for our youngsters going to school. Encouraging everyone to be extremely vigilant regarding what is going on and could have an adverse traumatic impact on our little ones (grade school through junior high), starting the new year.
- (Guita Bahramipour) Remember that thoughts matter, suicidal thoughts matter just as much.
- (Fatima Matal Sol) Also September is National Behavioral Health Recovery Month. (Behavioral Health includes both Mental Health and Substance Use).

III. COMMISSIONER COMMENTS:

- (Cmsr. Swirsding) Good news, today regarding the crisis center in Oakland. There were two young men I have helped and they brought their little brother to me while I was at a function in Richmond. The 8-year old wanted to know who he calls when he needs help? The concern is they did not want child protective services involved. He can call 988.
- (Cmsr. Burrell) Bay Area Air Quality Management District (BAAQMD) released their Strategic Plan 2024-2029 <URL: Draft Strategic Plan (baaqmd.gov) [baaqmd.gov]>. As a Community Emissions Reductions Plan committee member for Richmond, North Richmond, and San Pablo, I keep an eye on that plan. The public comment has closed as of August 1, there is still an opportunity to give public comments and send emails. There are two areas in the plan; Environmental Justice area; there is also Identifying and Reducing Health Disparities. I believe those are synergies and intersection powered work. It is a good plan overall. It is a heavy lift. If we are cut our pieces in, we can move this along collectively.
- (Cmsr. Carlson) We actually approved that plan (Just got back from that meeting in San Francisco this afternoon), there will be more work done because it is so much. There will be performance metrics coming forward. Watch the process, we will find ways to hold ourselves accountable and meet the needs, especially in those heavily impacted communities., like Richmond, San Pablo, West Oakland
- (Cmsr. Tate) Suicidal ideation, attempts or planning does not cause someone to complete the act. Some people shy away from talking about it because they believe speaking about it, that it leads to someone actually following through. Don't be afraid to be very direct. You don't have to beat around the bush and be very direct. That too can also save

a life. It allows them to feel seen/heard and witnessed. Many times the emotional distress is not feeling understood, seen or heard and feeling alone. Being direct allows individuals to finally feel seen. It can be an opening port of entry to introduce services. • (Cmsr. Towle) Frequently, we think when they are in the depth of their depression, that it is the danger point. The reality is that once they are medicated and start feeling better, that is where the danger zone is. They have the energy to do 'deed' and not out of their depression long enough to feel the hope again. I just want folks to know that the window of time is not what you might think.	
IV. CHAIR COMMENTS/ANNOUNCEMENTS: ➢ Suicide Awareness Month – Thanking Elaine for her presentation. Just a reminder that Suicide affects us all. It can be very private and must be very aware of people in our families, friends or anyone that you think might be struggling. It is not always those that show the 'signs'. This is a time to reflect take the time we need, contact those we need to and know that you (we) are not alone. I have had some people dear to me commit suicide and sometimes you just regret you didn't see any signs.	
V. APPROVE August 7, 2024 Mental Health Commission (MHC) Meeting Minutes The Mental Health Commission (MHC) August 7, 2024 Minutes were reviewed. **Motion:** K. Carlson, moved to approve the minutes. Seconded by G. Swirsding **Vote: 12-0-0** **Ayes:** L. Griffin (Chair), T. Payne(VC), Y. Burrell, K. Carlson, G. Loveday Cohen, S. Momoh, V. Rogers, B. Serwin, G. Stern, G. Swirsding, C. Tate, J. Towle Abstain: N/A	**Agenda and minutes can be found:** https://contra-costa.legistar.com/Calendar.aspx
VI. RECEIVE Presentation on the Integrated Behavioral Health Board – SB326: Board Guidelines – Cmsr. Laura Griffin Integrated Behavioral Health Board: SB 326: Board Guidelines. *<Please refer to Attachment A: BHB Integration presentation slides included in the meeting packet>* There is a workgroup created at the request of Supervisor Carlson consisting of: • Dr. Suzanne Tavano, Director of Behavioral Health Services (BHS) • Fatimah Matal Sol, Program Chief, Alcohol and Other Drugs (AOD) • Jennifer Bruggeman, Program Manager, Mental Health Services Act (MHSA) • Laura Griffin, Chair, Mental Health Commission (MHC) • Tavane Payne, Vice Chair, Mental Health Commission (MHC) • Logan Campbell, Chair, AOD Advisory Board • Nicole Green, Vice Chair, AOD Advisory Board As a workgroup, we do not make any decisions and just work on logistics and administrative details. We do not fall under the Brown Act. Thus far, we have created this presentation for you all today. Next month, we will have a joint meeting with AOD Advisory Board and the MHC to review what each entity does and together as a group getting ready for the merge in January. **Introduction** Proposition 1: Modernization of Mental Health Services Act • Passed in March 2024 • Requires all counties to have a combined Behavioral Health Advisory Board beginning 1/1/25 • Restructures the Mental Health Services Act (MHSA) also known as "millionaire's tax"	PowerPoint slide show presentation for this agenda item was shared to the Mental Health Commission via screen share. This will be added to the minutes as the file was not ready at time of posting. Documentation on this agenda item can also be found: https://contra-costa.legistar.com/Calendar.aspx

- Focus on Housing and related services, Intensive Wraparound Care (Full-Service Partnerships)
- Allows expanded use of MHSA funds to include Substance Use Disorder (SUD) services, in addition to Mental Health care.
- MHSA becomes Behavioral Health Services Act (BHSA)
- Full implementation to begin with the 2026-29 Three-Year Plan (7/1/26)

Membership:

The Behavioral Health Board will Consist of:

- 10 to 15 members
- 50% consumers, or the parents, spouses, siblings, or adult children of consumers.
  *One of these members will be 25 years of age or younger
- 20% will be consumers
- 20% will be families of consumers
- One member will be a veteran or veteran advocate
- One member will be an employee of a local education agency
- Term of three years
- Appointments will be staggered

Exceptions:

- Member of the board, or their spouse, shall not be a county employee of a county mental health or substance use disorder service, an employee of the State Department of Health Care Services (DHCS), or an employee, or paid member, of the governing board of a mental health or substance use disorder contract agency
- A consumer of behavioral health services who has obtained employment in any of the above and holds a positions in which the consumer does not have an interest, influence, or authority over a financial or contractual matter shall
  *abstain from voting on a financial or contractual issue concerning the member's employer

Functions:

- Review and evaluate the local public mental health system
- Review and evaluate the local public substance use disorder treatment system
- Advise the governing body on community mental health and substance use disorder services
- Review and evaluate the community's public behavioral health needs, services, facilities, and special problems where services are being provided
- Review county agreements
- Advise the governing body and the local behavioral health director
- Ensure citizen and professional involvement at all stages
- Submit and annual report
- Review and recommend appointment of the local director of behavioral health services
- Review and comment on county's performance outcome date
- Assess the impact of the realignment of services
- Conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision.
- Review adopted BHSA plan and make recommendations to the local behavioral health agency.
  *Provide an annual report of written explanations to the local governing body and DHCS

Development of bylaws to include:

- A specific number of members
- Quorum be one person more than one-half of members

- Establish the chairperson of the behavioral health board be in consultation with the local behavioral health director
- Establish that there may be an executive committee of the behavioral health board

Proposition Local Stakeholder Involvement (BHSA "Integrated Plan" Changes)

MHSA	BHSA
Stakeholder involvement on: • Mental health policy • Program planning and implementation • Monitoring • Quality improvement • Evaluation • Budget allocations Requires participation from unserved/underserved populations, individuals with SMI or SED and their families; providers of mental health, physical health, and/or social services; educators or their reps; law enforcement.	Stakeholder involvement on: • Mental health **and substance use disorder** policy • Program planning and implementation • Monitoring • **Workforce** • Quality improvement • **Health equity** • Evaluation • Budget allocation Also requires sufficient participation from diverse groups
30-day comment, public hearing, and annual report on recommendations not included in plan	30-day comment, public hearing, and annual report on recommendations not included in plan

Anyone interested in continuing on with the new commission, please send an email to your supervisor to let them know with the restructuring of the MHC into the new BHC that you are interested in continuing to serve. The creation and appointments will be in place as of January 1.

Questions and Comments

- (Cmsr. Towle) Specific questions regarding terminology and acronyms.
  (RESPONSE: Dr. Tavano) State terminology. SMI (Serious Mental Illness) is the adult term; SED (Serious Emotional Disturbance) is the term for children.
- (Cmsr. Swirsding) Concerned for children living in (AOD) homes where there is substance use. How does AOD help children in these homes.
  (RESPONSE: Fatima Matal Sol) Within AOD, we have a number of programs and children receive services with their parents. Parenting programs for substance use disorders (SUD) and parents go through treatment at the same time as the children; including pregnant mothers and those with small children. In addition, there is a large component around primary prevention. We know SUD is preventable and a large portion of our funding that is slated for this category, we are unable to spend for anything else but prevention. Our emphasis in Contra Costa (CC) is the youth in both middle school and elementary school. We work with parents, as we know how much of an influence they have in SUD. All services are listed in the Strategic Prevention Plan on the AOD's webpage <URL: https://www.cchealth.org/home/showpublisheddocument/10155/638428254490300000>.
- (Cmsr. Tate) Having the pleasure of writing grants and working on programs with Fatima when I worked as the Director at the Greater Richmond Interfaith program. All of her programs are amazing and never knew there was that much emphasis on providing substance use and substance abuse support, especially for youth. We partnered on substance use prevention for pregnant women and children. We also focused (under the First5 initiative) in helping parents work on parenting classes, but also had a SUD component to it, which I saw firsthand.
- (Dr. Tavano) Love this conversation because you are all doing the work of an integrated board. I know the commission has a lot of questions about AOD issues and the AOD has questions about MH issues.
- (Cmsr. Payne) This will be addressed in our next meeting – discussion what each advisory board does to start integrating.
- (Dr. Tavano) Last week at the AOD Advisory Board, is there are culture differences between the two boards and it is going to take some effort and commitment to work through culture issues. Example, speaking about consumers and people with lived experience, that didn't really resonate with

the AOD Advisory Board as the language is different. Merging these two cultures together there will be sharing information and the need to understand each other's culture. Along with that, I want to bring up the issues of stigma and discrimination because we will have to address those because people have different preferences in terms of whether they identify with having mental health issues or substance use issues. How do we make the space for everybody?

- (Cmsr. Payne) I think our workgroup is really moving toward wanting that kind of feel that integrates the two. We are learning each other's way of doing things and the understanding that this is like a family being brought back together.
- (Dr. Tavano) Just to add to that, we aren't making anything up, we are just following the law and trying to condense it and present in an understandable way. In the packet, we went through two pieces of legislation (SB326) the other is the bond measure. SB326, it is a large document, we provided the link: <URL: https://legiscan.com/CA/text/SB326/id/2834153> which was written before the law passed so there are sections that are no longer active. The summary is provided and will be sent out via email to all participants after the meeting (as well as attached to the end of the minutes as it was unavailable at the time the agenda packet was published).
- (Cmsr. Payne) Questions regarding the required composition of the members percentage broken down. It is confusing. (RESPONSE: Dr. Tavano) In total, 50% should be those with lived experience. Of that 50%, at least 20% must be clients/consumers with lived experience and the other 20% families. The other 50%, since we are a large county, someone representing education, veteran, TAY (transitional aged youth).
- (Cmsr. Burrell) Many of the functions, there is a line that states 'review county agreements' and I recall seeing that in this body's charter. What is the idea behind review and advise? Which county agreements?
  (RESPONSE: Contracts and Grants)
- (Cmsr. Carlson) When you look at the totality of the functions that are under purview, looking at it through evaluating a needs assessment that would fall under behavioral health, what services and then who are contract is with and what is the services supposed to be to assess how it matches up with the services we prioritize.
- (Cmsr. Burrell) We were also looking at (in Quality of Care committee) which goals we were deciding to focus on and carry into the new commission – one was the schools and contracts with the schools. That is what brought up the idea of having some connectivity to what is going on county-wide and what may integrate with some of the research and contracts/agreements that we are looking out. That is how this came up as we were discussing that. I wanted to bring Cmsr. Serwin into that thought process.
- (Cmsr. Payne) We are trying to focus our committees with specific goals that match up with the committee's focus and mission statements.
- (Cmsr. Griffin) To be clear, the new body will be in effect January 1st and will be looking at the committees to decide what the committees will be. AOD doesn't have the same committees that we do and there will be some merging and will be up to the new commission to hash it all out and see how it all fits. AOD doesn't have a finance committee.
- (Fatimah Matal Sol) They don't have a finance committee but they do have program and services committee that aligns some of the priorities with what is established at the beginning of the year, which right now, that committee is about to launch a survey to all of our programs asking about health disparities and cultural competency. That is evaluating programs to the extent it aligns to the strategic plan, it is something committee is going to have to review; not from the fiscal point of view, but from the quality of services.
- (Cmsr. Towle) I just want to know how we are going to stagger if we are all signing up again?

• (Cmsr. Carlson) That will be the hard part because we haven't gotten there quite yet. We will have two times as many members as we have seats. We want to be culturally diverse, district diverse and we want to represent as we do on the MHC, every district is represented in three different ways. How do we do that? How do we bring you all in? (Colleen Awad) Right now all seats are three years and staggered, it can be done and do some temporary shorter ones / longer ones. What we have gone over today is currently following. So there will be some adjustment. • (Cmsr. Payne) How are we going about the bylaws and the blending of those? Is the BoS staff merging those bylaws or is the workgroup going to work at creating a draft? • (Cmsr. Griffin) That will be up to the new commission. (Dr. Tavano) The California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) did a draft (template) of bylaws. It has all the required elements, so however it gets added to but not retracted from, so at least most of it is there when you review those models from the state. (Cmsr. Griffin) it will be up to the new body. • (Cmsr. Carlson) The new board will be created, you will likely choose a spokesperson and review/create a draft with whatever adjustments you have and then it goes to county counsel and it will come back to vote on it and then seat your executive board and so on. It will be a process and likely a couple months. • (Guita Bahramipour) I want to know how housing is going to be on the list of goals and priorities. (RESPONSE: Dr. Tavano) We already, under Prop 1/BHCIP, there is the opportunity to send proposals that would be for programs that are co-occuring but also for freestanding SUD. The big underlying piece about moving from the Mental Health Service Act (MHSA) to Behavioral Health Service Act (BHSA) is, for the first time, funds can be dedicated to services for those with primary/exclusive SUD diagnosis, so moving forward, everything we do will be done together.	
VII. UPDATE on the August 30, 2024 Detention Visits – Cmsr. Tavane Payne The tour visit participants consisted of a mix from each committee including: Cmsr. Rogers, Cmsr. Momoh, Cmsr. Tate and Cmsr. Payne. The tour consisted of the West County Detention Facility (WCDF) and the Martinez Detention Facility (MDF). It was an amazing tour. It was very informative and we learned a lot including what we were doing great, what we might be able to help out with; but the system is working. We have decided to create an ad hoc with our commissioners on tour and including Manju Mathews and will be inviting each lieutenant that conducted our tour to join on Zoom, as well as extend an invitation to Dr. Tavano and Supervisor Carlson. We will also be touring the juvenile detention facility in the future. This ad hoc committee will create a cohesive, all inclusive package for the BOS to show them how MH/AOD we are trying to be a partner with BHS. We want to focus on creating this site visit report in October/November to present to the BOS. It was suggested during the tour to survey the staff and inmates on their experience to include in this report (without names). **Questions and Comments** • (Cmsr. Rogers) It was very eye-opening, everyone was very welcoming. WCDF admin staff found an opportunity for surveys (particularly for the employees): what kind of support services to the employees need that they are not getting (not something they have been asking) and they will consider doing that. There is also a staffing issue with both locations for mental health counselors and found out the issue seems to be they are not able to hire because most people prefer remote positions. If the residents have access to tables, we proposed maybe there could be a way to access counseling via tablets and perhaps hire counselors who are virtual.	Documentation on this agenda item can be found: https://contra-costa.legistar.com/Calendar.aspx

- (Cmsr. Momoh) It was an overall good experience, "eye opening" and got an in-depth what is happening within the detention facilities. As Cmsr. Rogers stated, there is the understaffing issue and I think really causing burnout and causing the staff to feel overwhelmed. If we can look for ways to partner and get them more resources, improve the staffing. One major concerns was that I realized there was a lack of connection between the detention facilities and CBOs. I'm hoping there is a way they can explore utilizing CBO's to fill out most of the services they are lacking at this time.
- (Cmsr. Tate) I wanted to address was directed toward the Re-entry population in that process, especially in WCDF. Noticed how the atmosphere looks so much like a rehab center. It was very peaceful, I remember going there many years ago and what it looks like now. It looks like a rehab, which is a really great way to represent being in a detention facility, but something I noted while on the tour was on the comment "We have a mixed population" and the way the detention facility was constructed was not for individuals with higher level crimes. We could hyper focus on those CBOs with the weight lifting of the rehab and getting individuals who can do more community-based services and leaving the detention facilities for individuals who need more higher level of care. It would really help with the issue of the staffing, but also open to a more segregated way of looking at the work. This segways more into what was discussed at MDF where the lieutenant mentioned that they feel their hands are tied. They are to have more of a legal justice eye, not trained to have a mental health eye, so the work needs to be more separated with officers who can't do their job because they are asked to go outside the scope of their roles. MH professionals are there to have a more clinical eye and can't necessarily do what the offices do, so ensure the roles are easily defined and differentiated to ensure the inmates don't get lost in all these different providers. I look forward in continuing to find avenues to bring in CBOs to help. Also, helping the inmates inside the program find value in continuing their rehab when they are released. There are some inmates we were able to speak with that spoke very highly of how easily accessible obtaining mental health was.
- (Cmsr. Stern) The last time we were on tour, we toured the library and they do appreciate donations of paperbacks (as many as you can bring). If anyone wants to donate extra books, they are very excited and you just need to call to set up an appointment to drop off. Did you get to see the new psych sections?
  (Cmsr. Payne) The building is not completed yet but it does look great and it is huge but we don't know the completion date. It will be included in the report.
- (Nicole Green) I just wanted to say I was very excited about your conversation on this and yes, I will take you invitation to join that ad hoc group. I wanted to add from our AOD perspective, one of our recommendations are around the justice impacted. I am excited, outside of the AOD Board, I am also part of the office of re-entry and justice board, so there are other surveys done with in-custody and think it is great you all are doing that. One recommendation in reference to finding CBOs, inside the detention center there are a lot of different CBOs that come in touch with individuals for MH/BH/AOD, the tablet is great, but when they provide you with the CBOs, ask them to give you everyone that is in touch with the participants because there are a lot outside of the BHS aspect, there are CBOs that solely focus on the re-entry aspect.
- (Cmsr. Serwin) Clarification questions on book donations. Contact the librarian and make an appointment the librarian for donations.
- (Phil Arnold) I am enthused by the initiative and the deliberate actions you all are taking. My experience in custody services go back to 2009 when Sheriff Warren Rupf appointed me to the sheriff's Inmate Welfare Fund and part of that was to understand and to do things that would help make reentry successful, like parenting classes. I also served 9 years (2011-2020) as the chair person of the CCC Board of Parole and part of my process was to ask for a 90 day action plan, starting with the day of release. We start with basics – what are you going to wear, where are you going to work and how are you going to

get there? Decisions they haven't made in years since being in custody. Basic things that we think about every day. And that was what I enjoyed about the parole board hearing, because not only was I trying to help reduce recidivism, but also trying to make sure that our 1,100,000 constituents were safe. We helped them get their GED, the skills they need and plan for when they are released. We also need to ensure the mental health of our offices is in place too. You can't have an 8-hr stressful day with your eyes going back and forth and then come home and hug your spouse, pet your dog and ask Junior if his homework is done. You don't have a trouble tree to park that on. So it is bidirectional as far as the mental health is concerned for all of us actively involved. I invited every department head to come to a parole board hearing. The only person in the county that every attended was Joe Ovick. Thank you. You are on to something, don't let go of it. CBOs are going to be key. • (Cmsr. Serwin) I just wanted to reiterate Cmsr. Swirsding's question on change. What I am really focused on is what has changed? Certain promises were made with good intentions but many things haven't occurred. I am also very interested in the big settlement with the county that occurred about three years ago or so; What has been implemented? Where is that information being published? How on track are we? • (Dr. Tavano) Thank you Phil, when people speak to their lived experience, it makes it all the more real. Really we always appreciate when you speak. Also, there will be more about it going forward but the CAL Aim Justice-involved initiative will start while people are in detention and the work we do with them before they leave detention in a warm handoff in support services in the community. Behavioral Health had to submit an implementation plan to the state (which we did). We go live this October and we must be ready, the rest of the system goes live in 2026. Over the course of this next year, we will be having more conversations. • (Nicole Green) We had a survey and research done in reference to restorative justice and there is a report that can be shared as well. Maybe with the new commission, this information can be share to broaden the conversation on what is happening with reentry and the restorative justice. • (Dr. Tavano) Just to add that Fatima and I both sit on the CCP (Correctional Community Partnership) and there is a community advisory board with much work going on there. I think it would be really beneficial to hear from members, the work that has been going on, the surveys conducted, and take that whole body of work and build on it rather than start all over again.	
VIII. RECEIVE Committee report outs ➢ **MHC Finance Committee – Cmsr. Tavane Payne** ➢ **Justice Systems Committee – Cmsr. Tavane Payne** ➢ **Quality of Care Committee – Cmsr. Barbara Serwin**	***Due to time constraints brief summaries were given.***
IX. Adjourned: 6:15 pm	ZOOM recording available at: **https://zoom.us/rec/share/hB2bmEPuoiBK8UCjp-H5VsgYawDmDG9kjjnEOtKanZlx72H5s1O-uH6X3Q9gABV7.aJytSUAT2O_Tdmfc [zoom.us]** **Passcode: xnm$*1Od**

File #: 24-3646 **Agenda Date:** 11/6/2024 **Agenda #:** VII.

Advisory Board: Mental Health Commission
Subject: October 23rd Joint meeting discussion continuation
Presenter: Chair Griffin / Dr. Suzanne Tavano

Attachment A: California Senate Bill 326

Bill Text: CA SB326 | 2023-2024 | Regular Session | Chaptered California Senate Bill 326

Bill Title: The Behavioral Health Services Act.

Spectrum: Partisan Bill (Democrat 2-0)

Status: *(Passed)* 2023-10-12 - Chaptered by Secretary of State. Chapter 790, Statutes of 2023. [SB326 Detail]

Download: California-2023-SB326-Chaptered.html

Senate Bill No. 326

CHAPTER 790

An act to amend, repeal, and add Section 99277 of the Education Code, to amend, repeal, and add Section 131315 of the Health and Safety Code, to amend, repeal, and add Section 19602.5 of the Revenue and Taxation Code, to amend, repeal, and add Section 1095.5 of the Unemployment Insurance Code, and to amend Sections 4090, 4094, 4096.5, 5675, and 5813.6 of, to amend and repeal Sections 5840.5, 5840.8, 5846, 5847, 5848, 5878.2, 5895, and 5899 of, to amend, repeal, and add Sections 5604, 5604.1, 5604.2, 5604.3, 5604.5, 5610, 5613, 5614, 5664, 5771.1, 5805, 5806, 5813.5, 5830, 5835, 5835.2, 5840, 5840.6, 5840.7, 5845, 5845.5, 5848.5, 5849.1, 5849.2, 5849.3, 5852.5, 5868, 5878.1, 5878.3, 5881, 5886, 5890, 5891, 5891.5, 5892, 5892.1, 5892.5, 5893, 5897, 5898, 14197.7, and 14707.5 of, to add Sections 5831, 5845.1, and 14197.71 to, to add Part 4.1 (commencing with Section 5887) to Division 5 of, to add Chapter 3 (commencing with Section 5963) to Part 7 of Division 5 of, to add and repeal Section 5892.3, and to repeal Section 5963.06 of, the Welfare and Institutions Code, relating to behavioral health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor October 12, 2023. Filed with Secretary of State October 12, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

SB 326, Eggman. The Behavioral Health Services Act.

(1) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services. Existing law authorizes the MHSA to be amended by a $^{2}/_{3}$ vote of the Legislature if the amendments are consistent with and further the intent of the MHSA. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the MHSA by majority vote.

If approved by the voters at the March 5, 2024, statewide primary election, this bill would recast the MHSA by, among other things, renaming it the Behavioral Health Services Act (BHSA), expanding it to include treatment of substance use disorders, changing the county planning process, and expanding services for which counties and the state can use funds. The bill would revise the distribution of MHSA moneys, including allocating up to $36,000,000 to the department for behavioral health workforce funding. The bill would authorize the department to require a county to implement specific evidence-based practices.

This bill would require a county, for behavioral health services eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services (the department) under specific circumstances. The bill would require counties to pursue reimbursement through various channels and would authorize the counties to report issues with managed care plans and insurers to the Department of Managed Health Care or the Department of Insurance.

The MHSA establishes the Mental Health Services Oversight and Accountability Commission and requires it to adopt regulations for programs and expenditures for innovative programs and prevention and early intervention programs established by the act. Existing law requires counties to develop plans for innovative programs funded under the MHSA.

This bill would rename the commission the Behavioral Health Services Oversight and Accountability Commission and would change the composition and duties of the commission, as specified. The bill would delete the provisions relating to innovative programs and instead would require the counties to establish and administer a program to provide housing interventions. The bill would provide that "low rent housing project," as defined, does not apply to a project that meets specified criteria.

This bill would make extensive technical and conforming changes.

(2) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law further provides that, to the extent resources are available, community mental health services should be organized to provide an array of treatment options in specified areas, including, among others, case management and individual service plans. Under existing law, mental health services are provided through contracts with county mental health programs.

The bill would authorize the State Department of Health Care Services to develop and revise documentation standards for individual service plans, as specified. The bill would revise the contracting process, including authorizing the department to temporarily withhold funds or impose monetary sanctions on a county behavioral health department that is not in compliance with the contract.

(3) The bill would provide that its provisions are severable.

(4) The bill would provide for the submission of specified sections of this bill and AB 531 to the voters at the March 5, 2024, statewide primary election, as specified.

(5) This bill would declare that it is to take effect immediately as an urgency statute.

Digest Key

Vote: 2/3 Appropriation: no Fiscal Committee: yes Local Program: no

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Bill Text

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The people of the State of California hereby find and declare all of the following:

(a) One in 20 adults in California is living with a serious mental illness (SMI). One in 13 children in California has a serious emotional disturbance (SED) and 30 percent of youth 12 to 24 years of age experience serious psychological distress.

(b) One in 10 Californians meet the criteria for a substance use disorder.

(c) The number of amphetamine-related emergency department (ED) visits increased nearly 50 percent between 2018 and 2020, while the number of non-heroin-related opioid ED visits, including fentanyl ED visits, more than doubled in the same period. Data shows a 121% increase in opioid deaths between 2019 and 2021.

(d) Nationally, suicide rates among youth between 10 and 18 years of age have increased. Hospitals have reported a significant increase in the number of adolescents seeking psychiatric treatment in emergency departments.

(e) Veterans have a higher rate of suicide than the general population and experience higher rates of mental illness or substance abuse disorder. In 2020, there were over 10,000 Californian veterans experiencing homelessness.

(f) Recent research from the University of California, San Francisco found that the majority of homeless Californians (82%) reported a period in their life where they experienced a serious mental health condition. More than one quarter (27%) had been hospitalized for a mental health condition. Nearly two-thirds (65%) reported having had a period in their life in which they regularly used illicit drugs.

(g) California's behavioral health care system must serve the state's diversity of people, families, and communities and reduce gaps in access and outcomes for all—including gaps due to geography, age, gender, race, ethnicity, or other factors identified by data.

(h) Research shows that incarcerating the mentally ill is counterproductive to rehabilitation and long-term public safety due to recidivism. It costs $100,000 per person to incarcerate an estimated 150,000 people who are mentally ill; treatment provides far better outcomes at far less cost.

(i) The limited availability of community-based care facilities to support rehabilitation and recovery contributes to the growing crisis of homelessness and incarceration among those living with a mental health disorder. Research indicates that the state has a shortage of over 2,700 subacute and nearly 3,000 community residential beds. This shortage leads to huge increases in emergency department visits for mental health treatment at a very high cost.

SEC. 2. The purposes and intent in enacting this act are as follows:

(a) In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA) to expand mental health support and services in California communities.

(b) The time has come to modernize the MHSA to focus funds where they are most needed: expanding services to include treatment for those with substance use disorders and prioritizing care for those with the most serious mental illness, including the disproportionate number experiencing unsheltered homelessness.

(c) Reforms will provide guaranteed, ongoing resources for housing for those needing behavioral health services and continuing support for prevention and early intervention. This includes taking a whole person approach that is streamlined and seamless in service delivery, and supports the individual's recovery and well-being.

(d) Reforms will require strict accountability measures to ensure funds are focused on outcomes for all California families and communities and provide transparency for the public, utilizing all available behavioral health fund sources that local governments have at their disposal. Strong oversight will ensure investments are being made in effective, equitable and high-quality care.

(e) Reforms will provide funding for a robust behavioral health workforce, including thousands of counselors and psychologists. The state will lead efforts to recruit, train, and create pathways to high-quality jobs that can meet the growing and changing behavioral health care needs of Californians.

(f) Reforms will provide ongoing funding to build and sustain the necessary treatment centers and professional workforce to treat people with mental illness to avoid incarceration.

(g) Reforms will include bond funding that is intended to build more than 10,000 new treatment beds and supportive housing. Over 100,000 people per year with behavioral health conditions will get treatment, including those experiencing homelessness, veterans, and youth.

(h) The bond will dedicate funding for veterans experiencing challenges with mental health or substance abuse and homelessness.

(i) Overall, this measure strengthens the continuum of care for all Californians and especially the most vulnerable. It provides substantial state investment, improves statewide accountability, and increases Californians' access to behavioral health services.

SEC. 3. Section 99277 of the Education Code is amended to read:

99277. (a) Upon receiving funding for purposes of this chapter, UCSF, the UC college named in Section 92200, and the UC/CSU California Collaborative on Neurodiversity and Learning shall each appoint one member from the respective institutions. This group shall be charged with the development and oversight of the initiative, and shall function as the institute's management committee. The management committee shall be permitted, but not obligated, to retain a program director to assist in the implementation of the initiative.

(b) An advisory board, with its title and members to be named by the institute, shall be established to serve as an oversight body for the initiative in order to monitor progress and provide leadership from the perspectives of their respective participating organizations, departments, and divisions, and to facilitate collaboration among researchers, practitioners, administrators, legislators, and community stakeholders. The advisory board shall provide expertise and support to the management committee. The membership of the advisory board shall be constituted as set forth in subdivision (c). The advisory board shall be a check on accountability in order to ensure that the initiative is meeting its goals. The advisory board shall also conduct a fiscal review of the distribution of funds to ensure alignment with the goals of the initiative.

(c) The members of the advisory board shall be representatives from the following institutions, organizations, agencies, and groups:

(1) UCSF.

(2) UC college named in Section 92200.

(3) The UC/CSU California Collaborative for Learning and Neurodiversity.

(4) The Mental Health Services Oversight and Accountability Commission.

(5) A Member of the Assembly selected by the Speaker of the Assembly.

(6) A Senator selected by the President pro Tempore of the Senate.

(7) Community representatives, including formerly justice-involved persons and their family members, selected by the Governor, the Speaker of the Assembly, and the President pro Tempore of the Senate.

(d) The advisory board shall meet twice per year, with the potential for additional working group meetings. At each meeting, the advisory board shall participate in a review of reports, including updates on research, practice, and policy efforts, as well as fiscal reporting.

(e) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 4. Section 99277 is added to the Education Code, to read:

99277. (a) Upon receiving funding for purposes of this chapter, UCSF, the UC college named in Section 92200, and the UC/CSU California Collaborative on Neurodiversity and Learning shall each appoint one member from the respective institutions. This group shall be charged with the development and oversight of the initiative and shall function as the institute's management committee. The management committee shall be permitted, but not obligated, to retain a program director to assist in the implementation of the initiative.

(b) (1) An advisory board, with its title and members to be named by the institute, shall be established to serve as an oversight body for the initiative in order to monitor progress and provide leadership from the perspectives of their respective participating organizations, departments, and divisions and to facilitate collaboration among researchers, practitioners, administrators, legislators, and community stakeholders.

(2) The advisory board shall provide expertise and support to the management committee.

(3) The advisory board shall be a check on accountability to ensure that the initiative is meeting its goals.

(4) The advisory board shall conduct a fiscal review of the distribution of funds to ensure alignment with the goals of the initiative.

(5) The membership of the advisory board shall be constituted as set forth in subdivision (c).

(c) The members of the advisory board shall be representatives from the following institutions, organizations, agencies, and groups:

(1) UCSF.

(2) UC college named in Section 92200.

(3) The UC/CSU California Collaborative for Learning and Neurodiversity.

(4) The Behavioral Health Services Oversight and Accountability Commission.

(5) A Member of the Assembly selected by the Speaker of the Assembly.

(6) A Senator selected by the President pro Tempore of the Senate.

(7) Community representatives, including formerly justice-involved persons and their family members, selected by the Governor, the Speaker of the Assembly, and the President pro Tempore of the Senate.

(d) (1) The advisory board shall meet twice per year, with the potential for additional working group meetings.

(2) At each meeting, the advisory board shall participate in a review of reports, including updates on research, practice, and policy efforts, as well as fiscal reporting.

(e) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 5. Section 131315 of the Health and Safety Code is amended to read:

131315. If the Office of Suicide Prevention is established pursuant to Section 131300, all of the following shall apply:

(a) The Office of Suicide Prevention shall consult 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" and described pursuant to Provision 1 of Item 4560-001-3085 of Section 2.00 of the Budget Act of 2020.

(b) This section does not authorize the Office of Suicide Prevention to perform any of the duties required by the commission under Part 3.7 (commencing with Section 5845) of Division 5 of, or administer any program funded by Part 4.5 (commencing with Section 5890) of Division 5 of, the Welfare and Institutions Code.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 6. Section 131315 is added to the Health and Safety Code, to read:

131315. (a) If the Office of Suicide Prevention is established pursuant to Section 131300, both of the following shall apply:

(1) The Office of Suicide Prevention shall consult with the Behavioral Health Services Oversight and Accountability Commission to implement suicide prevention efforts consistent with the Suicide Prevention Report "Striving for Zero," as described pursuant to Provision 1 of Item 4560-001-3085 of Section 2.00 of the Budget Act of 2020.

(2) This section does not authorize the Office of Suicide Prevention to perform any of the duties required by the commission under Part 3.7 (commencing with Section 5845) of Division 5 of, or administer a program funded by Part 4.5 (commencing with Section 5890) of Division 5 of, the Welfare and Institutions Code.

(b) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 7. Section 19602.5 of the Revenue and Taxation Code is amended to read:

19602.5. (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Beginning with fiscal year 2004–05 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004–05, the applicable percentage shall be 0.70 percent.

(3) Beginning with fiscal year 2006–07, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the act establishing this section.

(c) No later than March 1, 2006, and each March 1 thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1 percent imposed under Section 17043, as reflected on the original returns filed by October 15 of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1 of the year that is two years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

Tax Year	Estimated Tax Liability Increase from the Additional Tax
2005	$634 million
2006	$672 million
2007	$713 million
2008	$758 million

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of 7 percent to the "estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

Applicable Fiscal Year	Estimated Revenue from Additional Tax
2004–05	$254 million
2005–06	$683 million
2006–07	$690 million
2007–08	$733 million

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007–08 and each applicable fiscal year thereafter shall be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than 10 business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

(g) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 8. Section 19602.5 is added to the Revenue and Taxation Code, to read:

19602.5. (a) There is in the State Treasury the Behavioral Health Services (BHS) Fund. The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the BHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Each fiscal year, the Controller shall deposit on a monthly basis in the BHS Fund an amount equal to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) The applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(3) Monthly deposits to the BHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the act establishing this section.

(c) No later than March 1, 2006, and each March 1 thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for a fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1 percent imposed under Section 17043 as reflected on the original returns filed by October 15 of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1 of the year that is two years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) The "estimated tax liability increase from the additional tax" for each tax year shall be determined by applying an annual growth rate of 7 percent to the "estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for each applicable fiscal year shall be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(ii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than 10 business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the BHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the BHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

(g) To the extent that there are moneys remaining in the Mental Health Services Fund on the date this section becomes operative, those moneys shall be transferred to the Behavioral Health Services Fund. Amounts owed or encumbered at the time of transfer shall be used in the manner required by the MHSA. Any funds not owed or encumbered by the MHSA may be used in the same manner as any other moneys in the BHS Fund.

(h) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 9. Section 1095.5 of the Unemployment Insurance Code is amended to read:

1095.5. (a) (1) The director shall permit the use of any information in their possession to the extent necessary to enable the Mental Health Services Oversight and Accountability Commission to receive quarterly wage data of mental health consumers served by the California public mental health system for the purpose of monitoring and evaluating employment outcomes to determine the effectiveness of those services.

(2) The director may require reimbursement for all direct costs incurred in providing any information specified in this section.

(3) The information shall be provided to the extent permitted under applicable federal statute and regulation.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 10. Section 1095.5 is added to the Unemployment Insurance Code, to read:

1095.5. (a) (1) The director shall permit the use of any information in their possession to the extent necessary to enable the Behavioral Health Services Oversight and Accountability Commission to receive quarterly wage data of individuals with a mental health disorder or a substance use disorder, or both, served by the California public mental health and substance use disorder system for the purpose of monitoring and evaluating employment outcomes to determine the effectiveness of those services.

(2) The director may require reimbursement for all direct costs incurred in providing any information specified in this section.

(3) The information shall be provided to the extent permitted under applicable federal statute and regulation.

(b) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 11. Section 4090 of the Welfare and Institutions Code is amended to read:

4090. (a) The State Department of Health Care Services shall establish, by regulation, standards for the programs listed in Chapter 2.5 (commencing with Section 5670) of Part 2 of Division 5. These standards shall also be applied by the department to any facility licensed as a social rehabilitation facility pursuant to paragraph (7) of subdivision (a) of Section 1502 of the Health and Safety Code.

(b) In establishing the standards required by this section, the department shall not establish standards that in themselves impose any new or increased costs on the programs or facilities affected by the standards.

(c) (1) Notwithstanding subdivision (a), pursuant to Section 5963.05, the State Department of Health Care Services may develop and revise documentation standards for social rehabilitation facilities and community residential treatment programs to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(2) The department shall require social rehabilitation facilities and community residential treatment programs to implement these documentation standards and shall monitor compliance with these standards as part of program reviews.

SEC. 12. Section 4094 of the Welfare and Institutions Code is amended to read:

4094. (a) The State Department of Mental Health shall establish, by regulations adopted at the earliest possible date, but no later than December 31, 1994, program standards for any facility licensed as a community treatment facility. This section shall apply only to community treatment facilities described in this subdivision.

(b) Commencing July 1, 2012, the State Department of Health Care Services may adopt or amend regulations pertaining to the program standards for any facility licensed as a community treatment facility.

(c) A certification of compliance issued by the State Department of Health Care Services shall be a condition of licensure for the community treatment facility by the State Department of Social Services. The department may, upon the request of a county, delegate the certification and supervision of a community treatment facility to the county department of mental health.

(d) The State Department of Health Care Services shall adopt regulations to include, but not be limited to, the following:

(1) Procedures by which the Director of Health Care Services shall certify that a facility requesting licensure as a community treatment facility pursuant to Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code is in compliance with program standards established pursuant to this section.

(2) Procedures by which the Director of Health Care Services shall deny a certification to a facility or decertify a facility that is licensed as a community treatment facility pursuant to Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code, but no longer complying with program standards established pursuant to this section, in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(3) Provisions for site visits by the State Department of Health Care Services for the purpose of reviewing a facility's compliance with program standards established pursuant to this section.

(4) Provisions for the community care licensing staff of the State Department of Social Services to report to the State Department of Health Care Services when there is reasonable cause to believe that a community treatment facility is not in compliance with program standards established pursuant to this section.

(5) Provisions for the State Department of Health Care Services to provide consultation and documentation to the State Department of Social Services in any administrative proceeding regarding denial, suspension, or revocation of a community treatment facility license.

(e) The standards adopted by regulations pursuant to subdivisions (a) and (b) shall include, but not be limited to, standards for treatment, staffing, and for the use of psychotropic medication, discipline, and restraints in the facilities. The standards shall also meet the requirements of Section 4094.5.

(f) (1) A community treatment facility shall not be required by the State Department of Health Care Services to have 24-hour onsite licensed nursing staff, but shall retain at least one full-time, or full-time-equivalent, registered nurse onsite if all of the following are applicable:

(A) The facility does not use mechanical restraint.

(B) The facility only admits children who have been assessed, at the point of admission, by a licensed primary care provider and a licensed psychiatrist, who have concluded, with respect to each child, that the child does not require medical services that require 24-hour nursing coverage. For purposes of this section, a "primary care provider" includes a person defined in Section 14254, or a nurse practitioner who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of care, and for initiating referral for specialist care.

(C) Other medical or nursing staff shall be available on call to provide appropriate services, when necessary, within one hour. In order for a placement in a community treatment facility to be funded with federal Aid to Families with Dependent Children-Foster Care on behalf of an eligible child, the facility shall maintain registered or licensed nursing staff and other licensed clinical staff who are onsite, according to the facility's treatment model, and who are available 24 hours a day and 7 days a week. If consistent with the facility's treatment model, a community treatment facility may access the same nursing resources as those made available to a short-term residential therapeutic program pursuant to Section 4096.55.

(D) All direct care staff shall be trained in first aid and cardiopulmonary resuscitation, and in emergency intervention techniques and methods approved by the Community Care Licensing Division of the State Department of Social Services.

(2) The State Department of Health Care Services may adopt emergency regulations as necessary to implement this subdivision. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. The regulations shall be exempt from review by the Office of Administrative Law and shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 180 days unless the adopting agency complies with all the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, as required by subdivision (e) of Section 11346.1 of the Government Code.

(g) During the initial public comment period for the adoption of the regulations required by this section, the community care facility licensing regulations proposed by the State Department of Social Services and the program standards proposed by the State Department of Health Care Services shall be presented simultaneously.

(h) A minor shall be admitted to a community treatment facility only if the requirements of Section 4094.5 of this code, Section 1530.9 of the Health and Safety Code, and either of the following conditions are met:

(1) The minor is within the jurisdiction of the juvenile court, and has made voluntary application for mental health services pursuant to Section 6552.

(2) Informed consent is given by a parent, guardian, conservator, or other person having custody of the minor.

(i) Any minor admitted to a community treatment facility shall have the same due process rights afforded to a minor who may be admitted to a state hospital, pursuant to the holding in In re Roger S. (1977) 19 Cal.3d 921. Minors who are wards or dependents of the court and to whom this subdivision applies shall be afforded due process in accordance with Section 6552 and related case law, including In re Michael E. (1975) 15 Cal.3d 183. Regulations adopted pursuant to Section 4094 shall specify the procedures for ensuring these rights, including provisions for notification of rights and the time and place of hearings.

(j) (1) Notwithstanding subdivisions (a) and (b), pursuant to Section 5963.05, the State Department of Health Care Services may develop and revise documentation standards for community treatment facilities to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(2) The department or the department's delegate shall require community treatment facilities to implement these documentation standards and shall monitor compliance with these standards as part of the program reviews required for certification pursuant to subdivision (c).

SEC. 13. Section 4096.5 of the Welfare and Institutions Code is amended to read:

4096.5. (a) This section governs standards for the mental health program approval for short-term residential therapeutic programs, which is required under subdivision (c) of Section 1562.01 of the Health and Safety Code.

(b) All short-term residential therapeutic programs that serve children who have either been assessed as meeting the medical necessity criteria for Medi-Cal specialty mental health services, as provided for in Section 1830.205 or 1830.210 of Title 9 of the California Code of Regulations, or who have been assessed as seriously emotionally disturbed, as defined in subdivision (a) of Section 5600.3, shall obtain and have in good standing a mental health program approval and a Medi-Cal mental health certification, as described in Section 11462.01, issued by the State Department of Health Care Services or a county mental health plan to which the department has

delegated approval authority. This approval, which is required pursuant to subdivision (c) of Section 1562.01 of the Health and Safety Code, is a condition for receiving an Aid to Families with Dependent Children-Foster Care rate pursuant to Section 11462.01.

(c) (1) A short-term residential therapeutic program shall not directly provide specialty mental health services without a current mental health program approval. A licensed short-term residential therapeutic program that has not obtained a program approval shall provide children in its care access to appropriate mental health services.

(2) County mental health plans shall ensure that Medi-Cal specialty mental health services, including, but not limited to, services under the Early and Periodic Screening, Diagnosis and Treatment benefit, are provided to all Medi-Cal beneficiaries served by short-term residential therapeutic programs who meet medical necessity criteria, as provided for in Section 1830.205 or 1830.210 of Title 9 of the California Code of Regulations.

(d) (1) The State Department of Health Care Services or a county mental health plan to which the department has delegated mental health program approval authority shall approve or deny mental health program approval requests within 45 days of receiving a request. The State Department of Health Care Services or a county mental health plan to which the department has delegated mental health program approval authority shall issue each mental health program approval for a period of one year, except for approvals granted pursuant to paragraph (2) and provisional approvals granted pursuant to regulations promulgated under subdivision (e), and shall specify the effective date of the approval. Approved entities shall meet all program standards to be reapproved.

(2) (A) Between January 1, 2017, and December 31, 2017, the State Department of Health Care Services, or a county mental health plan to which the department has delegated mental health program approval authority, shall approve or deny a mental health program approval request within 90 days of receipt.

(B) Between January 1, 2017, and December 31, 2017, the State Department of Health Care Services, or a county mental health plan to which the department has delegated mental health program approval authority, may issue a mental health program approval for a period of less than one year.

(e) (1) The State Department of Health Care Services and the county mental health plans to which the department has delegated mental health program approval authority may enforce the mental health program approval standards by taking any of the following actions against a noncompliant short-term residential therapeutic program:

(A) Suspend or revoke a mental health program approval.

(B) Impose monetary penalties.

(C) Place a mental health program on probation.

(D) Require a mental health program to prepare and comply with a corrective action plan.

(2) The State Department of Health Care Services and the county mental health plans to which the department has delegated mental health program approval authority shall provide short-term residential therapeutic programs with due process protections when taking any of the actions described in paragraph (1).

(f) The State Department of Health Care Services, in consultation with the State Department of Social Services, shall promulgate regulations regarding program standards, oversight, enforcement, issuance of mental health program approvals, including provisional approvals that are effective for a period of less than one year, and due process protections related to the mental health program approval process for short-term residential therapeutic programs.

(g) (1) Except for mental health program approval of short-term residential therapeutic programs operated by a county, the State Department of Health Care Services may, upon the request of a county, delegate to that county mental health plan the mental health program approval of short-term residential therapeutic programs within its borders.

(2) Any county to which mental health program approval is delegated pursuant to paragraph (1) shall be responsible for the oversight and enforcement of program standards and the provision of due process for approved and denied entities.

(h) The State Department of Health Care Services or a county mental health plan to which the department has delegated mental health program approval authority shall notify the State Department of Social Services immediately upon the termination of any mental health program approval issued in accordance with subdivisions (b) and (d).

(i) The State Department of Social Services shall notify the State Department of Health Care Services and, if applicable, a county to which the department has delegated mental health program approval authority, immediately upon the revocation of any license issued pursuant to Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code.

(j) Revocation of a license or a mental health program approval or failure to meet the requirements of subdivision (c) of Section 1562.01 of the Health and Safety Code shall be a basis for rate termination.

(k) (1) Notwithstanding subdivision (f), pursuant to Section 5963.05, the State Department of Health Care Services may develop and revise documentation standards to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(2) The department shall require short-term residential therapeutic programs to implement the documentation standards developed pursuant to paragraph (1) and shall monitor compliance with these standards as part of program reviews.

SEC. 14. Section 5604 of the Welfare and Institutions Code is amended to read:

5604. (a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of fewer than 80,000 may have a minimum of five members. A county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. This section does not limit the ability of the governing body to increase the number of members above 15.

(2) (A) The board shall serve in an advisory role to the governing body, and one member of the board shall be a member of the local governing body. Local mental health boards may recommend appointees to the county supervisors. The board membership should reflect the diversity of the client population in the county to the extent possible.

(B) Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(C) (i) In counties with a population of 100,000 or more, at least one member of the board shall be a veteran or veteran advocate. In counties with a population of fewer than 100,000, the county shall give a strong preference to appointing at least one member of the board who is a veteran or a veteran advocate.

(ii) To comply with clause (i), a county shall notify its county veterans service officer about vacancies on the board, if a county has a veterans service officer.

(D) In addition to the requirements in subparagraphs (B) and (C), counties are encouraged to appoint individuals who have experience with, and knowledge of, the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

(3) (A) In counties with a population that is fewer than 80,000, at least one member shall be a consumer and at least one member shall be a parent, spouse, sibling, or adult child of a consumer who is receiving, or has received, mental health services.

(B) Notwithstanding subparagraph (A), a board in a county with a population that is fewer than 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

(b) The mental health board shall review and evaluate the local public mental health system, pursuant to Section 5604.2, and advise the governing body on community mental health services delivered by the local mental health agency or local behavioral health agency, as applicable.

(c) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

(d) If two or more local agencies jointly establish a community mental health service pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.

(e) (1) Except as provided in paragraph (2), a member of the board or the member's spouse shall not be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(2) A consumer of mental health services who has obtained employment with an employer described in paragraph (1) and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the board. The member shall abstain from voting on any financial or contractual issue concerning the member's employer that may come before the board.

(f) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(g) If it is not possible to secure membership as specified in this section from among persons who reside in the county, the governing body may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the county mental health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

(h) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

(i) For purposes of this section, "veteran advocate" means either a parent, spouse, or adult child of a veteran, or an individual who is part of a veterans organization, including the Veterans of Foreign Wars or the American Legion.

(j) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2026, is repealed.

SEC. 15. Section 5604 is added to the Welfare and Institutions Code, to read:

5604. (a) (1) (A) Each community mental health service shall have a behavioral health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that a board in a county with a population of fewer than 80,000 may have a minimum of 5 members.

(B) A county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors.

(C) This section does not limit the ability of the governing body to increase the number of members above 15.

(2) (A) (i) The board shall serve in an advisory role to the governing body, and one member of the board shall be a member of the local governing body.

(ii) Local behavioral health boards may recommend appointees to the county supervisors.

(iii) The board membership shall reflect the diversity of the client population in the county to the extent possible.

(B) (i) Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received behavioral health services. At least one of these members shall be an individual who is 25 years of age or younger.

(ii) At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(C) (i) In a county with a population of 100,000 or more, at least one member of the board shall be a veteran or veteran advocate. In a county with a population of fewer than 100,000, the county shall give a strong preference to appointing at least one member of the board who is a veteran or a veteran advocate.

(ii) To comply with clause (i), a county shall notify its county veterans service officer about vacancies on the board, if the county has a veterans service officer.

(D) (i) At least one member of the board shall be an employee of a local education agency.

(ii) To comply with clause (i), a county shall notify its county office of education about vacancies on the board.

(E) (i) In addition to the requirements in subparagraphs (B), (C), and (D), counties are encouraged to appoint individuals who have experience with, and knowledge of, the behavioral health system.

(ii) This would include members of the community who engage with individuals living with mental illness or substance use disorder in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

(3) (A) In counties with a population that is fewer than 80,000, at least one member shall be a consumer and at least one member shall be a parent, spouse, sibling, or adult child of a consumer who is receiving, or has received, mental health or substance use disorder treatment services.

(B) Notwithstanding subparagraph (A), a board in a county with a population that is fewer than 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

(b) (1) The behavioral health board shall review and evaluate the local public mental health system, pursuant to Section 5604.2, and review and evaluate the local public substance use disorder treatment system.

(2) The behavioral health board shall advise the governing body on community mental health and substance use disorder services delivered by the local mental health agency or local behavioral health agency, as applicable.

(c) (1) The term of each member of the board shall be for three years.

(2) The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

(d) If two or more local agencies jointly establish a community mental health service pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the behavioral health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health or substance use disorder treatment services.

(e) (1) Except as provided in paragraph (2), a member of the board or the member's spouse shall not be a full-time or part-time county employee of a county mental health and substance use disorder service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health or substance use disorder contract agency.

(2) (A) A consumer of behavioral health services who has obtained employment with an employer described in paragraph (1) and who holds a position in which the consumer does not have an interest, influence, or authority over a financial or contractual matter concerning the employer may be appointed to the board.

(B) The member shall abstain from voting on a financial or contractual issue concerning the member's employer that may come before the board.

(f) Members of the board shall abstain from voting on an issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(g) If it is not possible to secure membership as specified in this section from among persons who reside in the county, the governing body may substitute representatives of the public interest in behavioral health who are not full-time or part-time employees of the county behavioral health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a behavioral health contract agency.

(h) The behavioral health board may be established as an advisory board or a commission, depending on the preference of the county.

(i) For purposes of this section, "veteran advocate" means either a parent, spouse, or adult child of a veteran, or an individual who is part of a veterans organization, including the Veterans of Foreign Wars or the American Legion.

(j) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 16. Section 5604.1 of the Welfare and Institutions Code is amended to read:

5604.1. (a) Local mental health advisory boards shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2026, is repealed.

SEC. 17. Section 5604.1 is added to the Welfare and Institutions Code, to read:

5604.1. (a) Local behavioral health boards are subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.

(b) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary.

SEC. 18. Section 5604.2 of the Welfare and Institutions Code is amended to read:

5604.2. (a) The local mental health board shall do all of the following:

(1) Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.

(2) Review any county agreements entered into pursuant to Section 5650. The local mental health board may make recommendations to the governing body regarding concerns identified within these agreements.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program. Local mental health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

(8) This part does not limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2026, is repealed.

SEC. 19. Section 5604.2 is added to the Welfare and Institutions Code, to read:

5604.2. (a) The local behavioral health board shall do all of the following:

(1) Review and evaluate the community's public behavioral health needs, services, facilities, and special problems in a facility within the county or jurisdiction where mental health or substance use disorder evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.

(2) (A) Review county agreements entered into pursuant to Section 5650.

(B) The local behavioral health board may make recommendations to the governing body regarding concerns identified within these agreements.

(3) (A) Advise the governing body and the local behavioral health director as to any aspect of the local behavioral health systems.

(B) Local behavioral health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health or substance use disorder evaluations or services provided in public facilities with limited access.

(4) (A) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(B) Involvement shall include individuals with lived experience of mental illness, substance use disorder, or both, and their families, community members, advocacy organizations, and behavioral health professionals. It shall also include other professionals who interact with individuals living with mental illnesses or substance use disorders on a daily basis, such as education, emergency services, employment, health care, housing, public safety, local business owners, social services, older adults, transportation, and veterans.

(5) Submit an annual report to the governing body on the needs and performance of the county's behavioral health system.

(6) (A) Review and make recommendations on applicants for the appointment of a local director of behavioral health services.

(B) The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

(8) This part does not limit the ability of the governing body to transfer additional duties or authority to a behavioral health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county on services delivered to clients and on the local community.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 20. Section 5604.3 of the Welfare and Institutions Code is amended to read:

5604.3. (a) The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses may include travel, lodging, childcare, and meals for the members of an advisory board while on official business as approved by the director of the local mental health program.

(b) Governing bodies are encouraged to provide a budget for the local mental health board, using planning and administrative revenues identified in subdivision (c) of Section 5892, that is sufficient to facilitate the purpose, duties, and responsibilities of the local mental health board.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2026, is repealed.

SEC. 21. Section 5604.3 is added to the Welfare and Institutions Code, to read:

5604.3. (a) (1) The board of supervisors may pay from available funds the actual and necessary expenses of the members of the behavioral health board of a community mental health service incurred incident to the performance of their official duties and functions.

(2) The expenses may include travel, lodging, childcare, and meals for the members of the board while on official business as approved by the director of the local behavioral health program.

(b) Governing bodies are encouraged to provide a budget for the local behavioral health board using planning and administrative revenues identified in paragraph (1) of subdivision (e) of Section 5892, that is sufficient to facilitate the purpose, duties, and responsibilities of the local behavioral health board.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 22. Section 5604.5 of the Welfare and Institutions Code is amended to read:

5604.5. The local mental health board shall develop bylaws to be approved by the governing body which shall do all of the following:

(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.

(b) Ensure that the composition of the mental health board represents and reflects the diversity and demographics of the county as a whole, to the extent feasible.

(c) Establish that a quorum be one person more than one-half of the appointed members.

(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.

(e) Establish that there may be an executive committee of the mental health board.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2026, is repealed.

SEC. 23. Section 5604.5 is added to the Welfare and Institutions Code, to read:

5604.5. The local behavioral health board shall develop bylaws to be approved by the governing body that shall do all of the following:

(a) Establish the specific number of members on the behavioral health board, consistent with subdivision (a) of Section 5604.

(b) Ensure that the composition of the behavioral health board represents and reflects the diversity and demographics of the county as a whole, to the extent feasible.

(c) Establish that a quorum be one person more than one-half of the appointed members.

(d) Establish that the chairperson of the behavioral health board be in consultation with the local behavioral health director.

(e) Establish that there may be an executive committee of the behavioral health board.

(f) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 24. Section 5610 of the Welfare and Institutions Code is amended to read:

5610. (a) Each county mental health system shall comply with reporting requirements developed by the State Department of Health Care Services, in consultation with the California Behavioral Health Planning Council and the Mental Health Services Oversight and Accountability Commission, which shall be uniform and simplified. The department shall review existing data requirements to eliminate unnecessary requirements and consolidate requirements that are necessary. These requirements shall provide comparability between counties in reports.

(b) The department shall develop, in consultation with the Performance Outcome Committee, the California Behavioral Health Planning Council, and the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5611, and with the California Health and Human Services Agency, uniform definitions and formats for a statewide, nonduplicative client-based information system that includes all information necessary to meet federal mental health grant requirements and state and federal Medicaid reporting requirements, and any other state requirements established by law. The data system, including performance outcome measures reported pursuant to Section 5613, shall be developed by July 1, 1992.

(c) Unless determined necessary by the department to comply with federal law and regulations, the data system developed pursuant to subdivision (b) shall not be more costly than that in place during the 1990–91 fiscal year.

(d) (1) The department shall develop unique client identifiers that permit development of client-specific cost and outcome measures and related research and analysis.

(2) The department's collection and use of client information, and the development and use of client identifiers, shall be consistent with clients' constitutional and statutory rights to privacy and confidentiality.

(3) Data reported to the department may include name and other personal identifiers. That information is confidential and subject to Section 5328 and any other state and federal laws regarding confidential client information.

(4) Personal client identifiers reported to the department shall be protected to ensure confidentiality during transmission and storage through encryption and other appropriate means.

(5) Information reported to the department may be shared with local public mental health agencies submitting records for the same person and that information is subject to Section 5328.

(e) All client information reported to the department pursuant to Chapter 2 (commencing with Section 4030) of Part 1 of Division 4, Sections 5328 to 5772.5, inclusive, Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9, and any other state and federal laws regarding reporting requirements, consistent with Section 5328, shall not be used for purposes other than those purposes expressly stated in the reporting requirements referred to in this subdivision.

(f) The department may adopt emergency regulations to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations to implement this section that are filed with the Office of Administrative Law within one year of the date on which the act that added this subdivision took effect shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare and shall remain in effect for no more than 180 days.

(g) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 25. Section 5610 is added to the Welfare and Institutions Code, to read:

5610. (a) (1) Each county behavioral health system shall comply with reporting requirements developed by the State Department of Health Care Services, in consultation with the California Behavioral Health Planning Council and the Behavioral Health Services

Oversight and Accountability Commission, which shall be uniform and simplified.

(2) The department shall review existing data requirements to eliminate unnecessary requirements and consolidate requirements that are necessary.

(3) These requirements shall provide comparability between counties in reports.

(b) (1) The department and the California Health and Human Services Agency shall develop, in consultation with the Performance Outcome Committee, the California Behavioral Health Planning Council, and the Behavioral Health Services Oversight and Accountability Commission, pursuant to Section 5611, uniform definitions and formats for a statewide, nonduplicative, client-based information system that includes all information necessary to meet federal mental health grant requirements, state and federal Medicaid reporting requirements, and other state requirements established by law.

(2) The data system, including performance outcome measures reported pursuant to Section 5613, shall be developed by July 1, 1992.

(c) Unless determined necessary by the department to comply with federal law and regulations, the data system developed pursuant to subdivision (b) shall not be more costly than that in place during the 1990–91 fiscal year.

(d) (1) The department shall develop unique client identifiers that permit development of client-specific cost and outcome measures and related research and analysis.

(2) The department's collection and use of client information, and the development and use of client identifiers, shall be consistent with clients' constitutional and statutory rights to privacy and confidentiality.

(3) (A) Data reported to the department may include name and other personal identifiers.

(B) That information is confidential and subject to Section 5328 and any other state and federal law regarding confidential client information.

(4) Personal client identifiers reported to the department shall be protected to ensure confidentiality during transmission and storage through encryption and other appropriate means.

(5) (A) Information reported to the department may be shared with local public behavioral health agencies submitting records for the same person.

(B) The information described in this paragraph is subject to Section 5328.

(e) All client information reported to the department pursuant to Chapter 2 (commencing with Section 4030) of Part 1 of Division 4 and Sections 5328 to 5772.5, inclusive, Chapter 8.9 (commencing with Section 14700), and any other state and federal law regarding reporting requirements, consistent with Section 5328, shall not be used for purposes other than those purposes expressly stated in the reporting requirements referred to in this subdivision.

(f) The department may adopt emergency regulations to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations to implement this section that are filed with the Office of Administrative Law within one year of the date on which the act that added this subdivision took effect shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare and shall remain in effect for no more than 180 days.

(g) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 26. Section 5613 of the Welfare and Institutions Code is amended to read:

5613. (a) Counties shall annually report data on performance measures established pursuant to Section 5612 to the local mental health advisory board and to the Director of Health Care Services.

(b) The Director of Health Care Services shall annually make data on county performance available to the Legislature, and post that data on the department's Internet Web site, by no later than March 15 of each year.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2027, is repealed.

SEC. 27. Section 5613 is added to the Welfare and Institutions Code, to read:

5613. (a) Counties shall annually report data on performance measures established pursuant to Section 5612 to the local behavioral health board and to the Director of Health Care Services.

(b) The Director of Health Care Services shall annually make data on county performance available to the Legislature and post that data on the department's internet website by no later than March 15 of each year.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 28. Section 5614 of the Welfare and Institutions Code is amended to read:

5614. (a) The department, in consultation with the Compliance Advisory Committee that shall have representatives from relevant stakeholders, including, but not limited to, local behavioral health departments, local behavioral health boards and commissions, private and community-based providers, consumers and family members of consumers, local educational agency representatives including, but not limited to, educators and school staff, and advocates, shall establish a protocol for ensuring that local behavioral health departments meet statutory and regulatory requirements for the provision of publicly funded community mental health services provided under this part.

(b) The protocol shall include a procedure for review and assurance of compliance for all of the following elements, and any other element required in law or regulation:

(1) Financial maintenance of effort requirements provided for under Section 17608.05.

(2) Each local behavioral health board has approved procedures that ensure citizen and professional involvement in the local mental health and substance use disorder planning process.

(3) Children's services are funded pursuant to the requirements of Sections 5704.5 and 5704.6.

(4) The local behavioral health department complies with reporting requirements developed by the department.

(5) To the extent resources are available, the local behavioral health department maintains the program principles and the array of treatment options required under Sections 5600.2 to 5600.9, inclusive.

(6) The local behavioral health department meets the reporting required by the performance outcome systems for adults and children.

(c) (1) The protocol developed pursuant to subdivision (a) shall focus on law and regulations and shall include, but not be limited to, the items specified in subdivision (b).

(2) The protocol shall include data collection procedures so that state review and reporting may occur.

(3) The protocol shall also include a procedure for the provision of technical assistance and formal decision rules and procedures for enforcement consequences when the requirements of law and regulations are not met.

(4) These standards and decision rules shall be established through the consensual stakeholder process established by the department.

(d) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of January 1, 2027, is repealed.

SEC. 29. Section 5614 is added to the Welfare and Institutions Code, to read:

5614. (a) The department, in consultation with the Compliance Advisory Committee that shall have representatives from relevant stakeholders, including, but not limited to, local behavioral health departments, local behavioral health boards and commissions, private and community-based providers, consumers and family members of consumers, local education agency representatives including, but not limited to, educators and school staff, and advocates, shall establish a protocol for ensuring that local behavioral health departments meet statutory and regulatory requirements for the provision of publicly funded community mental health services provided under this part.

(b) The protocol shall include a procedure for review and assurance of compliance for all of the following elements, and any other element required in law or regulation:

(1) Financial maintenance of effort requirements provided for under Section 17608.05.

(2) Each local behavioral health board has approved procedures that ensure citizen and professional involvement in the local mental health and substance use disorder planning process.

(3) Children's services are funded pursuant to the requirements of Sections 5704.5 and 5704.6.

(4) The local behavioral health department complies with reporting requirements developed by the department.

(5) To the extent resources are available, the local behavioral health department maintains the program principles and the array of treatment options required under Sections 5600.2 to 5600.9, inclusive.

(6) The local behavioral health department meets the reporting required by the performance outcome systems for adults and children.

(c) (1) The protocol developed pursuant to subdivision (a) shall focus on law and regulations and shall include, but not be limited to, the items specified in subdivision (b).

(2) The protocol shall include data collection procedures so that state review and reporting may occur.

(3) The protocol shall also include a procedure for the provision of technical assistance, and formal decision rules and procedures for enforcement consequences when the requirements of law and regulations are not met.

(4) These standards and decision rules shall be established through the consensual stakeholder process established by the department.

(d) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 30. Section 5664 of the Welfare and Institutions Code is amended to read:

5664. (a) In consultation with the County Behavioral Health Directors Association of California, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Behavioral Health Planning Council, and the California Health and Human Services Agency, county behavioral health systems shall provide reports and data to meet the information needs of the state, as necessary.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 31. Section 5664 is added to the Welfare and Institutions Code, to read:

5664. (a) In consultation with the County Behavioral Health Directors Association of California, the State Department of Health Care Services, the Behavioral Health Services Oversight and Accountability Commission, the California Behavioral Health Planning Council, and the California Health and Human Services Agency, county behavioral health systems shall provide reports and data to meet the information needs of the state, as necessary.

(b) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 32. Section 5675 of the Welfare and Institutions Code is amended to read:

5675. (a) (1) Mental health rehabilitation centers shall only be licensed by the State Department of Health Care Services subsequent to application by counties, county contract providers, or other organizations.

(2) In the application for a mental health rehabilitation center, program evaluation measures shall include, but not be limited to, all of the following:

(A) That the clients placed in the facilities show improved global assessment scores as measured by preadmission and postadmission tests.

(B) That the clients placed in the facilities demonstrate improved functional behavior as measured by preadmission and postadmission tests.

(C) That the clients placed in the facilities have reduced medication levels as determined by comparison of preadmission and postadmission records.

(b) The State Department of Health Care Services shall conduct annual licensing inspections of mental health rehabilitation centers.

(c) (1) All regulations relating to the licensing of mental health rehabilitation centers, heretofore adopted by the State Department of Mental Health, or its successor, shall remain in effect and shall be fully enforceable by the State Department of Health Care Services with respect to any facility or program required to be licensed as a mental health rehabilitation center, unless and until readopted, amended, or repealed by the Director of Health Care Services.

(2) The State Department of Health Care Services shall succeed to and be vested with all duties, powers, purposes, functions, responsibilities, and jurisdiction of the State Department of Mental Health, and its successor, if any, as they relate to licensing mental health rehabilitation centers.

(d) (1) Notwithstanding subdivision (c), pursuant to Section 5963.05, the State Department of Health Care Services may develop and revise documentation standards for individual service plans to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(2) The department shall require mental health rehabilitation centers to implement these documentation standards and shall conduct annual licensing inspections and investigations to determine compliance with these standards.

SEC. 33. Section 5771.1 of the Welfare and Institutions Code is amended to read:

5771.1. (a) The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Behavioral Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. This membership does not affect the composition requirements for the council specified in Section 5771.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 34. Section 5771.1 is added to the Welfare and Institutions Code, to read:

5771.1. (a) The members of the Behavioral Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Behavioral Health Planning Council.

(b) These members serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772.

(c) This membership does not affect the composition requirements for the council specified in Section 5771.

(d) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 35. Section 5805 of the Welfare and Institutions Code is amended to read:

5805. (a) The State Department of Health Care Services shall require counties to use available state and matching funds for the client target population as defined in Section 5600.3 to develop a comprehensive array of services as defined in Sections 5600.6 and 5600.7.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 36. Section 5805 is added to the Welfare and Institutions Code, to read:

5805. (a) The State Department of Health Care Services shall require counties to use funds distributed pursuant to subdivision (c) of Section 5891 for eligible adults and older adults, as defined in Section 5892, to develop a comprehensive array of services, as defined in Sections 5600.6 and 5600.7, and substance use disorder treatment services, as defined in Section 5891.5.

(b) A county may include services to address first episode psychosis.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 37. Section 5806 of the Welfare and Institutions Code is amended to read:

5806. The State Department of Health Care Services shall establish service standards that ensure that members of the target population are identified, and services provided to assist them to live independently, work, and reach their potential as productive citizens. The department shall provide annual oversight of grants issued pursuant to this part for compliance with these standards. These standards shall include, but are not limited to, all of the following:

(a) A service planning and delivery process that is target population based and includes the following:

(1) Determination of the numbers of clients to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.

(2) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans also shall contain evaluation strategies that shall consider cultural, linguistic, gender, age, and special needs of minorities in the target populations. Provision shall be made for a workforce with the cultural background and linguistic skills necessary to remove barriers to mental health services due to limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.

(3) Provision for services to meet the needs of target population clients who are physically disabled.

(4) Provision for services to meet the special needs of older adults.

(5) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate for the individual.

(6) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles.

(7) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.

(8) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated due to age.

(9) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

(10) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

(11) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services but are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs.

(12) Provision for services for veterans.

(b) A client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and followthrough of services, and necessary advocacy to ensure that the client receives those services that are agreed to in the personal services plan. A client shall participate in the development of their personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, consult with the family and other significant persons as appropriate.

(c) The individual personal services plan shall ensure that members of the target population involved in the system of care receive age-appropriate, gender-appropriate, and culturally appropriate services or appropriate services based on any characteristic listed or defined in Section 11135 of the Government Code, to the extent feasible, that are designed to enable recipients to:

(1) Live in the most independent, least restrictive housing feasible in the local community, and for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(2) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(3) Create and maintain a support system consisting of friends, family, and participation in community activities.

(4) Access an appropriate level of academic education or vocational training.

(5) Obtain an adequate income.

(6) Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(7) Access necessary physical health care and maintain the best possible physical health.

(8) Reduce or eliminate serious antisocial or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system.

(9) Reduce or eliminate the distress caused by the symptoms of mental illness.

(10) Have freedom from dangerous addictive substances.

(d) The individual personal services plan shall describe the service array that meets the requirements of subdivision (c) and, to the extent applicable to the individual, the requirements of subdivision (a).

(e) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 38. Section 5806 is added to the Welfare and Institutions Code, to read:

5806. (a) The State Department of Health Care Services shall establish service standards so that adults and older adults in the target population are identified and receive needed and appropriate services from qualified staff in the least restrictive environment to assist them to live independently, work, and thrive in their communities. This section shall not apply to services covered by the Medi-Cal program and services covered by a health care service plan or other insurance coverage. These standards shall include, but are not limited to, all of the following:

(1) For services funded pursuant to subdivision (a) of Section 5892, the county may consult with the stakeholders listed in paragraph (1) of subdivision (a) of Section 5963.03.

(2) (A) Outreach to adults with a serious mental illness or a substance use disorder to provide coordination and access to behavioral health services, medications, housing interventions pursuant to Section 5830, supportive services, as defined in subdivision (g) of Section 5887, and veterans' services.

(B) Service planning shall include evaluation strategies that consider cultural, linguistic, gender, age, and special needs of the target populations.

(C) Provision shall be made for a workforce with the cultural background and linguistic skills necessary to remove barriers to mental health services and substance use disorder treatment services due to limited-English-speaking ability and cultural differences.

(D) Recipients of outreach services may include families, the public, primary care physicians, hospitals, including emergency departments, behavioral health urgent care, and others who are likely to come into contact with individuals who may be suffering from either an untreated serious mental illness or substance use disorder, or both, who would likely become homeless or incarcerated if the illness continued to be untreated for a substantial period of time.

(E) Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a serious mental illness.

(3) Provision for services for populations with identified disparities in behavioral health outcomes.

(4) Provision for full participation of the family in all aspects of assessment, service planning, and treatment, including, but not limited to, family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate and when supported by the individual.

(5) Treatment for clients who have been suffering from an untreated serious mental illness or substance use disorder, or both, for less than one year and who do not require the full range of services but are at risk of becoming homeless or incarcerated unless comprehensive individual and family support services are provided consistent with the planning process specified in subdivision (d). This includes services that are available and designed to meet their needs, including housing for clients that is immediate, transitional, permanent, or all of these services.

(6) (A) Provision for services to be client-directed and to employ psychosocial rehabilitation and recovery principles.

(B) Services may be integrated with other services and may include psychiatric and psychological collaboration in overall service planning.

(7) Provision for services specifically directed to young adults 25 years of age or younger with either a serious mental illness or substance use disorder, or both, who are chronically homeless, experiencing homelessness or are at risk of homelessness, as defined in subdivision (j) of Section 5892, or experiencing first episode psychosis. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated due to age.

(8) Provision for services for frequent users of behavioral health urgent care, crisis stabilization units, and hospitals or emergency room services as the primary resource for mental health and substance use disorder treatment.

(9) Provision for services to meet the special needs of clients who are physically disabled, clients who are intellectually or developmentally disabled, veterans, or persons of American Indian or Alaska Native descent.

(10) Provision for services to meet the special needs of women from diverse cultural backgrounds, including supportive housing that accepts children and youth, personal services coordinators, therapeutic treatment, and substance use disorder treatment programs that address gender-specific trauma and abuse in the lives of persons with either a serious mental illness or a substance use disorder, or both, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

(b) Each adult or older adult shall have a clearly designated personal services coordinator, or case manager who may be part of a multidisciplinary treatment team who is responsible for providing case management services. The personal services coordinator may be a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.

(c) A personal services coordinator shall perform all of the following:

(1) Conduct a comprehensive assessment and periodic reassessment of a client's needs. The assessment shall include all of the following:

(A) Taking the client's history.

(B) Identifying the individual's needs, including reviewing available records and gathering information from other sources, including behavioral health service providers, medical providers, family members, social workers, and others needed to form a complete assessment.

(C) Assessing the client's living arrangements, employment status, and training needs.

(2) Plan for services using information collected through the assessment. The planning process shall do all of the following:

(A) Identify the client's goals and the behavioral health, supportive, medical, educational, social, prevocational, vocational, rehabilitative, housing, or other community services needed to assist the client to reach their goals.

(B) Include active participation of the client and others in the development of the client's goals.

(C) Identify a course of action to address the client's needs.

(D) Address the transition of care when a client has achieved their goals.

(3) Assist the client in accessing needed behavioral health, supportive, medical, educational, social, prevocational, vocational, rehabilitative, housing, or other community services.

(4) Coordinate the services the county furnishes to the client between settings of care, including appropriate discharge planning for short-term hospital and institutional stays.

(5) Coordinate the services the county furnishes to the client with the services the client receives from managed care organizations, the Medicaid fee-for-service delivery system, other human services agencies, and community and social support providers.

(6) Ensure that, in the course of coordinating care, the client's privacy is protected in accordance with all federal and state privacy laws.

(d) The county shall ensure that each provider furnishing services to clients maintains and shares, as appropriate, client health records in accordance with professional standards.

(e) The service planning process shall ensure that adults and older adults receive age-appropriate, gender-appropriate, and culturally appropriate services, or appropriate services based on a characteristic listed or defined in Section 11135 of the Government Code, to the extent feasible, that are designed to enable recipients to:

(1) (A) Live in the most independent, least restrictive housing feasible in the local community and for clients with children and youth, to live in a supportive housing environment that strives for reunification with their children and youth or assists clients in maintaining custody of their children and youth, as appropriate.

(B) Assist individuals to rejoin or return to a home that had previously been maintained with a family member or in a shared housing environment that is supportive of their recovery and stabilization.

(2) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(3) Create and maintain a support system consisting of friends, family, and participation in community activities.

(4) Access an appropriate level of academic education or vocational training.

(5) Obtain an adequate income.

(6) Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(7) Access necessary physical health care and maintain the best possible physical health.

(8) Reduce or eliminate serious antisocial or criminal behavior and thereby reduce or eliminate their contact with the justice system.

(9) Reduce or eliminate the distress caused by the symptoms of either serious mental illness or substance use disorder, or both.

(10) Utilize trauma-informed approaches to reduce trauma and avoid retraumatization.

(f) (1) (A) The client's clinical record shall describe the service array that meets the requirements of subdivisions (c) and (e) and, to the extent applicable to the individual, the requirements of subdivisions (a) and (b).

(B) The State Department of Health Care Services may develop and revise documentation standards for service planning to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(2) Documentation of the service planning process in the client's clinical record pursuant to paragraph (1) may fulfill the documentation requirements for both the Medi-Cal program and this section.

(g) For purposes of this section, "behavioral health services" shall have the meaning as defined in subdivision (j) of Section 5892.

(h) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(i) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 39. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, "seniors" means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds, including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state

prison. Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1), and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5, shall refer to those contracts.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 40. Section 5813.5 is added to the Welfare and Institutions Code, to read:

5813.5. (a) Counties shall use funds distributed pursuant to subdivision (c) of Section 5891 for the provision of behavioral health services under Sections 5801, 5802, 5806, and 5891.5 to county behavioral health programs. This part does not obligate the counties to use funds from any other source for services pursuant to this part.

(b) Services shall be available to eligible adults and older adults, as defined in Section 5892.

(c) Funding shall be provided at sufficient levels to ensure counties can provide each adult and older adult served pursuant to this part with the medically necessary mental health and substance use disorder treatment services and medications identified during the service planning process pursuant to Section 5806, which are in the applicable client clinical record.

(1) To maximize federal financial participation in furtherance of subdivision (d) of Section 5890, a county shall submit claims for reimbursement to the State Department of Health Care Services in accordance with applicable Medi-Cal rules and procedures for a behavioral health service or supportive service eligible for reimbursement pursuant to Title XIX or XXI of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq. and 1397aa, et seq.) when such service is paid, in whole or in part, using funds from the Behavioral Health Services Fund established pursuant to Section 5890.

(2) (A) To maximize funding from other sources, a county shall seek reimbursement for a behavioral health service, supportive service, housing intervention, or other related activity provided pursuant to subdivision (a) of Section 5892 that is covered by or can be paid from another available funding source, including other mental health funds, substance use disorder funds, public and private insurance, and other local, state, and federal funds. This paragraph does not require counties to exhaust other funding sources before using behavioral health services fund moneys to pay for a service or related activity.

(B) A county shall make a good faith effort to enter into contracts, single case agreements, or other agreements to obtain reimbursement with health care service plans and disability insurance plans, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code.

(C) A county shall submit requests for prior authorization for services, request letters of agreement for payment as an out-of-network provider, and pursue other means to obtain reimbursement in accordance with state and federal laws.

(3) (A) A county may report to the Department of Managed Health Care or the Department of Insurance, as appropriate, complaints about a health plan's or a health insurer's failure to make a good faith effort to contract or enter into a single case agreement or other agreements to obtain reimbursement with the county.

(B) A county may also report to the Department of Managed Health Care or the Department of Insurance, respectively, a failure by a health plan or insurer to timely reimburse the county for services the plan or insurer must cover as required by state or federal law, including, but not limited to, Sections 1374.72 and 1374.721 of the Health and Safety Code and Sections 10144.5 and 10144.52 of the Insurance Code.

(C) Upon receipt of a complaint from a county, the Department of Managed Health Care or the Department of Insurance, as applicable, shall timely investigate the complaint.

(d) Each county behavioral health program's integrated plan pursuant to Section 5963.02 shall provide for services to eligible adults and older adults, as defined in Section 5892, in accordance with the system of care for adults and older adults.

(e) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for behavioral health consumers:

(1) To promote concepts key to the recovery for individuals who have a mental illness or substance use disorder, or both: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of behavioral health consumers by addressing the inequities in behavioral health service delivery.

(4) To plan for each consumer's individual needs.

(f) The integrated plan for each county pursuant to Section 5963.02 shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) and other funds available for behavioral health services as defined in Section 5892, that eligible adults and older adults, as defined in Section 5892, being served by this program are either receiving services from this

program or have a mental illness or substance use disorder that is not sufficiently severe to require the level of services required of this program.

(g) (1) Each county integrated plan and annual update pursuant to Section 5963.02 shall consider ways to provide mental health services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program.

(2) Funds shall not be used to pay for persons incarcerated in state prison.

(3) Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision or in a community reentry program.

(4) When included in county integrated plans pursuant to Section 5963.02, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1) and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970).

(h) (1) The department shall contract for services with county behavioral health programs pursuant to Section 5897.

(2) After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5, shall refer to those contracts.

(i) For purposes of this section, "behavioral health services" shall have the meaning as defined in subdivision (j) of Section 5892.

(j) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(k) For purposes of this section, "substance use disorder treatment services" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(l) For purposes of this section, "supportive services" shall have the meaning as defined in subdivision (h) of Section 5887.

(m) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 41. Section 5813.6 of the Welfare and Institutions Code is amended to read:

5813.6. (a) (1) By July 1 of each year, the Director of Health Care Services shall submit to the Legislature final budget enactment information regarding the expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure, for local assistance.

(2) This shall include actual past-year expenditures, estimated current-year expenditures, and projected budget-year expenditures of local assistance funding.

(3) It shall also include a complete listing of state support expenditures for the current year and for the budget year by the State Department of Health Care Services, including the number of state positions and any contract funds.

(4) A description of these state expenditures shall accompany the fiscal information the director is required to submit to the Legislature pursuant to this section.

(b) (1) During each fiscal year, the Director of Health Care Services shall submit to the fiscal committees of the Legislature, 30 days in advance, written notice of the intention to expend Proposition 63 local assistance funding in excess of the amounts presented in its May Revision projection for that fiscal year.

(2) The written notice shall include information regarding the amount of the additional spending and its purpose.

SEC. 42. Section 5830 of the Welfare and Institutions Code is amended to read:

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services, including, but not limited to, services provided through permanent supportive housing.

(b) All projects included in the innovative program portion of the county plan shall meet the following requirements:

(1) Address one of the following purposes as its primary purpose:

(A) Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.

(B) Increase the quality of services, including measurable outcomes.

(C) Promote interagency and community collaboration.

(D) Increase access to services, which may include providing access through the provision of permanent supportive housing.

(2) Support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.

(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.

(D) Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.

(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

(1) Administrative, governance, and organizational practices, processes, or procedures.

(2) Advocacy.

(3) Education and training for service providers, including nontraditional mental health practitioners.

(4) Outreach, capacity building, and community development.

(5) System development.

(6) Public education efforts.

(7) Research. If research is chosen for an innovative project, the county mental health program shall consider, but is not required to implement, research of the brain and its physical and biochemical processes that may have broad applications, but that have specific potential for understanding, treating, and managing mental illness, including, but not limited to, research through the Cal-BRAIN program pursuant to Section 92986 of the Education Code or other collaborative, public-private initiatives designed to map the dynamics of neuron activity.

(8) Services and interventions, including prevention, early intervention, and treatment.

(9) Permanent supportive housing development.

(d) If an innovative project has proven to be successful and a county chooses to continue it, the project workplan shall transition to another category of funding as appropriate.

(e) County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 43. Section 5830 is added to the Welfare and Institutions Code, to read:

5830. (a) (1) Each county shall establish and administer a program for housing interventions to serve persons who are chronically homeless or experiencing homelessness or are at risk of homelessness, as defined in Section 5892, and meet one of the following conditions:

(A) Eligible children and youth, as defined in Section 5892.

(B) Eligible adults and older adults, as defined in Section 5892.

(2) Housing interventions shall not be limited to individuals enrolled in full-service partnerships pursuant to subdivision (d) of Section 5887.

(3) Housing interventions shall not be limited to individuals enrolled in Medi-Cal.

(4) Housing interventions shall not discriminate against or deny access to housing for individuals that are utilizing medications for addiction treatment or other authorized medications.

(5) Housing interventions shall comply with the core components of Housing First, as defined in subdivision (b) of Section 8255, and may include recovery housing, as defined by the federal Department of Housing and Urban Development.

(b) (1) County programs for housing interventions may include any of the following:

(A) Rental subsidies.

(B) Operating subsidies.

(C) Shared housing.

(D) Family housing for eligible children and youth who meet the criteria specified in subdivision (a).

(E) The nonfederal share for transitional rent.

(F) Other housing supports, as defined by the State Department of Health Care Services, including, but not limited to, the community supports policy guide.

(G) Capital development projects, including affordable housing, as described in paragraph (2).

(H) Project-based housing assistance, including master leasing of project-based housing.

(I) Funds pursuant to paragraph (1) of subdivision (a) of Section 5892 shall not be used for mental health and substance use disorder treatment services.

(2) (A) County programs for housing interventions may include capital development projects, under the provisions of Section 5831, to either construct or rehabilitate housing units, or both, for the persons meeting the criteria specified in subdivision (a) consistent with the State Department of Health Care Services guidelines for this purpose.

(B) The units funded pursuant to this provision shall be available in a reasonable timeframe, as specified by the State Department of Health Care Services and consistent with the county integrated plan pursuant to Section 5963.02, and shall meet a cost-per-unit threshold as specified by the State Department of Health Care Services.

(C) For purposes of this section and Section 5831, "affordable housing" includes supportive housing. "Supportive housing" has the same meaning as defined in Section 50675.14 of the Health and Safety Code.

(3) County programs for housing interventions shall comply with all requirements specified by the State Department of Health Care Services, pursuant to Section 5963.05, for the purposes of administering paragraphs (1) and (2).

(c) (1) To the extent that necessary federal approvals have been obtained for the Medi-Cal program to cover housing interventions and federal financial participation is available and not otherwise jeopardized, the housing interventions funds distributed pursuant to paragraph (1) of subdivision (a) of Section 5892 may be used for the nonfederal share of Medi-Cal covered housing related services. The housing intervention funds distributed pursuant to paragraph (1) of subdivision (a) of Section 5892 shall only cover the costs that cannot be paid for with Medi-Cal program funds, including costs for Medi-Cal members enrolled in a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, that does not cover those services.

(2) Funds shall not be used for housing interventions covered by a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101.

(d) Notwithstanding any other law, a capital development project funded pursuant to this section shall not constitute a "low rent housing project," as provided for in subdivision (e).

(e) "Low rent housing project," as defined in Section 1 of Article XXXIV of the California Constitution, does not apply to a project that meets any of the following criteria:

(1) The project meets both of the following criteria:

(A) Is privately owned housing, receiving no ad valorem property tax exemption other than exemptions granted pursuant to subdivision (f) or (g) of Section 214 of the Revenue and Taxation Code, not fully reimbursed to all taxing entities.

(B) Not more than 49 percent of the dwellings, apartments, or other living accommodations of the development may be occupied by persons of low income.

(2) The project is privately owned housing, is not exempt from ad valorem taxation by reason of public ownership, and is not financed with direct long-term financing from a public body.

(3) The project is intended for owner-occupancy, which may include a limited-equity housing cooperative, as defined in Section 50076.5 of the Health and Safety Code, cooperative, or condominium ownership rather than for rental-occupancy.

(4) The project consists of newly constructed, privately owned, one- to four-family dwellings not located on adjoining sites.

(5) The project consists of existing dwelling units leased by the state public body from the private owner of these dwelling units.

(6) The project consists of the rehabilitation, reconstruction, improvement, or addition to, or replacement of, dwelling units of a previously existing low-rent housing project or a project previously or currently occupied by lower income households, as defined in Section 50079.5 of the Health and Safety Code.

(7) The project consists of the acquisition, rehabilitation, reconstruction, or improvement, or any combination thereof, of a project that, prior to the date of the transaction to acquire, rehabilitate, reconstruct, or improve, or any combination thereof, was subject to a contract for federal or state public body assistance for the purpose of providing affordable housing for low-income households and maintains, or enters into, a contract for federal or state public body assistance for the purpose of providing affordable housing for low-income households.

(8) The project consists of the acquisition, rehabilitation, reconstruction, alterations work, or new construction, or a combination thereof, of lodging facilities or dwelling units using moneys received from the Behavioral Health Services Fund established pursuant to subdivision (a) of Section 5890.

(f) This section shall be implemented only to the extent that funds are provided from the Behavioral Health Services Fund for purposes of this section. This section does not obligate the counties to use funds from any other source for services pursuant to this section.

(g) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 44. Section 5831 is added to the Welfare and Institutions Code, to read:

5831. (a) (1) Notwithstanding any other law, a capital development project funded, in whole or in part, pursuant to Section 5892 shall be a use by right that shall be subject to the streamlined, ministerial review process, pursuant to subdivision (b), if it meets all of the following criteria:

(A) (i) Affordable housing shall be located in a zone where multifamily residential, office, retail, or parking are a principally permitted use. Nothing here shall be construed to limit other housing interventions pursuant to Section 5830 that conform to existing zoning.

(ii) The intent of capital development funding is to prioritize the production of housing that provides long-term housing stability.

(B) At least 75 percent of the perimeter of the site adjoins parcels that are developed with urban uses.

(C) It satisfies the requirements specified in subparagraphs (B) to (K), inclusive, of paragraph (6) of subdivision (a) of Section 65913.4 of the Government Code.

(D) It is not on a site or adjoined to any site where more than one-third of the square footage on the site is dedicated to industrial use.

(E) The development will meet the following objective zoning standards, objective subdivision standards, and objective design review standards:

(i) For affordable housing, the applicable objective standards shall be those for the zone that allows residential use at a greater density between the following:

(I) The existing zoning designation for the parcel if existing zoning allows for residential use.

(II) The zoning designation for the closest parcel that allows residential use at a density deemed appropriate to accommodate housing for lower income households in that jurisdiction as specified in paragraph (3) of subdivision (c) of Section 65583.2 of the Government Code.

(ii) The applicable objective standards shall be those in effect at the time that the development application is submitted to the local government pursuant to this article.

(iii) A development proposed pursuant to this section shall be eligible for the same density bonus, incentives or concessions, waivers or reductions of development standards, and parking ratios applicable to a project that meets the criteria specified in subparagraph (G) of paragraph (1) of subdivision (b) of Section 65915 of the Government Code.

(F) No housing units were acquired by eminent domain.

(G) The housing units will be in decent, safe, and sanitary condition at the time of their occupancy.

(H) The project meets the labor standards contained in Sections 65912.130 and 65912.131 of the Government Code.

(I) The project provides housing for individuals who meet the criteria specified in subdivision (a) of Section 5830 and their families.

(J) Affordable housing shall require long-term covenants and restrictions require the housing units to be restricted to persons who meet the criteria specified in subdivision (a) for no fewer than 30 years.

(2) (A) For purposes of this subdivision, parcels only separated by a street or highway shall be considered to be adjoined.

(B) For purposes of this subdivision, "dedicated to industrial use" means any of the following:

(i) The square footage is currently being used as an industrial use.

(ii) The most recently permitted use of the square footage is an industrial use.

(iii) The site was designated for industrial use in the latest version of a local government's general plan adopted before January 1, 2022.

(b) The project shall be subject to the following streamlined, ministerial review process:

(1) (A) If the local government determines that a development submitted pursuant to this article is consistent with the objective planning standards specified in this article, it shall approve the development.

(B) If a local government determines that a development submitted pursuant to this article is in conflict with any of the objective planning standards specified in this article, it shall provide the development proponent written documentation of which standard or standards the development conflicts with, and an explanation for the reason or reasons the development conflicts with that standard or standards, within the following timeframes:

(i) Within 60 days of submission of the development proposal to the local government if the development contains 150 or fewer housing units.

(ii) Within 90 days of submission of the development proposal to the local government if the development contains more than 150 housing units.

(C) If the local government fails to provide the required documentation pursuant to subparagraph (B), the development shall be deemed to satisfy the required objective planning standards.

(D) (i) For purposes of this section, a development is consistent with the objective planning standards if there is substantial evidence that would allow a reasonable person to conclude that the development is consistent with the objective planning standards.

(ii) For purposes of this section, a development is not in conflict with the objective planning standards solely on the basis that application materials are not included, if the application contains substantial evidence that would allow a reasonable person to conclude that the development is consistent with the objective planning standards.

(E) The determination of whether a proposed project submitted pursuant to this section is or is not in conflict with the objective planning standards is not a "project" as defined in Section 21065 of the Public Resources Code.

(2) Design review of the development may be conducted by the local government's planning commission or any equivalent board or commission responsible for design review. That design review shall be objective and be strictly focused on assessing compliance with criteria required for streamlined, ministerial review of projects, as well as any reasonable objective design standards published and adopted by ordinance or resolution by a local jurisdiction before submittal of the development to the local government, and shall be broadly applicable to developments within the jurisdiction. That design review shall be completed as follows and shall not in any way inhibit, chill, or preclude the ministerial approval provided by this section or its effect, as applicable:

(A) Within 90 days of submittal of the development proposal to the local government pursuant to this section if the development contains 150 or fewer housing units.

(B) Within 180 days of submittal of the development proposal to the local government pursuant to this section if the development contains more than 150 housing units.

(c) Division 13 (commencing with Section 21000) of the Public Resources Code shall not apply to actions taken by the Department of Housing and Community Development, the State Department of Health Care Services, or a local agency not acting as the lead agency to provide financial assistance or insurance for the development and construction of projects built pursuant to this section.

(d) The applicant shall file a notice of exemption with the Office of Planning and Research and the county clerk of the county in which the project is located in the manner specified in subdivisions (b) and (c) of Section 21152 of the Public Resources Code.

(e) For purposes of this section, the following definitions shall apply:

(1) "Objective zoning standards," "objective subdivision standards," and "objective design review standards" mean standards that involve no personal or subjective judgment by a public official and are uniformly verifiable by reference to an external and uniform benchmark or criterion available and knowable by both the development applicant or proponent and the public official before submittal. These standards may be embodied in alternative objective land use specifications adopted by a city or county, and may include, but are not limited to, housing overlay zones, specific plans, inclusionary zoning ordinances, and density bonus ordinances.

(2) "Use by right" means a development project that satisfies both of the following conditions:

(A) The development project does not require a conditional use permit, planned unit development permit, or other discretionary local government review.

(B) The development project is not a "project" for purposes of Division 13 (commencing with Section 21000) of the Public Resources Code.

(f) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 45. Section 5835 of the Welfare and Institutions Code is amended to read:

5835. (a) This part shall be known, and may be cited, as the Early Psychosis Intervention Plus (EPI Plus) Program to encompass early psychosis and mood disorder detection and intervention.

(b) As used in this part, the following definitions shall apply:

(1) "Commission" means the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(2) "Early psychosis and mood disorder detection and intervention" refers to a program that utilizes evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode

psychotic symptoms, other early markers of serious mental illness, such as mood disorders, keeping individuals in school or at work, and putting them on a path to better health and wellness. This may include, but is not limited to, all of the following:

(A) Focused outreach to at-risk and in-need populations as applicable.

(B) Recovery-oriented psychotherapy, including cognitive behavioral therapy focusing on cooccurring disorders.

(C) Family psychoeducation and support.

(D) Supported education and employment.

(E) Pharmacotherapy and primary care coordination.

(F) Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.

(G) Case management.

(3) "County" includes a city receiving funds pursuant to Section 5701.5.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 46. Section 5835 is added to the Welfare and Institutions Code, to read:

5835. (a) This part shall be known, and may be cited, as the Early Psychosis Intervention (EPI) Plus Program to encompass early psychosis and mood disorder detection and intervention.

(b) As used in this part, the following definitions shall apply:

(1) "Commission" means the Behavioral Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(2) "Early psychosis and mood disorder detection and intervention" refers to a program that utilizes evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms, other early markers of serious mental illness, such as mood disorders, keeping individuals in school or at work, and putting them on a path to better health and wellness. This may include, but is not limited to, all of the following:

(A) Focused outreach to at-risk and in-need populations as applicable.

(B) Recovery-oriented psychotherapy, including cognitive behavioral therapy focusing on cooccurring disorders.

(C) Family psychoeducation and support.

(D) Supported education and employment.

(E) Pharmacotherapy and primary care coordination.

(F) Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.

(G) Case management.

(3) "County" includes a city receiving funds pursuant to Section 5701.5.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 47. Section 5835.2 of the Welfare and Institutions Code is amended to read:

5835.2. (a) There is hereby established an advisory committee to the commission. The Mental Health Services Oversight and Accountability Commission shall accept nominations and applications to the committee, and the chair of the Mental Health Services Oversight and Accountability Commission shall appoint members to the committee, unless otherwise specified. Membership on the committee shall be as follows:

(1) The chair of the Mental Health Services Oversight and Accountability Commission, or their designee, who shall serve as the chair of the committee.

(2) The president of the County Behavioral Health Directors Association of California, or their designee.

(3) The director of a county behavioral health department that administers an early psychosis and mood disorder detection and intervention-type program in their county.

(4) A representative from a nonprofit community mental health organization that focuses on service delivery to transition-aged youth and young adults.

(5) A psychiatrist or psychologist.

(6) A representative from the Behavioral Health Center of Excellence at the University of California, Davis, or a representative from a similar entity with expertise from within the University of California system.

(7) A representative from a health plan participating in the Medi-Cal managed care program and the employer-based health care market.

(8) A representative from the medical technologies industry who is knowledgeable in advances in technology related to the use of innovative social media and mental health information feedback access.

(9) A representative knowledgeable in evidence-based practices as they pertain to the operations of an early psychosis and mood disorder detection and intervention-type program, including knowledge of other states' experiences.

(10) A representative who is a parent or guardian caring for a young child with a mental illness.

(11) An at-large representative identified by the chair.

(12) A representative who is a person with lived experience of a mental illness.

(13) A primary care provider from a licensed primary care clinic that provides integrated primary and behavioral health care.

(b) The advisory committee shall be convened by the chair and shall, at a minimum, do all of the following:

(1) Provide advice and guidance broadly on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective.

(2) Review and make recommendations on the commission's guidelines or any regulations in the development, design, selection of awards pursuant to this part, and the implementation or oversight of the early psychosis and mood disorder detection and intervention competitive selection process established pursuant to this part.

(3) Assist and advise the commission in the overall evaluation of the early psychosis and mood disorder detection and intervention competitive selection process.

(4) Provide advice and guidance as requested and directed by the chair.

(5) Recommend a core set of standardized clinical and outcome measures that the funded programs would be required to collect, subject to future revision. A free data sharing portal shall be available to all participating programs.

(6) Inform the funded programs about the potential to participate in clinical research studies.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 48. Section 5835.2 is added to the Welfare and Institutions Code, to read:

5835.2. (a) There is hereby established an advisory committee to the commission. The Behavioral Health Services Oversight and Accountability Commission shall accept nominations and applications to the committee, and the chair of the Behavioral Health Services Oversight and Accountability Commission shall appoint members to the committee, unless otherwise specified. Membership on the committee shall be as follows:

(1) The chair of the Behavioral Health Services Oversight and Accountability Commission, or their designee, who shall serve as the chair of the committee.

(2) The president of the County Behavioral Health Directors Association of California, or their designee.

(3) The director of a county behavioral health department that administers an early psychosis and mood disorder detection and intervention-type program in their county.

(4) A representative from a nonprofit community mental health organization that focuses on service delivery to transition-aged youth and young adults.

(5) A psychiatrist or psychologist.

(6) A representative from the Behavioral Health Center of Excellence at the University of California, Davis, or a representative from a similar entity with expertise from within the University of California system.

(7) A representative from a health plan participating in the Medi-Cal managed care program and the employer-based health care market.

(8) A representative from the medical technologies industry who is knowledgeable in advances in technology related to the use of innovative social media and mental health information feedback access.

(9) A representative knowledgeable in evidence-based practices as they pertain to the operations of an early psychosis and mood disorder detection and intervention-type program, including knowledge of other states' experiences.

(10) A representative who is a parent or guardian caring for a young child with a mental illness.

(11) An at-large representative identified by the chair.

(12) A representative who is a person with lived experience of a mental illness.

(13) A primary care provider from a licensed primary care clinic that provides integrated primary and behavioral health care.

(14) A school social worker, school psychologist, or school counselor holding a pupil personnel services credential.

(15) A California public school administrator.

(16) A representative knowledgeable in community-defined evidence practices and reducing behavioral health disparities.

(b) The advisory committee shall be convened by the chair and shall, at a minimum, do all of the following:

(1) Provide advice and guidance broadly on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective.

(2) Review and make recommendations on the commission's guidelines or regulations in the development, design, and selection of awards pursuant to this part, and the implementation or oversight of the early psychosis and mood disorder detection and intervention competitive selection process established pursuant to this part.

(3) Assist and advise the commission in the overall evaluation of the early psychosis and mood disorder detection and intervention competitive selection process.

(4) Provide advice and guidance as requested and directed by the chair.

(5) Recommend a core set of standardized clinical and outcome measures that the funded programs would be required to collect, subject to future revision. A free data sharing portal shall be available to all participating programs.

(6) Inform the funded programs about the potential to participate in clinical research studies.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 49. Section 5840 of the Welfare and Institutions Code is amended to read:

5840. (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with serious mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs that are effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services, including prevention and early intervention strategies that address mental health needs, substance misuse or substance use disorders, or needs relating to cooccurring mental health and substance use services.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 50. Section 5840 is added to the Welfare and Institutions Code, to read:

5840. (a) (1) Each county shall establish and administer an early intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.

(2) Early intervention programs shall be funded pursuant to clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a) of Section 5892.

(b) An early intervention program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, behavioral health urgent care, hospitals, inclusive of emergency departments, education, including early care and learning, T-12, and higher education, and others to recognize the early signs of potentially severe and disabling mental health illnesses and substance use disorders.

(2) (A) Access and linkage to medically necessary care provided by county behavioral health programs as early in the onset of these conditions as practicable.

(B) Access and linkage to care includes the scaling of, and referral to, the Early Psychosis Intervention (EPI) Plus Program, pursuant to Part 3.4 (commencing with Section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs.

(3) (A) Mental health and substance use disorder treatment services, evidence-based practices and community-defined evidence practices for similar to those provided under other programs that are effective in preventing mental health illnesses and substance use disorders from becoming severe, and components similar to programs that have been successful in reducing the duration of untreated serious mental health illnesses and substance use disorders and assisting people in quickly regaining productive lives.

(B) Mental health treatment services may include services to address first episode psychosis.

(C) Mental health and substance use disorder services shall include services that are demonstrated to be effective at meeting the cultural and linguistic needs of diverse communities.

(D) Mental health and substance use disorder services may be provided to the following eligible children and youth:

(E) Mental health and substance use services may include services that prevent, respond, or treat a behavioral health crisis.

(i) Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an adverse childhood experiences (ACEs) screening tool, involvement in the child welfare system or juvenile justice system, or experiencing homelessness.

(ii) Individual children and youth in populations with identified disparities in behavioral health outcomes.

(4) Additional components developed by the State Department of Health Care Services.

(c) (1) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, and stakeholders, shall establish a biennial list of evidence-based practices and community-defined evidence practices that may include practices identified pursuant to the Children and Youth Behavioral Health Initiative Act set forth in Chapter 2 (commencing with Section 5961) of Part 7.

(2) Evidence-based practices and community-defined evidence practices may focus on addressing the needs of those who decompensate into severe behavioral health conditions.

(3) Local programs utilizing evidence-based practices and community-defined evidence practices may focus on addressing the needs of underserved communities, such as BIPOC and LGBTQ+.

(4) Counties shall utilize the list to determine which evidence-based practices and community-defined evidence practices to implement locally.

(5) The State Department of Health Care Services may require a county to implement specific evidence-based and community-defined evidence practices.

(d) The early intervention program shall emphasize the reduction of the likelihood of:

(1) Suicide and self-harm.

(2) Incarcerations.

(3) School, including early childhood 0 to 5 years of age, inclusive, TK-12, and higher education, suspension, expulsion, referral to an alternative or community school, or failure to complete.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(8) Overdose.

(9) Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood.

(e) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(f) For purposes of this section, "community-defined evidence practices" is defined as an alternative or complement to evidence-based practices, that offers culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(g) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 51. Section 5840.5 of the Welfare and Institutions Code is amended to read:

5840.5. It is the intent of the Legislature that this chapter achieve all of the following:

(a) Expand the provision of high quality Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs at the county level in California.

(b) Increase the number of PEI programs and systems, including those utilizing community-defined practices, that focus on reducing disparities for unserved, underserved, and inappropriately served racial, ethnic, and cultural communities.

(c) Reduce unnecessary hospitalizations, homelessness, suicides, and inpatient days by appropriately utilizing community-based services and improving timely access to prevention and early intervention services.

(d) Increase participation in community activities, school attendance, social interactions, physical and primary health care services, personal bonding relationships, and rehabilitation, including employment and daily living function development for clients.

(e) Increase collaboration and coordination among primary care, mental health, and aging service providers, and reduce hesitance to seek treatment and services due to mental health stigma.

(f) Create a more focused approach for PEI requirements.

(g) Increase programmatic and fiscal oversight of county MHSA-funded PEI programs.

(h) Encourage counties to coordinate and blend funding streams and initiatives to ensure services are integrated across systems.

(i) Encourage counties to leverage innovative technology platforms.

(j) Reflect the stated goals as outlined in the PEI component of the MHSA, as stated in Section 5840.

(k) This section shall be repealed on January 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 52. Section 5840.6 of the Welfare and Institutions Code is amended to read:

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) "Commission" means the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(b) "County" also includes a city receiving funds pursuant to Section 5701.5.

(c) "Prevention and early intervention funds" means funds from the Mental Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (3) of subdivision (a) of Section 5892.

(d) "Childhood trauma prevention and early intervention" refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health needs and prevent long-term mental health concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to children that qualify for these services.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.

(4) Support from peer support specialists and community health workers trained to provide mental health services.

(5) Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and families.

(6) Linkages to primary care health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, and school-based programs.

(7) Leveraging the healing value of traditional cultural connections, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(8) Coordinated and blended funding streams to ensure individuals and families experiencing toxic stress have comprehensive and integrated supports across systems.

(e) "Early psychosis and mood disorder detection and intervention" has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(f) "Youth outreach and engagement" means strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs that educate and engage students and provide either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges. Outreach and engagement may include, but is not limited to, all of the following:

(1) Meeting the mental health needs of students that cannot be met through existing education funds.

(2) Establishing direct linkages for students to community-based mental health services.

(3) Addressing direct services, including, but not limited to, increasing college mental health staff-to-student ratios and decreasing wait times.

(4) Participating in evidence-based and community-defined best practice programs for mental health services.

(5) Serving underserved and vulnerable populations, including, but not limited to, lesbian, gay, bisexual, transgender, and queer persons, victims of domestic violence and sexual abuse, and veterans.

(6) Establishing direct linkages for students to community-based mental health services for which reimbursement is available through the students' health coverage.

(7) Reducing racial disparities in access to mental health services.

(8) Funding mental health stigma reduction training and activities.

(9) Providing college employees and students with education and training in early identification, intervention, and referral of students with mental health needs.

(10) Interventions for youth with signs of behavioral or emotional problems who are at risk of, or have had any, contact with the juvenile justice system.

(11) Integrated youth mental health programming.

(12) Suicide prevention programming.

(g) "Culturally competent and linguistically appropriate prevention and intervention" refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code, or clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(1) "Culturally competent and linguistically appropriate" means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.

(2) "Underserved cultural populations" means those who are unlikely to seek help from any traditional mental health service because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the gay, lesbian, bisexual, and transgender communities, and veterans, across their lifespans.

(h) "Strategies targeting the mental health needs of older adults" means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Suicide prevention programming.

(3) Outreach to older adults who are isolated.

(4) Early identification programming of mental health symptoms and disorders, including, but not limited to, anxiety, depression, and psychosis.

(i) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 53. Section 5840.6 is added to the Welfare and Institutions Code, to read:

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) "County" includes a city receiving funds pursuant to Section 5701.5.

(b) "Early intervention funds" means funds from the Behavioral Health Services Fund allocated for early intervention services and programs pursuant to clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a) of Section 5892.

(c) "Childhood trauma early intervention" refers to a program that targets eligible children and youth exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health and substance use disorder needs and prevent long-term mental health and substance use disorder concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations, including youth experiencing homelessness, justice-involved youth, LGBTQ+ youth, and child welfare-involved youth.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to eligible children and youth who qualify for these services.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.

(4) Support from peer support specialists, wellness coaches, and community health workers trained to provide mental health and substance use disorder treatment services with an emphasis on culturally and linguistically tailored approaches.

(5) Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and youth and their families.

(6) Collaboration with county child welfare agencies and other system partners, including Medi-Cal managed care plans, as defined in subdivision (j) of Section 14184.101, and homeless youth service providers, to address the physical and behavioral health-related needs and social needs of child-welfare-involved youth.

(7) Linkages to primary care health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, school-linked providers, and school-based programs and community-based organizations specializing in serving underserved communities.

(8) Leveraging the healing value of traditional cultural connections and faith-based organizations, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(9) Blended funding streams to provide individuals and families experiencing toxic stress comprehensive and integrated supports across systems.

(10) Partnerships with local educational agencies and school-based behavioral health professionals to identify and address children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress.

(d) "Early psychosis and mood disorder detection and intervention" has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(e) "Youth outreach and engagement" means strategies that target out-of-school youth and secondary schoolage youth, including, but not limited to, all of the following:

(1) Establishing direct linkages for youth to community-based mental health and substance use disorder treatment services.

(2) Participating in evidence-based practices and community-defined evidence programs for mental health and substance use disorder treatment services.

(3) Providing supports to facilitate access to services and programs, including those utilizing community-defined evidence practices, for underserved and vulnerable populations, including, but not limited to, members of ethnically and racially diverse communities, members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans.

(4) Establishing direct linkages for students to community-based mental health and substance use disorder treatment services for which reimbursement is available through the students' health coverage.

(5) Reducing racial disparities in access to mental health and substance use disorder treatment services.

(6) Providing school employees and students with education and training in early identification, intervention, and referral of students with mental health and substance use disorder needs.

(7) Strategies and programs for youth with signs of behavioral or emotional problems or substance misuse who are at risk of, or have had, contact with the child welfare or juvenile justice system.

(8) Integrated youth mental health and substance use disorder programming.

(f) "Culturally competent and linguistically appropriate intervention" refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code and clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code. The community-based organizations include facilities and providers licensed or certified by the State Department of Health Care Services, including, but not limited to, residential substance use disorder facilities licensed pursuant to Section 11834.01 of the Health and

Safety Code or certified pursuant to Section 11830.1 of the Health and Safety Code and narcotic treatment programs licensed pursuant to Section 11839 of the Health and Safety Code. Community-based organizations may also include those organizations that provide community-defined evidence practices.

(1) "Culturally competent and linguistically appropriate" means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.

(2) "Underserved cultural populations" means those who are unlikely to seek help from providers of traditional mental health and substance use disorder services because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans, across their lifespans.

(g) "Strategies targeting the mental health and substance use disorder needs of older adults" means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Outreach to older adults who are isolated.

(3) Programs for early identification of mental health disorders and substance use disorders.

(h) "Community-defined evidence practices" is defined as an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(i) This section shall become operative on July 1, 2026, if amendments to the Mental Health Service Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 54. Section 5840.7 of the Welfare and Institutions Code is amended to read:

5840.7. (a) On or before January 1, 2020, the commission shall establish priorities for the use of prevention and early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

(2) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.

(3) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.

(4) Culturally competent and linguistically appropriate prevention and intervention.

(5) Strategies targeting the mental health needs of older adults.

(6) Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

(b) On or before January 1, 2020, the commission shall develop a statewide strategy for monitoring implementation of this part, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. The commission shall analyze and monitor the established metrics using existing data, if available, and shall propose new data collection and reporting strategies, if necessary.

(c) The commission shall establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.

(d) (1) The portion of funds in the county plan relating to prevention and early intervention shall focus on the established priorities, and shall be allocated, as determined by the county, with stakeholder input. A county may include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established priorities. If the county chooses to include other programs, the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.

(2) Counties may act jointly to meet the requirements of this section.

(e) If the commission requires additional resources for these purposes, it may prepare a proposal for consideration by the appropriate policy committees of the Legislature.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 55. Section 5840.7 is added to the Welfare and Institutions Code, to read:

5840.7. (a) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, shall establish priorities for the use of early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma early intervention to deal with the early origins of mental health and substance use disorder treatment needs, including strategies focused on eligible children and youth experiencing homelessness, justice-involved children and youth, child welfare-involved children and youth with a history of trauma, and other populations at risk of developing a mental health disorder or condition as specified in subdivision (d) of Section 14184.402 or substance use disorders. Childhood trauma early intervention services shall not be limited to individuals enrolled in the Medi-Cal program.

(2) Early psychosis and mood disorder detection and intervention and mood disorder programming that occurs across the lifespan.

(3) Outreach and engagement strategies that target early childhood 0 to 5 years of age, inclusive, out-of-school youth, and secondary school youth. Partnerships with community-based organizations and college mental health and substance use disorder programs may be utilized to implement the strategies.

(4) Culturally competent and linguistically appropriate interventions.

(5) Strategies targeting the mental health and substance use disorder needs of older adults.

(6) Strategies targeting the mental health needs of eligible children and youth, as defined in Section 5892, who are 0 to 5 years of age, including, but not limited to, infant and early childhood mental health consultation.

(7) Strategies to advance equity and reduce disparities.

(8) Programs that include community-defined evidence practices and evidence-based practices and mental health and substance use disorder treatment services similar to those provided under other programs that are effective in preventing mental illness and substance use disorders from becoming severe and components similar to programs that have been successful in reducing the duration of untreated severe mental illness and substance use disorders to assist people in quickly regaining productive lives.

(9) Other programs the State Department of Health Care Services identifies that are proven effective in preventing mental illness and substance use disorders from becoming severe and disabling, consistent with Section 5840.

(10) Strategies to address the needs of individuals at high risk of crisis.

(b) (1) (A) The portion of funds in the county plan relating to early intervention shall focus on the established priorities and shall be allocated as determined by the county with stakeholder input.

(B) (i) A county may include other priorities, as determined through the stakeholder process, in addition to the established priorities.

(ii) If a county chooses to include other programs, the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.

(2) Counties may act jointly to meet the requirements of this section.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 56. Section 5840.8 of the Welfare and Institutions Code is amended to read:

5840.8. (a) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the commission may implement this chapter without taking regulatory action until regulations are adopted. The commission may use information notices or related communications to implement this chapter.

(b) This section shall be repealed on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 57. Section 5845 of the Welfare and Institutions Code is amended to read:

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or the Attorney General's designee.

(2) The Superintendent of Public Instruction or the Superintendent's designee.

(3) The Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Committee on Health or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care service plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness. At least one person appointed pursuant to this paragraph shall have a background in auditing.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(3) Establish technical advisory committees, such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to an officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and the other provisions of the Mental Health Services Act.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services for consideration pursuant to the department's authority in Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California.

(12) Work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

(13) Establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, as determined by the commission, to support the mental health and wellness of employees. The commission shall consult with the Labor and Workforce Development Agency or its designee to develop the standard.

(e) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 58. Section 5845 is added to the Welfare and Institutions Code, to read:

5845. (a) The Behavioral Health Services Oversight and Accountability Commission is hereby established to promote transformational change in California's behavioral health system through research, evaluation and tracking outcomes, and other strategies to assess and report progress. The commission shall use this information and analyses to inform the commission's grant making, identify key policy issues and emerging best practices, provide technical assistance and training, promote high-quality programs implemented, and advise

the Governor and the Legislature, pursuant to the Behavioral Health Services Act and related components of California's behavioral health system. For this purpose, the commission shall collaborate with the California Health and Human Services Agency, its departments and other state entities.

(b) (1) The commission shall replace the advisory committee established pursuant to Section 5814.

(2) The commission shall consist of 27 voting members as follows:

(A) The Attorney General or the Attorney General's designee.

(B) The Superintendent of Public Instruction or the Superintendent's designee.

(C) The Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate, or their designee.

(D) The Chairperson of the Assembly Committee on Health, the Chairperson of the Assembly Committee on Human Services, or another Member of the Assembly selected by the Speaker of the Assembly, or their designee.

(E) (i) The following individuals, all appointed by the Governor:

(I) Two persons who have or have had a mental health disorder.

(II) Two persons who have or have had a substance use disorder.

(III) A family member of an adult or older adult who has or has had a mental health disorder.

(IV) One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or cooccurring disorder.

(V) A family member of an adult or older adult who has or has had a substance use disorder.

(VI) A family member of a child or youth who has or has had a mental health disorder.

(VII) A family member of a child or youth who has or has had a substance use disorder.

(VIII) A current or former county behavioral health director.

(IX) A physician specializing in substance use disorder treatment, including the provision of medications for addiction treatment.

(X) A mental health professional.

(XI) A professional with expertise in housing and homelessness.

(XII) A county sheriff.

(XIII) A superintendent of a school district.

(XIV) A representative of a labor organization.

(XV) A representative of an employer with less than 500 employees.

(XVI) A representative of an employer with more than 500 employees.

(XVII) A representative of a health care service plan or insurer.

(XVIII) A representative of an aging or disability organization.

(XIX) A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities.

(XX) A representative of a children and youth organization.

(XXI) A veteran or a representative of a veterans organization.

(ii) In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness or substance use disorder.

(c) Members shall serve without compensation but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(d) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(e) (1) The commission shall have an Executive Director.

(2) The Executive Director will be responsible for management over the administrative, fiscal, and program performance of the commission.

(3) The Executive Director shall be selected by the commission.

(f) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) (A) Meet at least once each quarter at a time and location convenient to the public as it may deem appropriate.

(B) All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including clerical, legal, and technical assistance, as necessary.

(3) The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(4) Establish technical advisory committees, such as a committee of consumers and family members, and a reducing disparities committee focusing on demographic, geographic, and other communities. The commission may provide pertinent information gained from those committees to relevant state agencies and departments, including, but not limited to, the California Health and Humans Services Agency and its departments.

(5) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding authority expressly granted to an officer or employee of state government.

(6) Enter into contracts.

(7) Make reasonable requests for data and information to the State Department of Health Care Services, the Department of Health Care Access and Information, the State Department of Public Health, or other state and local entities that receive Behavioral Health Services Act funds. These entities shall respond in a timely manner and provide information and data in their possession that the commission deems necessary for the purposes of carrying out its responsibilities.

(8) Participate in the joint state-county decisionmaking process, as described in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(9) Identify best practices to overcome stigma and discrimination, in consultation with the State Department of Public Health.

(10) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness or substance use disorder.

(11) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655 or 5963.04.

(12) Provide technical assistance to counties on implementation planning, training, and capacity building investments as defined by the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California. Technical assistance may also include innovative behavioral health models of care and innovative promising practices pursuant to subparagraph (A) of paragraph (4) of subdivision (a) of Section 5892. Technical assistance may also include compiling and publishing a list of innovative behavioral health models of care programs and promising practices for each of the programs set forth in subparagraphs (1), (2), and (3) of subdivision (a) of Section 5892.

(13) Work in collaboration with the State Department of Health Care Services to define the parameters of a report that includes recommendations for improving and standardizing promising practices across the state based on the technical assistance provided to counties as specified in paragraph (12). The commission shall prepare and publish the report on its internet website. In formulating this report, the commission shall prioritize the perspectives of the California behavioral health community through a robust public engagement process with a focus on priority populations and diverse communities.

(14) Establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, as determined by the commission, to support the mental health and wellness of employees. The commission shall consult with the Labor and Workforce Development Agency or its designee to develop the standard.

(g) (1) The commission shall work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, to write a report that includes recommendations for improving and standardizing promising practices for Behavioral Health Services Act programs.

(2) The commission shall complete the report and provide a written report on its internet website no later than January 1, 2030, and every three years thereafter.

(h) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(i) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 59. Section 5845.1 is added to the Welfare and Institutions Code, to read:

5845.1. (a) (1) The Behavioral Health Services Act Innovation Partnership Fund is hereby created in the State Treasury.

(2) The fund shall be administered by the state for the purposes of funding a grant program administered by the Behavioral Health Services Oversight and Accountability Commission pursuant to this section and subdivision (f) of Section 5892.

(b) (1) The Behavioral Health Services Oversight and Accountability Commission shall award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices.

(2) The innovative mental health and substance use disorder programs and practices shall be designed for the following purposes:

(A) Improving Behavioral Health Services Act programs and practices funded pursuant to subdivision (a) of Section 5892 for the following groups:

(i) Underserved populations.

(ii) Low-income populations.

(iii) Communities impacted by other behavioral health disparities.

(iv) Other populations, as determined by the Behavioral Health Services Oversight and Accountability Commission.

(B) Meeting statewide Behavioral Health Services Act goals and objectives.

(3) The Behavioral Health Services Oversight and Accountability Commission, in determining the allowable uses of the funds, shall consult with the California Health and Human Services Agency and the State Department of Health Care Services. If the Behavioral Health Services Oversight and Accountability Commission utilizes funding for population-based prevention or workforce innovation grants, the commission shall consult with the State Department of Public Health for population-based prevention innovations and the Department of Health Care Access and Information for workforce innovations.

(c) (1) The Behavioral Health Services Oversight and Accountability Commission shall submit a report to the Legislature by January 1, 2030, and every three years thereafter. The report shall cover the three-fiscal-year period immediately preceding the date of submission.

(2) The report shall include the practices funded pursuant to this section and the extent to which they accomplished the purposes specified in paragraphs (1), (2), and (3) of subdivision (b).

(3) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 60. Section 5845.5 of the Welfare and Institutions Code is amended to read:

5845.5. In addition to the activities authorized under Section 5845, the commission may establish a fellowship program in accordance with this section for the purpose of providing an experiential learning opportunity for a mental health consumer and a mental health professional.

(a) Participants in the fellowship shall serve on an annual basis and may serve only one term as a fellow.

(b) The fellowship program established under this section shall support the broad goals of the commission, including, but not limited to, subdivision (d) of Section 5846, and be based upon the following principles:

(1) To enhance opportunities for the work of the commission to reflect the perspective of persons with personal experience and state-of-the-art practices in the mental health field.

(2) To strengthen opportunities for the goals of the Mental Health Services Act, and the work of the commission in promoting those goals, to be accessible and understandable to mental health consumers, mental health professionals, and the general public.

(3) To improve opportunities for outreach and engagement with mental health consumers and mental health professionals relating to the work of the commission.

(4) To increase the awareness for mental health consumers and professionals of the goals of the Mental Health Services Act and the role of the state in meeting those goals; the role of public policy, regulation development, fiscal strategies, use of data, research, and evaluation; and communication strategies to improve mental health outcomes in California.

(c) The commission shall establish an advisory committee to provide guidance on the fellowship program goals, design, eligibility criteria, application process, and other issues as the commission deems necessary. The advisory committee shall include persons with personal experience with the mental health system, mental health professionals, persons with experience with similar fellowship programs, and others with diverse perspectives who can assist the commission to meet the goals of the fellowship program.

(d) The commission may enter into an interagency agreement or other contractual agreement with a state, local, or private entity, as determined by the commission, to receive technical assistance or relevant services to support the establishment and implementation of the fellowship program.

(e) The commission shall ensure that the fellowship program does not cause the displacement of any civil service employee. For purposes of this subdivision, "displacement" means a layoff, a demotion, an involuntary transfer to a new class, an involuntary transfer to a new location requiring a change of residence, a time base reduction, a change in shift or days off, or a reassignment to another position within the same class and general location.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 61. Section 5845.5 is added to the Welfare and Institutions Code, to read:

5845.5. In addition to the activities authorized under Section 5845, the commission may establish a fellowship program in accordance with this section for the purpose of providing an experiential learning opportunity for mental health or substance use disorder consumers and mental health or substance use disorder professionals.

(a) Participants in the fellowship shall serve on an annual basis and may serve only one term as a fellow.

(b) The fellowship program established under this section shall support the broad goals of the commission and be based upon the following principles:

(1) To enhance opportunities for the work of the commission to reflect the perspective of persons with personal experience and state-of-the-art practices in the mental health and substance use disorder fields.

(2) To strengthen opportunities for the goals of the Behavioral Health Services Act and the work of the commission in promoting those goals and to be accessible and understandable to mental health and substance use disorder individuals, mental health and substance use disorder professionals, and the general public.

(3) To improve opportunities for outreach and engagement with individuals who have a mental health disorder or a substance use disorder and mental health and substance use disorder professionals relating to the work of the commission.

(4) To increase the awareness of mental health and substance use disorder individuals and professionals of the goals of the Behavioral Health Services Act and both of the following:

(A) The role of the state in meeting those goals.

(B) The role of public policy, regulation development, fiscal strategies, use of data, research, and evaluation and communication strategies to improve mental health and substance use disorder outcomes in California.

(c) (1) The commission shall establish an advisory committee to provide guidance on the fellowship program goals, design, eligibility criteria, application process, and other issues as the commission deems necessary.

(2) The advisory committee shall include persons with personal experience with the mental health and substance use disorder system, mental health and substance use disorder professionals, persons with experience with similar fellowship programs, and others with diverse perspectives who can assist the commission to meet the goals of the fellowship program.

(d) The commission may enter into an interagency agreement or other contractual agreement with a state, local, or private entity, as determined by the commission, to receive technical assistance or relevant services to support the establishment and implementation of the fellowship program.

(e) (1) The commission shall ensure that the fellowship program does not cause the displacement of a civil service employee.

(2) For purposes of this subdivision, "displacement" means a layoff, a demotion, an involuntary transfer to a new class, an involuntary transfer to a new location requiring a change of residence, a time base reduction, a change in shift or days off, or a reassignment to another position within the same class and general location.

(f) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 62. Section 5846 of the Welfare and Institutions Code is amended to read:

5846. (a) The commission shall adopt regulations for programs and expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention.

(b) Any regulations adopted by the department pursuant to Section 5898 shall be consistent with the commission's regulations.

(c) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.

(d) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

(e) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 63. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission and the State

Department of Health Care Services within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements, as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age, inclusive. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the County Behavioral Health Directors Association of California and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

(g) The department shall post on its internet website the three-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.

(h) (1) Notwithstanding subdivision (a), a county that is unable to complete and submit a three-year program and expenditure plan or annual update for the 2020–21 or 2021–22 fiscal years due to the COVID-19 Public Health Emergency may extend the effective timeframe of its currently approved three-year plan or annual update to include the 2020–21 and 2021–22 fiscal years. The county shall submit a three-year program and expenditure plan or annual update to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services by July 1, 2022.

(2) For purposes of this subdivision, "COVID-19 Public Health Emergency" means the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(i) Notwithstanding paragraph (7) of subdivision (b) and subdivision (f), a county may, during the 2020–21 and 2021–22 fiscal years, use funds from its prudent reserve for prevention and early intervention programs created in accordance with Part 3.6 (commencing with Section 5840) and for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the

children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific subdivisions (h) and (i) of this section and subdivision (i) of Section 5892 by means of all-county letters or other similar instructions.

(k) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 64. Section 5848 of the Welfare and Institutions Code is amended to read:

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the local mental health agency or local behavioral health agency, as applicable, for revisions. The local mental health agency or local behavioral health agency, as applicable, shall provide an annual report of written explanations to the local governing body and the State Department of Health Care Services for any substantive recommendations made by the local mental health board that are not included in the final plan or update.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

(e) The department shall annually post on its internet website a summary of the performance outcomes reports submitted by counties if clearly and separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).

(f) For purposes of this section, "substantive recommendations made by the local mental health board" means any recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local mental health board that has established its quorum.

(g) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 65. Section 5848.5 of the Welfare and Institutions Code is amended to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective prevention, early intervention, outpatient, and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high-

quality, patient-centered, and cost-effective care for individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to prevention, early intervention, and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis prevention, crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(8) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The funds included in the 2016 Budget Act for the purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(A) Provide a continuum of crisis services for children and youth 21 years of age and under, regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes or a sole-source contracting process as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties, or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Rehabilitative mental health services, as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the California Behavioral Health Directors Association.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grant awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project, geographic region, and target ages. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated to support crisis prevention, early intervention, and crisis response strategies, as determined by the commission with input from peers, county behavioral health agencies, community-based organizations, and others. In allocating these funds, the commission shall consult with the California Health and Human Services Agency and other state agencies as needed, in order to leverage existing funds and share best practices, and shall take into consideration data on populations at risk for experiencing a mental health crisis, including the needs of early childhood, children and youth, transition age youth, adults, and older adults. These funds shall be made available to selected entities, including, but not limited to, counties, counties acting jointly, city mental health departments, other local governmental agencies and community-based organizations such as health care providers, hospitals, health systems, childcare providers, early childhood education providers, and other entities, as determined by the commission through a competitive selection process or a sole-source process, as determined by the commission. The commission may utilize a sole-source process when it determines, during a public hearing, that it is in the public interest to do so and would address barriers to participation for local governmental agencies, including small counties, other local agencies, and community-based organizations, or is aligned with the goals of this section. It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage prevention, early intervention, and receipt of needed services for individuals with mental health needs, or who are at risk of needing crisis services, and to assist in navigating the local service sector to improve efficiencies and the delivery of services. The commission shall consider existing data sources for populations who are at higher risk for experiencing a mental health crisis when allocating these funds.

(1) Funding may be used to support services, supports, education, and training that are offered in person, by telephone, by videoconference, or by telehealth with the individual in need of assistance, their significant support person, or others, and may be provided anywhere in the community. These service and related activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(E) Education and training.

(F) Innovative, best practice, evidence-based, and related approaches to support crisis prevention, early intervention, and crisis response.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including use of peers and peer support.

(C) Description of how funding will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the entities that receive the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, a city mental health department, a community-based organization, or other entity that receives an award of funds for the purpose of supporting crisis prevention, early intervention, and crisis response strategies pursuant to this subdivision may be required to provide a matching contribution of local funds. The commission may, at its discretion, allow and approve grants that include matching funds, in whole or in part, to enhance the impact of limited public funding. Matching fund requirements shall not be designed in a manner that will prevent participation from local agencies, community-based organizations, or other entities that are eligible to participate in the funding opportunities created by this section.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 66. Section 5848.5 is added to the Welfare and Institutions Code, to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties, and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective prevention, early intervention, outpatient, and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less-intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high-quality, patient-centered, and cost-effective care for individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to prevention, early intervention, and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis prevention, crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with a mental health disorder at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(8) (A) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

(B) The funds included in the 2016 Budget Act for the purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(i) Provide a continuum of crisis services for children and youth 21 years of age and under, regardless of where they live in the state.

(ii) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(iii) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(iv) Add at least 200 mobile crisis support teams.

(v) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level and improve access to mental health crisis services and address unmet mental health care needs.

(vi) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(vii) Expand family respite care to help families and sustain caregiver health and well-being.

(viii) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(ix) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(x) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(xi) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with a mental health disorder.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Behavioral Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes or a sole-source contracting process as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) (1) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties or counties acting jointly.

(2) The authority may, at its discretion, give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(3) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children’s crisis residential program as defined in Section 1502 of the Health and Safety Code.

(D) Rehabilitative mental health services as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(4) (A) The authority shall develop selection criteria to expand local resources, including those described in paragraph (3), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority.

(B) The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding.

(C) The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(i) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(ii) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(iii) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(iv) Level of community engagement and commitment to project completion.

(v) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(vi) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(vii) Memorandum of understanding among project partners, if applicable.

(viii) Information regarding the legal status of the collaborating partners, if applicable.

(ix) Ability to measure key outcomes, including improved access to services, health, and mental health outcomes, and cost benefit of the project.

(5) (A) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (3), and shall reflect reasonable costs for the project and geographic region.

(B) The authority may allocate a grant in increments contingent upon the phases of a project.

(6) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or another member of a collaborative effort that has been awarded a grant.

(7) (A) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority.

(B) Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority’s satisfaction.

(C) If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(8) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(9) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(10) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(11) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(12) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, workforce, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) (1) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly.

(2) The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this designation and collaboration in lieu of a county government directly receiving grant funds.

(3) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

(A) Crisis intervention as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program as defined in Section 1502 of the Health and Safety Code.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(4) (A) The authority shall develop selection criteria to expand local resources, including those described in paragraph (3), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority.

(B) The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding.

(C) The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(i) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(ii) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(iii) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the California Behavioral Health Directors Association.

(iv) Level of community engagement and commitment to project completion.

(v) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(vi) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(vii) Memorandum of understanding among project partners, if applicable.

(viii) Information regarding the legal status of the collaborating partners, if applicable.

(ix) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

(5) (A) The authority shall determine maximum grant awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project, geographic region, and target ages.

(B) The authority may allocate a grant in increments contingent upon the phases of a project.

(6) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or another member of a collaborative effort that has been awarded a grant.

(7) (A) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority.

(B) Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction.

(C) If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(8) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(9) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(10) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(11) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation, that include, but are not limited to, all of the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(12) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, workforce, and building codes.

(g) (1) (A) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated to support crisis prevention, early intervention, and crisis response strategies, as determined by the commission with input from peers, county behavioral health agencies, community-based organizations, and others.

(B) In allocating these funds, the commission shall consult with the California Health and Human Services Agency and other state agencies as needed, to leverage existing funds and share best practices and shall take into consideration data on populations at risk for experiencing a mental health crisis, including the needs of early childhood, children and youth, transition age youth, adults, and older adults.

(C) These funds shall be made available to selected entities, including, but not limited to, counties, counties acting jointly, city mental health departments, other local governmental agencies and community-based organizations, such as health care providers, hospitals, health systems, childcare providers, early childhood education providers, and other entities as determined by the commission through a competitive selection process or a sole-source process, as determined by the commission.

(D) The commission may utilize a sole-source process when it determines, during a public hearing, that it is in the public interest to do so and would address barriers to participation for local governmental agencies, including small counties, other local agencies, and community-based organizations or is aligned with the goals of this section.

(E) It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage prevention, early intervention, and receipt of needed services for individuals with mental health needs, or who are at risk of needing crisis services, and to assist in navigating the local service sector to improve efficiencies and the delivery of services.

(F) The commission shall consider existing data sources for populations who are at higher risk for experiencing a mental health crisis when allocating these funds.

(2) Funding may be used to support services, supports, education, and training that are offered in person, by telephone, by videoconference, or by telehealth with the individual in need of assistance, their significant support person, or others, and may be provided anywhere in the community. These service and related activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual’s progress.

(D) Providing placement service assistance and service plan development.

(E) Education and training.

(F) Innovative, best practice, evidence-based, and related approaches to support crisis prevention, early intervention, and crisis response.

(3) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including use of peers and peer support.

(C) Description of how funding will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, if applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(4) The commission shall determine maximum grant awards and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(5) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the entities that receive the grant.

(6) (A) Notwithstanding any other law, a county, counties acting jointly, a city mental health department, a community-based organization, or other entity that receives an award of funds for the purpose of supporting crisis prevention, early intervention, and crisis response strategies pursuant to this subdivision may be required to provide a matching contribution of local funds.

(B) The commission may, at its discretion, allow and approve grants that include matching funds, in whole or in part, to enhance the impact of limited public funding. Matching fund requirements shall not be designed in a manner that will prevent participation from local agencies, community-based organizations, or other entities that are eligible to participate in the funding opportunities created by this section.

(7) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(h) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 67. Section 5849.1 of the Welfare and Institutions Code is amended to read:

5849.1. (a) The Legislature finds and declares that this part is consistent with and furthers the purposes of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election, within the meaning of Section 18 of that measure.

(b) The Legislature further finds and declares all of the following:

(1) Housing is a key factor for stabilization and recovery to occur and results in improved outcomes for individuals living with a mental illness.

(2) Untreated mental illness can increase the risk of homelessness, especially for single adults.

(3) California has the nation’s largest homeless population that is disproportionally comprised of women with children, veterans, and the chronically homeless.

(4) California has the largest number of homeless veterans in the United States at 24 percent of the total population in our nation. Fifty percent of California’s veterans live with serious mental illness and 70 percent have a substance use disorder.

(5) Fifty percent of mothers experiencing homelessness have experienced a major depressive episode since becoming homeless and 36 percent of these mothers live with post-traumatic stress disorder and 41 percent have a substance use disorder.

(6) Ninety-three percent of supportive housing tenants who live with mental illness and substance use disorders voluntarily participated in the services offered.

(7) Adults who receive two years of “whatever-it-takes,” or Full-Service Partnership services, experience a 68-percent reduction in homelessness.

(8) For every dollar of bond funds invested in permanent supportive housing, the state and local governments can leverage a significant amount of additional dollars through tax credits, Medicaid health services funding, and other housing development funds.

(9) Tenants of permanent supportive housing reduced their visits to the emergency department by 56 percent, and their hospital admissions by 45 percent.

(10) The cost in public services for a chronically homeless Californian ranges from $60,000 to $100,000 annually. When housed, these costs are cut in half and some reports show reductions in cost of more than 70 percent, including potentially less involvement with the health and criminal justice systems.

(11) Californians have identified homelessness as their top tier priority; this measure seeks to address the needs of the most vulnerable people within this population.

(12) Having counties provide mental health programming and services is a benefit to the state.

(13) The Department of Housing and Community Development is the state entity with sufficient expertise to implement and oversee a grant or loan program for permanent supportive housing of the target population.

(14) The California Health Facilities Financing Authority is authorized by law to issue bonds and to consult with the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services concerning the implementation of a grant or loan program for California counties to support the development of programs that increase access to, and capacity for, crisis mental health services. It is therefore appropriate for the authority to issue bonds and contract for services with the Department of Housing and Community Development to provide grants or loans to California counties for permanent supportive housing for the target population.

(15) Use of bond funding will accelerate the availability of funding for the grant or loan program to provide permanent supportive housing for the target population as compared to relying on annual allocations from the Mental Health Services Fund and better allow counties to provide permanent supportive housing for homeless individuals living with mental illness.

(16) The findings and declarations set forth in subdivision (c) of Section 5849.35 are hereby incorporated herein.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date, is repealed.

SEC. 68. Section 5849.1 is added to the Welfare and Institutions Code, to read:

5849.1. (a) The Legislature finds and declares that this part is consistent with and furthers the purposes of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election, within the meaning of Section 18 of that measure.

(b) The Legislature further finds and declares all of the following:

(1) Housing is a key factor for stabilization and recovery to occur and results in improved outcomes for individuals living with a mental illness.

(2) Untreated mental illness can increase the risk of homelessness, especially for single adults.

(3) California has the nation's largest homeless population, which is disproportionally comprised of women with children and youth, veterans, and the chronically homeless.

(4) California has the largest number of homeless veterans in the United States at 24 percent of the total population in our nation. Fifty percent of California's homeless veterans live with serious mental illness and 70 percent have a substance use disorder.

(5) Fifty percent of mothers experiencing homelessness have experienced a major depressive episode since becoming homeless, and 36 percent of these mothers live with post-traumatic stress disorder and 41 percent have a substance use disorder.

(6) Ninety-three percent of supportive housing tenants who live with mental illness and substance use disorders voluntarily participated in the services offered.

(7) Adults who receive two years of "whatever-it-takes," or Full-Service Partnership services, experience a 68-percent reduction in homelessness.

(8) For every dollar of bond funds invested in permanent supportive housing, the state and local governments can leverage a significant amount of additional dollars through tax credits, Medicaid health services funding, and other housing development funds.

(9) Tenants of permanent supportive housing reduced their visits to the emergency department by 56 percent and their hospital admissions by 45 percent.

(10) The cost in public services for a chronically homeless Californian ranges from $60,000 to $100,000 annually. When housed, these costs are cut in half and some reports show reductions in cost of more than 70 percent, including potentially less involvement with the health and criminal justice systems.

(11) Californians have identified homelessness as their top tier priority. This measure seeks to address the needs of the most vulnerable people within this population.

(12) Having counties provide mental health programming and services is a benefit to the state.

(13) The Department of Housing and Community Development is the state entity with sufficient expertise to implement and oversee a grant or loan program for permanent supportive housing of the target population.

(14) The California Health Facilities Financing Authority is authorized by law to issue bonds and to consult with the Behavioral Health Services Oversight and Accountability Commission and the State Department of Health Care Services concerning the implementation of a grant or loan program for California counties to support the development of programs that increase access to, and capacity for, crisis mental health services. It is therefore appropriate for the authority to issue bonds and contract for services with the Department of Housing and Community Development to provide grants or loans to California counties for permanent supportive housing for the target population.

(15) Use of bond funding will accelerate the availability of funding for the grant or loan program to provide permanent supportive housing for the target population as compared to relying on annual allocations from the Behavioral Health Services Fund and better allow counties to provide permanent supportive housing for homeless individuals living with mental illness.

(16) The findings and declarations set forth in subdivision (c) of Section 5849.35 are hereby incorporated herein.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 69. Section 5849.2 of the Welfare and Institutions Code is amended to read:

5849.2. As used in this part, the following definitions shall apply:

(a) "At risk of chronic homelessness" includes, but is not limited to, persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings, including, but not limited to, jail and mental health facilities, who were homeless prior to admission, transition age youth experiencing homelessness or with significant barriers to housing stability, and others, as defined in program guidelines.

(b) "Authority" means the California Health Facilities Financing Authority established pursuant to Part 7.2 (commencing with Section 15430) of Division 3 of Title 2 of the Government Code.

(c) "Chronically homeless" has the same meaning as defined in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on May 1, 2016.

(d) "Commission" means the Mental Health Services Oversight and Accountability Commission established by Section 5845.

(e) "Committee" means the No Place Like Home Program Advisory Committee established pursuant to Section 5849.3.

(f) "County" includes, but is not limited to, a city and county, and a city receiving funds pursuant to Section 5701.5.

(g) "Department" means the Department of Housing and Community Development.

(h) "Development sponsor" has the same meaning as "sponsor" as defined in Section 50675.2 of the Health and Safety Code.

(i) "Fund" means the No Place Like Home Fund established pursuant to Section 5849.4.

(j) "Homeless" has the same meaning as defined in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on May 1, 2016.

(k) "Permanent supportive housing" has the same meaning as "supportive housing," as defined in Section 50675.14 of the Health and Safety Code, except that "permanent supportive housing" shall include associated facilities if used to provide services to housing residents.

(l) "Program" means the process for awarding funds and distributing moneys to applicants established in Sections 5849.7, 5849.8, and 5849.9 and the ongoing monitoring and enforcement of the applicants' activities pursuant to Sections 5849.8, 5849.9, and 5849.11.

(1) "Competitive program" means that portion of the program established by Section 5849.8.

(2) "Distribution program" means that portion of the program described in Section 5849.9.

(m) "Target population" means individuals or households as provided in Section 5600.3 who are homeless, chronically homeless, or at risk of chronic homelessness.

(n) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 70. Section 5849.2 is added to the Welfare and Institutions Code, to read:

5849.2. As used in this part, the following definitions shall apply:

(a) "At risk of chronic homelessness" includes, but is not limited to, persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings, including, but not limited to, jail, mental health, and substance use disorder facilities, who were homeless prior to admission, transition age youth experiencing homelessness or with significant barriers to housing stability, and others, as defined in program guidelines.

(b) "Authority" means the California Health Facilities Financing Authority established pursuant to Part 7.2 (commencing with Section 15430) of Division 3 of Title 2 of the Government Code.

(c) "Chronically homeless" has the same meaning as defined in Section 578.3 of Title 24 of the Code of Federal Regulations as that section read on May 1, 2016, or as otherwise modified or expanded by the State Department of Health Care Services.

(d) "Commission" means the Behavioral Health Services Oversight and Accountability Commission established by Section 5845.

(e) "Committee" means the No Place Like Home Program Advisory Committee established pursuant to Section 5849.3.

(f) "County" includes, but is not limited to, a city and a city and county receiving funds pursuant to Section 5701.5.

(g) "Department" means the Department of Housing and Community Development.

(h) "Development sponsor" has the same meaning as "sponsor" as defined in Section 50675.2 of the Health and Safety Code.

(i) "Fund" means the No Place Like Home Fund established pursuant to Section 5849.4.

(j) "Homeless" has the same meaning as defined in Section 578.3 of Title 24 of the Code of Federal Regulations as that section read on May 1, 2016.

(k) "Permanent supportive housing" has the same meaning as "supportive housing," as defined in Section 50675.14 of the Health and Safety Code, except that "permanent supportive housing" shall include associated facilities if used to provide services to housing residents.

(l) (1) "Program" means the process for awarding funds and distributing moneys to applicants established in Sections 5849.7, 5849.8, and 5849.9 and the ongoing monitoring and enforcement of the applicants' activities pursuant to Sections 5849.8, 5849.9, and 5849.11.

(2) "Competitive program" means the portion of the program established by Section 5849.8.

(3) "Distribution program" means the portion of the program described in Section 5849.9.

(m) "Target population" means individuals or households, as provided in Section 5600.3, who are homeless, chronically homeless, or at risk of chronic homelessness.

(n) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 71. Section 5849.3 of the Welfare and Institutions Code is amended to read:

5849.3. (a) There is hereby established the No Place Like Home Program Advisory Committee. Membership on the committee shall be as follows:

(1) The Director of Housing and Community Development, or their designee, who shall serve as the chairperson of the committee.

(2) The Director of Health Care Services, or their designee, and an additional representative.

(3) The Secretary of Veterans Affairs, or their designee.

(4) The Director of Social Services, or their designee.

(5) The Treasurer, or their designee.

(6) The Chair of the Mental Health Services Oversight and Accountability Commission, or their designee.

(7) A chief administrative officer of a small county or a member of a county board of supervisors of a small county, as provided by subdivision (d) of Section 5849.6, to be appointed by the Governor.

(8) A chief administrative officer of a large county or a member of a county board of supervisors of a large county, as provided by subdivision (b) of Section 5849.6, to be appointed by the Governor.

(9) A director of a county behavioral health department, to be appointed by the Governor.

(10) An administrative officer of a city, to be appointed by the Governor.

(11) A representative of an affordable housing organization, to be appointed by the Speaker of the Assembly.

(12) A resident of supportive housing, to be appointed by the Governor.

(13) A representative of a community mental health organization, to be appointed by the Senate Committee on Rules.

(14) A representative of a local or regional continuum of care organization that coordinates homelessness funding, to be appointed by the Governor.

(b) The committee shall do all of the following:

(1) Assist and advise the department in the implementation of the program.

(2) Review and make recommendations on the department's guidelines.

(3) Review the department's progress in distributing moneys pursuant to this part.

(4) Provide advice and guidance more broadly on statewide homelessness issues.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 72. Section 5849.3 is added to the Welfare and Institutions Code, to read:

5849.3. (a) There is hereby established the No Place Like Home Program Advisory Committee. Membership on the committee shall be as follows:

(1) The Director of Housing and Community Development, or their designee, who shall serve as the chairperson of the committee.

(2) The Director of Health Care Services, or their designee, and an additional representative.

(3) The Secretary of Veterans Affairs or their designee.

(4) The Director of Social Services or their designee.

(5) The Treasurer or their designee.

(6) The Chair of the Behavioral Health Services Oversight and Accountability Commission or their designee.

(7) A chief administrative officer of a small county or a member of a county board of supervisors of a small county, as provided by subdivision (d) of Section 5849.6, to be appointed by the Governor.

(8) A chief administrative officer of a large county or a member of a county board of supervisors of a large county, as provided by subdivision (b) of Section 5849.6, to be appointed by the Governor.

(9) A director of a county behavioral health department, to be appointed by the Governor.

(10) An administrative officer of a city, to be appointed by the Governor.

(11) A representative of an affordable housing organization, to be appointed by the Speaker of the Assembly.

(12) A resident of supportive housing, to be appointed by the Governor.

(13) A representative of a community behavioral health organization, to be appointed by the Senate Committee on Rules.

(14) A representative of a local or regional continuum of care organization that coordinates homelessness funding, to be appointed by the Governor.

(b) The committee shall do all of the following:

(1) Assist and advise the department in the implementation of the program.

(2) Review and make recommendations on the department's guidelines.

(3) Review the department's progress in distributing moneys pursuant to this part.

(4) Provide advice and guidance more broadly on statewide homelessness issues.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 73. Section 5852.5 of the Welfare and Institutions Code is amended to read:

5852.5. The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission shall review those counties that have been awarded funds to implement a comprehensive system for the delivery of mental health services to children with serious emotional disturbance and to their families or foster families to determine compliance with either of the following:

(a) The total estimated cost avoidance in all of the following categories shall equal or exceed the applications for funding award moneys:

(1) Group home costs paid by Aid to Families with Dependent Children-Foster Care (AFDC-FC) program.

(2) Children and adolescent state hospital and acute inpatient programs.

(3) Nonpublic school residential placement costs.

(4) Juvenile justice reincarcerations.

(5) Other short- and long-term savings in public funds resulting from the applications for funding award moneys.

(b) If the department determines that the total cost avoidance listed in subdivision (a) does not equal or exceed applications for funding award amounts, the department shall determine that the county that has been awarded funding shall achieve substantial compliance with all of the following goals:

(1) Total cost avoidance in the categories listed in subdivision (a) to exceed 50 percent of the applications for funding award moneys.

(2) A 20-percent reduction in out-of-county ordered placements of juvenile justice wards and social service dependents.

(3) A statistically significant reduction in the rate of recidivism by juvenile offenders.

(4) A 25-percent reduction in the rate of state hospitalization of minors from placements of special education pupils.

(5) A 10-percent reduction in out-of-county nonpublic school residential placements of special education pupils.

(6) Allow at least 50 percent of children at risk of imminent placement served by the intensive in-home crisis treatment programs, which are wholly or partially funded by applications for funding award moneys, to remain at home at least six months.

(7) Statistically significant improvement in school attendance and academic performance of seriously emotionally disturbed special education pupils treated in day treatment programs, which are wholly or partially funded by applications for funding award moneys.

(8) Statistically significant increases in services provided in nonclinic settings among agencies.

(9) Increase in ethnic minority and gender access to services proportionate to the percentage of these groups in the county's schoolage population.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 74. Section 5852.5 is added to the Welfare and Institutions Code, to read:

5852.5. The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, shall review those counties that have been awarded funds to implement a comprehensive system for the delivery of mental health services to children with a serious emotional disturbance and to their families or foster families to determine compliance with either of the following:

(a) The total estimated cost avoidance in all of the following categories shall equal or exceed the applications for funding award moneys:

(1) Group home costs paid by Aid to Families with Dependent Children-Foster Care (AFDC-FC) program.

(2) Children and adolescent state hospital and acute inpatient programs.

(3) Nonpublic school residential placement costs.

(4) Juvenile justice reincarcerations.

(5) Other short- and long-term savings in public funds resulting from the applications for funding award moneys.

(b) If the department determines that the total cost avoidance listed in subdivision (a) does not equal or exceed applications for funding award amounts, the department shall determine that the county that has been awarded funding shall achieve substantial compliance with all of the following goals:

(1) Total cost avoidance in the categories listed in subdivision (a) to exceed 50 percent of the applications for funding award moneys.

(2) A 20-percent reduction in out-of-county ordered placements of juvenile justice wards and social service dependents.

(3) A statistically significant reduction in the rate of recidivism by juvenile offenders.

(4) A 25-percent reduction in the rate of state hospitalization of minors from placements of special education pupils.

(5) A 10-percent reduction in out-of-county nonpublic school residential placements of special education pupils.

(6) Allow at least 50 percent of children at risk of imminent placement served by the intensive in-home crisis treatment programs, which are wholly or partially funded by applications for funding award moneys, to remain at home at least six months.

(7) Statistically significant improvement in school attendance and academic performance of seriously emotionally disturbed special education pupils treated in day treatment programs that are wholly or partially funded by applications for funding award moneys.

(8) Statistically significant increases in services provided in nonclinic settings among agencies.

(9) Increase in ethnic minority and gender access to services proportionate to the percentage of these groups in the county's schoolage population.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 75. Section 5868 of the Welfare and Institutions Code is amended to read:

5868. (a) The State Department of Health Care Services shall establish service standards that ensure that children in the target population are identified and receive needed and appropriate services from qualified staff in the least restrictive environment.

(b) The standards shall include, but not be limited to:

(1) Providing a comprehensive assessment and treatment plan for each target population client to be served, and developing programs and services that will meet their needs and facilitate client outcome goals.

(2) Providing for full participation of the family in all aspects of assessment, case planning, and treatment.

(3) Providing methods of assessment and services to meet the cultural, linguistic, and special needs of minorities in the target population.

(4) Providing for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services resulting from a limited ability to speak English or from cultural differences.

(5) Providing mental health case management for all target population clients in, or being considered for, out-of-home placement.

(6) Providing mental health services in the natural environment of the child to the extent feasible and appropriate.

(c) The responsibility of the case managers shall be to ensure that each child receives the following services:

(1) A comprehensive mental health assessment.

(2) Case planning with all appropriate interagency participation.

(3) Linkage with all appropriate mental health services.

(4) Service plan monitoring.

(5) Client advocacy to ensure the provision of needed services.

(d) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 76. Section 5868 is added to the Welfare and Institutions Code, to read:

5868. (a) The State Department of Health Care Services shall establish service standards so that children and youth in the target population are identified and receive needed and appropriate services from qualified staff in the least restrictive environment to correct or ameliorate their behavioral health condition. This section shall not apply to services covered by the Medi-Cal program and services covered by a health care service plan or other insurance coverage.

(b) These standards shall include, but are not limited to, all of the following:

(1) For services funded pursuant to subdivision (a) of Section 5892, the county may consult with the stakeholders listed in paragraph (1) of subdivision (a) of Section 5963.03.

(2) (A) Outreach to families with a child or youth with a serious emotional disturbance or a substance use disorder to provide coordination and access to behavioral health services, medications, housing interventions pursuant to Section 5830, and supportive services as defined in subdivision (h) of Section 5887.

(B) Service planning shall include evaluation strategies that shall consider cultural, linguistic, gender, age, and special needs of the target populations.

(C) Provision shall be made for a workforce with the cultural background and linguistic skills necessary to remove barriers to mental health and substance use disorder treatment services due to limited-English-speaking ability and cultural differences.

(D) Recipients of outreach services may include families, the public, primary care physicians, hospitals inclusive of emergency departments, behavioral health urgent care, and others who are likely to come into contact with individuals who may be suffering from either an untreated serious emotional disturbance or substance use disorder, or both, who would likely become homeless or incarcerated if the illness continued to be untreated for a substantial period of time.

(3) Provision for services for populations with identified disparities in behavioral health outcomes.

(4) Provision for full participation of the family in all aspects of assessment, service planning, and treatment, including, but not limited to, family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate for the individual.

(5) Provision for clients who have been suffering from an untreated serious emotional disturbance or substance use disorder, or both, for less than one year and who do not require the full range of services but are at risk of becoming homeless or justice involved unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs, including housing for clients that is immediate, transitional, permanent, or all of these.

(6) Provision for services to be client-directed, to use psychosocial rehabilitation and recovery principles, and to be integrated with other services.

(7) Provision for psychiatric and psychological collaboration in overall service planning.

(8) Provision for services specifically directed to children and youth experiencing first episode psychosis.

(9) Provision for services for frequent users of behavioral health urgent care, crisis stabilization units, and hospitals or emergency departments as the primary resource for mental health and substance use disorder treatment.

(10) Provision for services to meet the special needs of clients who are physically disabled, clients who are intellectually or developmentally disabled, or persons of American Indian or Alaska Native descent.

(c) Each child or youth shall have a clearly designated personal services coordinator or case manager who may be part of a multidisciplinary treatment team that is responsible for providing case management services. The personal services coordinator may be

a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.

(d) A personal services coordinator shall perform all of the following:

(1) Conduct a comprehensive assessment and periodic reassessment of a client's needs. The assessment shall include the following:

(A) Taking the client's history.

(B) Identifying the individual's needs, including reviewing available records and gathering information from other sources, including behavioral health service providers, medical providers, family members, social workers, and others needed to form a complete assessment.

(C) Assessing the client's living arrangements, employment or education status, and training needs.

(2) Plan for services using information collected through the assessment. The planning process shall do all of the following:

(A) Identify the client's goals and the behavioral health, supportive, medical, educational, social, prevocational, vocational, rehabilitative, housing, or other community services needed to assist the client to reach their goals.

(B) Include active participation of the client and others in the development of the client's goals.

(C) Identify a course of action to address the client's needs.

(D) Address the transition of care when a client has achieved their goals.

(3) Assist the client in accessing needed behavioral health, supportive, medical, educational, social, prevocational, vocational, rehabilitative, housing, or other community services.

(4) Coordinate the services the county furnishes to the client between settings of care, including appropriate discharge planning for short-term hospital and institutional stays.

(5) Coordinate the services the county furnishes to the client with the services the client receives from managed care organizations, the Medicaid fee-for-service delivery system, other human services agencies, and community and social support providers, including local educational agencies.

(6) Ensure that, in the course of coordinating care, the client's privacy is protected in accordance with all federal and state privacy laws.

(e) The county shall ensure that each provider furnishing services to clients maintains and shares, as appropriate, client health records in accordance with professional standards.

(f) The service planning process shall ensure children and youth receive age-appropriate, gender-appropriate, and culturally appropriate services or appropriate services based on a characteristic listed or defined in Section 11135 of the Government Code, to the extent feasible, that are designed to enable recipients to:

(1) (A) Live in the most independent, least restrictive housing feasible in the local community and to live in a supportive housing environment that strives for family reunification.

(B) Rejoin or return to a home they had previously maintained with a family member or in shared housing environment that is supportive of their recovery and stabilization.

(2) Engage in the highest level of educational or productive activity appropriate to their age, abilities, and experience.

(3) Create and maintain a support system consisting of friends, family, and participation in community activities.

(4) Access necessary physical health care and maintain the best possible physical health.

(5) Reduce or eliminate serious antisocial or criminal behavior and thereby reduce or eliminate their contact with the justice system.

(6) Reduce or eliminate the distress caused by the symptoms of either mental illness or substance use disorder, or both.

(7) Utilize trauma-informed approaches to reduce trauma and avoid retraumatization.

(g) (1) (A) The client's clinical record shall describe the service array that meets the requirements of subdivisions (d) and (f) and, to the extent applicable to the individual, the requirements of subdivision (a) and (b).

(B) The State Department of Health Care Services may develop and revise documentation standards for service planning to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(2) Documentation of the service planning process in the client's clinical record pursuant to paragraph (1) may fulfill the documentation requirements for both the Medi-Cal program and this section.

(h) For purposes of this section, "behavioral health services" shall have the meaning as defined in Section 5892.

(i) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(j) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 77. Section 5878.1 of the Welfare and Institutions Code is amended to read:

5878.1. (a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 78. Section 5878.1 is added to the Welfare and Institutions Code, to read:

5878.1. (a) It is the intent of this article to establish programs that ensure services will be provided to eligible children and youth, as defined in Section 5892, and that they are part of the children and youth system of care established pursuant to this part.

(b) It is the intent of this act that services provided under this chapter are accountable, developed in partnership with youth and their families and child welfare agencies, are culturally competent, and individualized to the strengths and needs of each child and their family.

(c) Nothing in this act shall be construed to authorize a service to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

(d) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 79. Section 5878.2 of the Welfare and Institutions Code is amended to read:

5878.2. (a) For purposes of this article, "children with a serious emotional disturbance" means minors under 18 years of age who meet the criteria set forth in subdivision (a) of Section 5600.3.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 80. Section 5878.3 of the Welfare and Institutions Code is amended to read:

5878.3. (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890) of this division, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The State Department of Health Care Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

(d) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 81. Section 5878.3 is added to the Welfare and Institutions Code, to read:

5878.3. (a) (1) (A) Counties shall use funds distributed pursuant to subdivision (c) of Section 5891 to offer services to eligible children and youth, as defined in of Section 5892, for whom services under other public or private insurance or other mental health, substance use disorder, or other entitlement program is inadequate or unavailable. Counties are not required to spend funds for services pursuant to this part from any other source, including funds deposited in the mental health account of the local health and welfare fund.

(B) Other entitlement programs include, but are not limited to, mental health and substance use disorder treatment services available pursuant to Medi-Cal, child welfare, and special education programs.

(C) The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health and substance use disorder funds, or other entitlement programs.

(2) To maximize federal financial participation in furtherance of subdivision (d) of Section 5890, a county shall submit claims for reimbursement to the State Department of Health Care Services in accordance with applicable Medi-Cal rules and procedures for a

behavioral health service or supportive service eligible for reimbursement pursuant to Title XIX or XXI of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq. and 1397aa, et seq.) when such service is paid, in whole or in part, using funds from the Behavioral Health Services Fund established pursuant to Section 5890.

(3) (A) To maximize funding from other sources, a county shall seek reimbursement for a behavioral health service, supportive service, housing intervention, or other related activity provided pursuant to subdivision (a) of Section 5892 that is covered by, or can be paid from, another available funding source, including other mental health funds, substance use disorder funds, public and private insurance, and other local, state, and federal funds. This paragraph does not require counties to exhaust other funding sources before using behavioral health services fund moneys to pay for a service or related activity.

(B) A county shall make a good faith effort to enter into contracts or single case agreements with health care service plans and disability insurance plans, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, as a contracted provider.

(C) A county shall also submit requests for prior authorization for services, request letters of agreement for payment as an out-of-network provider, and pursue other means to obtain reimbursement in accordance with state and federal laws.

(4) (A) A county may report to the Department of Managed Health Care or the Department of Insurance, as appropriate, complaints about a health plan's or a health insurer's failure to make a good faith effort to contract or enter into a single case agreement with the county.

(B) A county may also report to the Department of Managed Health Care or the Department of Insurance, respectively, a failure by a health plan or insurer to timely reimburse the county for services the plan or insurer must cover as required by state or federal law, including, but not limited to, Sections 1374.72 and 1374.721 of the Health and Safety Code and Sections 10144.5 and 10144.52 of the Insurance Code.

(C) Upon receipt of a complaint from a county, the Department of Managed Health Care or the Department of Insurance, as applicable, shall timely investigate the complaint.

(b) (1) Funding shall be at sufficient levels to ensure counties can provide each child served all of the services determined to be necessary during the service planning process in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(2) A county may use this funding to provide services to address first episode psychosis.

(c) The State Department of Health Care Services shall contract with county behavioral health programs for the provision of services under this article in the manner set forth in Section 5897.

(d) For purposes of this section, the following definitions shall apply:

(1) "Behavioral health services" shall have the meaning as defined in Section 5892.

(2) "Substance use disorder treatment services" shall have the meaning as defined in subdivision (c) of Section 5891. 5.

(3) "Supportive services" shall have the meaning as defined in subdivision (h) of Section 5887.

(e) This act shall not be construed to modify or reduce a health plan's obligations under the Knox-Keene Health Care Service Plan Act of 1975.

(f) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 82. Section 5881 of the Welfare and Institutions Code is amended to read:

5881. (a) Evaluation shall be conducted by participating county evaluation staff and, subject to the availability of funds, by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.

(b) Evaluation at both levels shall do all of the following:

(1) Ensure that county level systems of care are serving the targeted population.

(2) Ensure that the timely performance data related to client outcome and cost avoidance is collected, analyzed, and reported.

(3) Ensure that system of care components are implemented as intended.

(4) Provide information documenting needs for future planning.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 83. Section 5881 is added to the Welfare and Institutions Code, to read:

5881. (a) Evaluation shall be conducted by participating county evaluation staff and, subject to the availability of funds, by the State Department of Health Care Services and the Behavioral Health Services Oversight and Accountability Commission.

(b) Evaluation at both levels shall do all of the following:

(1) Ensure county level systems of care are serving the targeted population.

(2) Ensure the timely performance data related to client outcome and cost avoidance is collected, analyzed, and reported.

(3) Ensure system of care components are implemented as intended.

(4) Provide information documenting needs for future planning.

(c) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 84. Section 5886 of the Welfare and Institutions Code is amended to read:

5886. (a) The Mental Health Student Services Act is hereby established as a mental health partnership grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Mental Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities. Subject to an appropriation for this purpose, commencing with the 2021–22 fiscal year, the commission shall award a grant under this section to a county mental health or behavioral health department or another lead agency, as identified by the partnership within each county that meets the requirements of this section.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application. The county, city, or multicounty department, or consortium, shall be the grantee and receive any grant funds awarded pursuant to this section even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for awarding funds under the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children from their homes.

(viii) Involuntary mental health detentions.

(4) That the plan includes a description of the following:

(A) The need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) How the partnership will collaborate with preschool and childcare providers, or other early childhood service organizations, to ensure the mental health needs of children are met before and after they transition to a school setting.

(E) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of schoolage youth in participating educational entities when determining grant amounts. In determining the distribution of funds appropriated in the 2021–22 fiscal year, the commission shall take into consideration any previous funding the grantee received under this section.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) If the commission is unable to provide a grant to a partnership in a county because of a lack of applicants or because no applicants met the minimum requirements within the timeframes established by the commission, the commission may redistribute those funds to other eligible grantees.

(i) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(j) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(k) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall 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, and provide an updated report no later than March 1, 2024. The reports shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the schoolage children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) The reports to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(l) This section does not require the use of funds allocated for the purpose of satisfying the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(m) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis in order to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(n) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(o) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 85. Section 5886 is added to the Welfare and Institutions Code, to read:

5886. (a) The Behavioral Health Student Services Act is hereby established as a mental health partnership grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Behavioral Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities. Subject to an appropriation for this purpose, commencing with the 2021–22 fiscal year, the commission shall award a grant under this section to a county mental health or behavioral health department, or another lead agency, as identified by the partnership within each county that meets the requirements of this section.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) (A) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application.

(B) The county, city, or multicounty department, or consortium, shall be the grantee and receive grant funds awarded pursuant to this section, even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for awarding funds under the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to, all of the following:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children and youth from their homes.

(viii) Involuntary mental health detentions.

(4) That plans include a description of the following:

(A) The need for mental health services for children and youth, including campus-based mental health services and potential gaps in local service connections.

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) How the partnership will collaborate with preschool and childcare providers, or other early childhood service organizations, to ensure the mental health needs of children are met before and after they transition to a school setting.

(E) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as LGBTQ+, victims of domestic violence and sexual abuse, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) (1) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of schoolage youth in participating educational entities when determining grant amounts.

(2) In determining the distribution of funds appropriated in the 2021–22 fiscal year, the commission shall take into consideration previous funding the grantee received under this section.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) If the commission is unable to provide a grant to a partnership in a county because of a lack of applicants or because no applicants met the minimum requirements within the timeframes established by the commission, the commission may redistribute those funds to other eligible grantees.

(i) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(j) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(k) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall 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, and provide an updated report no later than March 1, 2024. The reports shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the schoolage children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) The reports to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(l) This section does not require the use of funds allocated for the purpose of satisfying the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(m) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement this section.

(n) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(o) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 86. Part 4.1 (commencing with Section 5887) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.1. Full-Service Partnership

5887. (a) Each county shall establish and administer a full service partnership program that include the following services:

(1) Mental health services, supportive services, and substance use disorder treatment services.

(2) Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services. Counties with a population of less than 200,000 may request an exemption from these requirements. Exemption requests shall be subject to approval by the State Department of Health Care Services. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process.

(3) Assertive field-based initiation for substance use disorder treatment services, including the provision of medications for addiction treatment, as specified by the State Department of Health Care Services.

(4) Outpatient behavioral health services, either clinic or field based, necessary for the ongoing evaluation and stabilization of an enrolled individual.

(5) Ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services, including services to support maintaining housing.

(6) Other evidence-based services and treatment models, as specified by the State Department of Health Care Services.

(7) The service planning process pursuant to Sections 5806 or 5868 and all services identified during the applicable process.

(8) Housing interventions pursuant to Section 5830.

(b) (1) (A) Full-service partnership services shall be provided pursuant to a whole-person approach that is trauma informed, age appropriate, and in partnership with families or an individual's natural supports.

(B) These services shall be provided in a streamlined and coordinated manner so as to reduce any barriers to services.

(2) Full-service partnership services shall support the individual in the recovery process, reduce health disparities, and be provided for the length of time identified during the service planning process pursuant to Sections 5806 and 5868.

(c) Full-service partnership programs shall employ community-defined evidence practices, as specified by the State Department of Health Care Services.

(d) (1) Full-service partnership programs shall enroll eligible adults and older adults, as defined in Section 5892, who meet the priority population criteria specified in subdivision (c) of Section 5892 and other criteria, as specified by the State Department of Health Care Services.

(2) Full-service partnership programs shall enroll eligible children and youth, as defined in Section 5892.

(e) Full-service partnership programs shall have an established standard of care with levels based on an individual's acuity and criteria for step-down into the least intensive level of care, as specified by the State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, providers, and other stakeholders.

(f) All behavioral health services, as defined in subdivision (j) of Section 5891.5, and supportive services provided to a client enrolled in a full-service partnership shall be paid from the funds allocated pursuant to paragraph (2) of subdivision (a) of Section 5892, subject to Section 5891.

(g) (1) The clinical record of each client participating in a full service partnership program shall describe all services identified during the service planning process pursuant to Sections 5806 and 5868 that are provided to the client pursuant to this section.

(2) The State Department of Health Care Services may develop and revise documentation standards for service planning to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(3) Documentation of the service planning process in the client's clinical record pursuant to paragraph (1) may fulfill the documentation requirements for both the Medi-Cal program and this section.

(h) For purposes of this part, the following definitions shall apply:

(1) "Community-defined evidence practices" means an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(2) "Substance use disorder treatment services" means those services as defined in subdivision (c) of Section 5891.5.

(3) "Supportive services" means those services necessary to support clients' recovery and wellness, including, but not limited to, food, clothing, linkages to needed social services, linkages to programs administered by the federal Social Security Administration, vocational and education-related services, employment assistance, including supported employment, psychosocial rehabilitation, family engagement, psychoeducation, transportation assistance, occupational therapy provided by an occupational therapist, and group and individual activities that promote a sense of purpose and community participation.

(i) This section shall be implemented only to the extent that funds are provided from the Behavioral Health Services Fund for purposes of this section. This section does not obligate the counties to use funds from any other source for services pursuant to this section.

5887.1. This part shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 87. Section 5890 of the Welfare and Institutions Code is amended to read:

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) Part 3.9 (commencing with Section 5849.1), No Place Like Home Program.

(5) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) The establishment of this fund and any other provisions of the act establishing it or the programs funded shall not be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code,

related to mental health parity. This act shall not be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) This act shall not be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method of Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining copayments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

(f) (1) The Supportive Housing Program Subaccount is hereby created in the Mental Health Services Fund. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount are reserved and continuously appropriated, without regard to fiscal years, to the California Health Facilities Financing Authority to provide funds to meet its financial obligations pursuant to any service contracts entered into pursuant to Section 5849.35. Notwithstanding any other law, including any other provision of this section, no later than the last day of each month, the Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month, transfer from the Mental Health Services Fund to the Supportive Housing Program Subaccount an amount that has been certified by the California Health Facilities Financing Authority pursuant to paragraph (3) of subdivision (a) of Section 5849.35, but not to exceed an aggregate amount of one hundred forty million dollars ($140,000,000) per year. If, in any month, the amounts in the Mental Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount certified by the California Health Facilities Financing Authority, the shortfall shall be carried over to the next month, to be transferred by the Controller with any transfer required by the preceding sentence. Moneys in the Supportive Housing Program Subaccount shall not be loaned to the General Fund pursuant to Section 16310 or 16381 of the Government Code.

(2) Prior to the issuance of any bonds pursuant to Section 15463 of the Government Code, the Legislature may appropriate for transfer funds in the Mental Health Services Fund to the Supportive Housing Program Subaccount in an amount up to one hundred forty million dollars ($140,000,000) per year. Any amount appropriated for transfer pursuant to this paragraph and deposited in the No Place Like Home Fund shall reduce the authorized but unissued amount of bonds that the California Health Facilities Financing Authority may issue pursuant to Section 15463 of the Government Code by a corresponding amount. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount transferred pursuant to this paragraph are reserved and continuously appropriated, without regard to fiscal years, for transfer to the No Place Like Home Fund, to be used for purposes of Part 3.9 (commencing with Section 5849.1). The Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month but after any transfer from the fund for purposes of paragraph (1), transfer moneys appropriated from the Mental Health Services Fund to the subaccount pursuant to this paragraph in equal amounts over the following 12-month period, beginning no later than 90 days after the effective date of the appropriation by the Legislature. If, in any month, the amounts in the Mental Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount appropriated for transfer pursuant to this paragraph, the shortfall shall be carried over to the next month.

(3) The sum of any transfers described in paragraphs (1) and (2) shall not exceed an aggregate of one hundred forty million dollars ($140,000,000) per year.

(4) Paragraph (2) shall become inoperative once any bonds authorized pursuant to Section 15463 of the Government Code are issued.

(g) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 88. Section 5890 is added to the Welfare and Institutions Code, to read:

5890. (a) (1) The Behavioral Health Services Fund is hereby created in the State Treasury.

(2) The fund shall be administered by the state.

(3) Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (e) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the programs, services, and other related activities as specified in Section 5892 and Part 3.9 (commencing with Section 5849.1), the No Place Like Home Program.

(b) (1) The establishment of this fund and other provisions of the act establishing it or the programs funded shall not be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for behavioral health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health and substance use disorder parity.

(2) This act does not modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) This act does not modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children and youth, adults, and older adults for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be determined in accordance with the Uniform Method of Determining Ability to Pay applicable to other publicly funded mental health and substance use disorder treatment services, unless this uniform method is replaced by another method of determining copayments, in which case the new method applicable to other mental health and substance use disorder treatment services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(f) (1) (A) The Supportive Housing Program Subaccount is hereby created in the Behavioral Health Services Fund.

(B) Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount are reserved and continuously appropriated, without regard to fiscal years, to the California Health Facilities Financing Authority to provide funds to meet its financial obligations pursuant to service contracts entered into pursuant to Section 5849.35.

(C) Notwithstanding any other law, including any other provision of this section, no later than the last day of each month, the Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month, transfer from the Behavioral Health Services Fund to the Supportive Housing Program Subaccount an amount that has been certified by the California Health Facilities Financing Authority pursuant to paragraph (3) of subdivision (a) of Section 5849.35 but not to exceed an aggregate amount of one hundred forty million dollars ($140,000,000) per year.

(D) If, in any month, the amounts in the Behavioral Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount certified by the California Health Facilities Financing Authority, the shortfall shall be carried over to the next month, to be transferred by the Controller with any transfer required by the preceding sentence.

(E) Moneys in the Supportive Housing Program Subaccount shall not be loaned to the General Fund pursuant to Section 16310 or 16381 of the Government Code.

(2) (A) Prior to the issuance of any bonds pursuant to Section 15463 of the Government Code, the Legislature may appropriate for transfer funds in the Behavioral Health Services Fund to the Supportive Housing Program Subaccount in an amount up to one hundred forty million dollars ($140,000,000) per year.

(B) Any amount appropriated for transfer pursuant to this paragraph and deposited in the No Place Like Home Fund shall reduce the authorized but unissued amount of bonds that the California Health Facilities Financing Authority may issue pursuant to Section 15463 of the Government Code by a corresponding amount.

(C) Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount transferred pursuant to this paragraph are reserved and continuously appropriated, without regard to fiscal years, for transfer to the No Place Like Home Fund, to be used for purposes of Part 3.9 (commencing with Section 5849.1).

(D) The Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month but after any transfer from the fund for purposes of paragraph (1), transfer moneys appropriated from the Behavioral Health Services Fund to the subaccount pursuant to this paragraph in equal amounts over the following 12-month period, beginning no later than 90 days after the effective date of the appropriation by the Legislature.

(E) If, in any month, the amounts in the Behavioral Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount appropriated for transfer pursuant to this paragraph, the shortfall shall be carried over to the next month.

(3) The sum of any transfer described in paragraphs (1) and (2) shall not exceed an aggregate of one hundred forty million dollars ($140,000,000) per year.

(4) Paragraph (2) shall become inoperative once bonds authorized pursuant to Section 15463 of the Government Code are issued.

(g) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 89. Section 5891 of the Welfare and Institutions Code is amended to read:

5891. (a) (1) (A) The funding established pursuant to this act shall be utilized to expand mental health services.

(B) Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services.

(C) The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act.

(D) The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk.

(E) These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892. These funds may not be used to pay for any other program.

(F) These funds may not be loaned to the General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Sections 5890 and 5892.

(2) To maximize federal financial participation in furtherance of subdivision (d) of Section 5890, a county shall submit claims for reimbursement to the State Department of Health Care Services in accordance with applicable Medi-Cal rules and procedures for a behavioral health service or supportive service eligible for reimbursement pursuant to Title XIX or XXI of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq. and 1397aa, et seq.) when such service is paid, in whole or in part, using the funding established pursuant to this act.

(3) (A) To maximize funding from other sources, a county shall seek reimbursement for a behavioral health service, supportive service, housing intervention, or other related activity provided, pursuant to subdivision (a) of Section 5892, that is covered by or can be paid from another available funding source, including other mental health funds, substance use disorder funds, public and private insurance, and other local, state, and federal funds. This paragraph does not require counties to exhaust other funding sources before using behavioral health services fund moneys to pay for a service-related activity.

(B) A county shall make a good faith effort to enter into contracts, single case agreements, or other agreements to obtain reimbursement with health care service plans and disability insurance plans, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code.

(C) A county shall also submit requests for prior authorization for services, request letters of agreement for payment as an out-of-network provider, and pursue other means to obtain reimbursement in accordance with state and federal laws.

(b) (1) Notwithstanding subdivision (a), and except as provided in paragraph (2), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (f) of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).

(d) (1) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847.

(2) This subdivision does not affect subdivision (a) or (b).

(e) This act shall not be construed to modify or reduce a health plan's obligations under the Knox-Keene Health Care Service Plan Act of 1975.

(f) This section shall become operative immediately if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(g) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 90. Section 5891 is added to the Welfare and Institutions Code, to read:

5891. (a) (1) (A) The funding established pursuant to this act shall be utilized by counties to expand mental health and substance use disorder treatment services.

(B) These funds shall not be used to supplant existing state or county funds utilized to provide mental health services or substance use disorder treatment services.

(C) The state shall continue to provide financial support for mental health and substance use disorder programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act.

(D) The state shall not make a change to the structure of financing mental health and substance use disorder treatment services that increases a county's share of costs or financial risk for behavioral health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk.

(E) These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892.

(F) These funds may not be used to pay for another program.

(G) These funds may not be loaned to the General Fund or another fund of the state, a county general fund, or another county fund for any purpose other than those authorized by Sections 5890 and 5892.

(2) To maximize federal financial participation in furtherance of subdivision (d) of Section 5890, a county shall submit claims for reimbursement to the State Department of Health Care Services in accordance with applicable Medi-Cal rules and procedures for a

behavioral health service or supportive service eligible for reimbursement pursuant to Title XIX or XXI of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq. and 1397aa, et seq.) when such service is paid, in whole or in part, using the funding established pursuant to this act.

(3) (A) To maximize funding from other sources, a county shall seek reimbursement for a behavioral health service, supportive service, housing intervention, or other related activity provided, pursuant to subdivision (a) of Section 5892, that is covered by or can be paid from another available funding source, including other mental health funds, substance use disorder funds, public and private insurance, and other local, state, and federal funds. This paragraph does not require counties to exhaust other funding sources before using behavioral health services fund moneys to pay for a service or related activity.

(B) A county shall make a good faith effort to enter into contracts, single case agreements, or other agreements to obtain reimbursement with health care service plans and disability insurance plans, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code.

(C) A county shall also submit requests for prior authorization for services, request letters of agreement for payment as an out-of-network provider, and pursue other means to obtain reimbursement in accordance with state and federal laws.

(4) (A) A county may report to the Department of Managed Health Care or the Department of Insurance, as appropriate, complaints about a health plan's or a health insurer's failure to make a good faith effort to contract or enter into a single case agreement or other agreement with the county.

(B) A county may also report to the Department of Managed Health Care or the Department of Insurance, respectively, a failure by a health plan or insurer to timely reimburse the county for services the plan or insurer must cover as required by state or federal law, including, but not limited to, Sections 1374.72 and 1374.721 of the Health and Safety Code and Sections 10144.5 and 10144.52 of the Insurance Code.

(C) Upon receipt of a complaint from a county, the Department of Managed Health Care or the Department of Insurance, as applicable, shall timely investigate the complaint.

(b) (1) (A) Notwithstanding subdivision (a) and except as provided in paragraph (2), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(B) Those loans shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund.

(C) This subdivision does not authorize a transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (f) of Section 5890 or moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Behavioral Health Service Fund established by counties, pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Behavioral Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Section 5892.

(d) (1) A county shall base its expenditures on the county mental health and substance use disorder program's integrated plan or annual update as required by Section 5963.02 or intermittent update pursuant to subdivision (c) of Section 5963.03.

(2) This subdivision does not affect subdivision (a) or (b).

(e) Each year, the State Department of Health Care Services shall post on its internet website the methodology used for allocating revenue from the Behavioral Health Service Fund to the counties.

(f) For purposes of this section, "behavioral health services" shall have the meaning as defined in subdivision (k) of Section 5892.

(g) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(h) For purposes of this section, "substance use disorder treatment services" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(i) For purposes of this section, "supportive services" shall have the meaning as defined in subdivision (h) of Section 5887.

(j) This act shall not be construed to modify or reduce a health plan's obligations under the Knox-Keene Health Care Service Plan Act of 1975.

(k) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 91. Section 5891.5 of the Welfare and Institutions Code is amended to read:

5891.5. (a) (1) The programs in paragraphs (1) to (3), inclusive, and paragraph (5) of subdivision (a) of Section 5890 may include substance use disorder treatment for children, adults, and older adults with cooccurring mental health and substance use disorders

who are eligible to receive mental health services pursuant to those programs. The MHSA includes persons with a serious mental disorder and a diagnosis of substance abuse in the definition of persons who are eligible for MHSA services in Sections 5878.2 and 5813.5, which reference paragraph (2) of subdivision (b) of Section 5600.3.

(2) Provision of substance use disorder treatment services pursuant to this section shall comply with all applicable requirements of the Mental Health Services Act.

(3) Treatment of cooccurring mental health and substance use disorders shall be identified in a county's three-year program and expenditure plan or annual update, as required by Section 5847.

(b) (1) When a person being treated for cooccurring mental health and substance use disorders pursuant to subdivision (a) is determined to not need the mental health services that are eligible for funding pursuant to the MHSA, the county shall refer the person receiving treatment to substance use disorder treatment services in a timely manner.

(2) Funding established pursuant to the MHSA may be used to assess whether a person has cooccurring mental health and substance use disorders and to treat a person who is preliminarily assessed to have cooccurring mental health and substance use disorders, even when the person is later determined not to be eligible for services provided with funding established pursuant to the MHSA.

(c) A county shall report to the department, in a form and manner determined by the department, both of the following:

(1) The number of people assessed for cooccurring mental health and substance use disorders.

(2) The number of people assessed for cooccurring mental health and substance use disorders who were ultimately determined to have only a substance use disorder without another cooccurring mental health condition.

(d) The department shall by January 1, 2022, and each January 1 thereafter, publish on its internet website a report summarizing county activities pursuant to this section for the prior fiscal year. Data shall be reported statewide and by county or groupings of counties, as necessary to protect the private health information of persons assessed.

(e) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(2) On or before July 1, 2025, the department shall adopt regulations necessary to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 92. Section 5891.5 is added to the Welfare and Institutions Code, to read:

5891.5. (a) (1) Notwithstanding any other law, the programs and services and supports in paragraphs (1), (2), and (3) of subdivision (a) of Section 5892 may include substance use disorder treatment services, as defined in this section for children, youth, adults, and older adults.

(2) Notwithstanding Section 5830, the provision of housing interventions to individuals with a substance use disorder shall be optional for counties.

(3) Counties that provide substance use disorder treatment services shall provide all forms of federal Food and Drug Administration approved medications for addiction treatment.

(4) Funding established pursuant to the Behavioral Health Services Act may be used to assess whether a person has a substance use disorder and to treat a person prior to a diagnosis of a substance use disorder, even when the person is later determined not to be eligible for services provided with funding established pursuant to the Behavioral Health Services Act.

(5) Substance use disorder treatment services shall be identified in a county's integrated plan or annual update, as required by Section 5963.02.

(b) (1) A county shall report to the department data and information regarding implementation of this section specified by the department.

(2) The data and information shall be reported in a form, manner, and frequency determined by the department.

(c) (1) For purposes of this section, "substance use disorder" means an adult, child, or youth who has at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.

(2) For purposes of this section, "substance use disorder treatment services" include harm reduction, treatment, and recovery services, including federal Food and Drug Administration approved medications.

(d) (1) The department shall, by January 1, 2022, and each January 1 thereafter, publish on its internet website a report summarizing county activities pursuant to this section for the prior fiscal year.

(2) Data shall be reported statewide and by county or groupings of counties, as necessary to protect the private health information of persons assessed.

(e) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 93. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1 (commencing with Section 5820).

(2) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent for capital facilities and technological needs shall be distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to persons with severe mental illness in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850), shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) (1) In any fiscal year after the 2007–08 fiscal year, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

(2) A county shall calculate an amount it establishes as the prudent reserve for its Local Mental Health Services Fund, not to exceed 33 percent of the average community services and support revenue received for the fund in the preceding five years. The county shall reassess the maximum amount of this reserve every five years and certify the reassessment as part of the three-year program and expenditure plan required pursuant to Section 5847.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may allow counties to determine the percentage of funds to allocate across programs created pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care for the 2020–21 and 2021–22 fiscal years by means of all-county letters or other similar instructions without taking further regulatory action.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(e) In the 2004–05 fiscal year, funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820).

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future fiscal years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) (A) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until three years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(3) Notwithstanding paragraph (1), funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) (A) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until five years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(i) Notwithstanding subdivision (h) and Section 5892.1, unspent funds allocated to a county, and interest accruing on those funds, which are subject to reversion as of July 1, 2019, and July 1, 2020, shall be subject to reversion on July 1, 2021.

(j) If there are revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

(k) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 94. Section 5892 is added to the Welfare and Institutions Code, to read:

5892. (a) To promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(2) The expenditure for prevention and early intervention may be increased in a county in which the department determines that the increase will decrease the need and cost for additional services to persons with severe mental illness in that county by an amount at least commensurate with the proposed increase.

(3) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(4) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5963.03.

(b) (1) Programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

(2) A county shall calculate a maximum amount it establishes as the prudent reserve for its Local Behavioral Health Services Fund, not to exceed 33 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

(3) A county with a population of less than 200,000 shall calculate a maximum amount it establishes as the prudent reserve for its Local Behavioral Health Services Fund, not to exceed 25 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

(c) Notwithstanding subdivision (a) of Section 5891, the allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Sections 5847 and 5963.03. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the Local Behavioral Health Services Fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(d) (1) Notwithstanding subdivision (a) of Section 5891, the allocations pursuant to subdivision (a) may include funding to improve plan operations, quality outcomes, fiscal and programmatic data reporting, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants.

(2) The total of these costs shall not exceed 2 percent of the total of annual revenues received for the Local Behavioral Health Services Fund.

(3) A county may commence use of funding pursuant to this paragraph on July 1, 2025.

(e) (1) (A) Prior to making the allocations pursuant to subdivisions (a), (b), (c), and (d), funds shall be reserved for state directed purposes for the California Health and Human Services Agency, the State Department of Health Care Services, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, the Behavioral Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency.

(B) These costs shall not exceed 5 percent of the total of annual revenues received for the fund.

(C) The costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services.

(D) The amounts allocated for state directed purposes shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(E) The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(2) Prior to making the allocations pursuant to subdivisions (a), (b), (c), and (d), funds shall be reserved for the costs of the Department of Health Care Access and Information to administer a behavioral health workforce initiative in collaboration with the California Health and Human Services Agency. Funding for this purpose shall not exceed thirty-six million dollars. The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future fiscal years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) (A) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until three years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(3) Notwithstanding paragraph (1), funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) (A) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until five years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(i) Notwithstanding subdivision (h) and Section 5892.1, unspent funds allocated to a county, and interest accruing on those funds, which are subject to reversion as of July 1, 2019, and July 1, 2020, shall be subject to reversion on July 1, 2021.

(j) If there are revenues available in the fund after the State Department of Health Care Services has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, the department, in consultation with counties, shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the department's plan that furthers the purposes of this act.

(k) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(l) This section shall become inoperative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 95. Section 5892 is added to the Welfare and Institutions Code, to read:

5892. (a) To promote efficient implementation of this act, subject to subdivision (c), the county shall use funds distributed from the Behavioral Health Services Fund as follows:

(1) (A) (i) Thirty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for housing interventions programs pursuant to Part 3.2 (commencing with Section 5830).

(ii) Of the funds distributed pursuant to clause (i), 50 percent shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

(iii) Of the funds distributed to pursuant clause (i), no more than 25 percent may be used for capital development projects pursuant to paragraph (2) of subdivision (b) of Section 5830.

(B) Commencing with the 2026–29 fiscal years' county integrated plan, pursuant to Section 5963.02, and ongoing thereafter, for counties with a population of less than 200,000, the State Department of Health Care Services shall establish criteria and a process for approving county requests for an exemption from subparagraph (A) that considers factors including a county's homeless population, the number of individuals receiving Medi-Cal specialty behavioral health services or substance use disorder treatment services in another county, and other factors as determined by the State Department of Health Care Services. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process. Requests for approval of an exemption under this subparagraph shall be responded to, approved, or denied within 30 days of receipt by the department, or shall otherwise be deemed approved by the department.

(C) Commencing with the 2032–35 fiscal years' county integrated plan, pursuant to Section 5963.02, and ongoing thereafter, the State Department of Health Care Services may establish criteria and a process for approving county requests for an exemption from subparagraph (A) that considers the factors set forth in subparagraph (B), regardless of the population size of the county. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process.

(2) (A) Thirty-five percent of the funds distributed to counties pursuant to subdivision (c) of Section 5891 shall be used for full-service partnership programs pursuant to Part 4.1 (commencing with Section 5887).

(B) Commencing with the 2032–35 fiscal years' county integrated plan, pursuant to Section 5963.02, and ongoing thereafter, the State Department of Health Care Services may establish criteria and a process for approving requests for an exemption from subparagraph (A) that considers factors such as county population, client counts, and other factors as determined by the State Department of Health Care Services. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process.

(C) Housing interventions provided to individuals enrolled in full-service partnership programs shall be funded pursuant to subparagraph (A) of paragraph (1).

(3) (A) Thirty-five percent of the funds distributed to counties pursuant to subdivision (c) of Section 5891 shall be used for the following Behavioral Health Services and Supports:

(i) Services pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care, excluding those services specified in paragraphs (1) and (2).

(ii) Early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(iii) Outreach and engagement.

(iv) Workforce education and training.

(v) Capital facilities and technological needs.

(vi) Innovative behavioral health pilots and projects.

(B) (i) A county shall utilize at least 51 percent of Behavioral Health Services and Supports funding for early intervention programs.

(ii) A county shall utilize at least 51 percent of the county's funding allocated for early intervention programs to serve individuals who are 25 years of age and younger.

(iii) A county shall comply with other funding allocations specified by the State Department of Health Care Services for the purposes listed in subparagraph (A).

(4) (A) A county may pilot and test innovative behavioral health models of care programs or innovative promising practices for the programs specified in paragraphs (1), (2), and (3).

(B) The goal of these innovative pilots and innovative promising practices is to build the evidence base for the effectiveness of new statewide strategies.

(5) The programs established pursuant to paragraphs (1), (2), (3), and (4) shall include services to address the needs of eligible children and youth, 0 to 5 years of age, inclusive, transition age youth, and foster youth.

(6) A county is only obligated to fund the programs established pursuant to paragraphs (1) to (4), inclusive, with the funds it receives pursuant to subdivision (c) of Section 5891.

(b) (1) A county shall establish and maintain a prudent reserve to ensure county programs are able to continue to meet the needs of children and youth, adults, and older adults participating in housing intervention programs pursuant to paragraph (1) of subdivision (a), full-service partnership programs pursuant to paragraph (2) of subdivision (a), and receiving services pursuant to clauses (i), (ii), and (iii) of paragraph (3) of subdivision (a), during years in which revenues for the Behavioral Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(2) Notwithstanding the allocation percentages specified in paragraphs (1), (2), and (3) of subdivision (a), a county may transfer funds into the prudent reserve from housing intervention programs pursuant to paragraph (1) of subdivision (a), full-service partnership programs pursuant to paragraph (2) of subdivision (a), and Behavioral Health Services and Supports pursuant to paragraph (3) of subdivision (a).

(3) A county shall calculate a maximum amount it establishes as the prudent reserve for its Local Behavioral Health Services Fund, not to exceed 20 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

(4) A county with a population of less than 200,000 shall calculate a maximum amount it establishes as the prudent reserve for its Local Behavioral Health Services Fund, not to exceed 25 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

(5) (A) A county shall assess the maximum amount of its prudent reserve pursuant to paragraphs (3) and (4) every three years and shall include a plan for the expenditure of funds exceeding the maximum amount in the county's integrated plan required pursuant to Section 5963.02.

(B) A county shall spend funds exceeding the maximum amount on programs and services authorized in paragraphs (1), (2), and (3) of subdivision (a).

(6) (A) A county shall spend prudent reserve funds on the programs and services authorized in paragraphs (1) and (3), and clauses (i), (ii), and (iii) of paragraph (3) of subdivision (a).

(B) A county shall not spend prudent reserve funds for the purposes specified in paragraph (2) of subdivision (b) of Section 5830.

(c) (1) A county may transfer up to 14 percent of the total funds allocated to the county in a fiscal year between one or more of the purposes authorized in paragraphs (1), (2) and (3) of subdivision (a). A county shall not decrease the allocation for any one of the purposes authorized in paragraph (1), (2) or (3) by more than 7 percent of the total funds allocated to the county in a fiscal year. County changes to the allocation percentages specified in paragraphs (1), (2), and (3) of subdivision (a) shall be subject to the approval of the State Department of Health Care Services.

(2) A county changing its allocation percentages pursuant to this subdivision does not relieve the county from the obligation to comply with any applicable laws, including, but not limited to, clauses (ii) and (iii) of subparagraph (A) of paragraph (1), and paragraphs (3) and (5), of subdivision (a).

(3) A county shall include proposed changes to the allocation percentages in the county integrated plan pursuant to Section 5963.02, and shall consult with local stakeholders pursuant to Section 5963.03.

(4) A county shall submit a request to shift funding allocation to the State Department of Health Care Services for approval after fulfilling the integrated planning and local stakeholder consultation requirements pursuant to Sections 5963.02 and 5963.03. The

county shall submit the request for approval in a form and manner, and in accordance with timelines, prescribed by the department. Counties shall provide any other information, records, and reports that the department deems necessary for the purposes of this subdivision. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient approval process. Requests for approval of a shift under this subparagraph shall be responded to, approved, or denied within 30 days of receipt by the department, or shall otherwise be deemed approved by the department.

(A) The department shall review a county's request based on the county's compliance with paragraphs (1) and (2) and demonstration that the requested shift is responsive to local priorities, based on, at a minimum, local data and community input in the planning process.

(B) The State Department of Health Care Services may approve a proposed shift in funding allocations for the current integrated planning period based upon data and information a county submits demonstrating the need for the adjustment.

(C) Unless an annual change is approved by the State Department of Health Care Services, approved allocation adjustments are irrevocable during the applicable three-year period and a county shall not adjust the allocation of funds in the county's subsequent annual and intermittent updates to the county's integrated plan. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association on reasonable criteria for such requests and a timely and efficient approval process. Requests for approval of a change under this subparagraph shall be responded to, approved, or denied within 30 days of receipt by the department, or shall otherwise be deemed approved by the department.

(d) The programs established pursuant to subdivision (a) shall prioritize services for the following populations:

(1) Eligible adults and older adults, as defined in subdivision (k), who satisfy one of the following:

(A) Are chronically homeless or experiencing homelessness or are at risk of homelessness.

(B) Are in, or are at risk of being in, the justice system.

(C) Are reentering the community from prison or jail.

(D) Are at risk of conservatorship pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5.

(E) Are at risk of institutionalization.

(2) Eligible children and youth, as defined in subdivision (k), who satisfy one of the following:

(A) Are chronically homeless or experiencing homelessness or are at risk of homelessness.

(B) Are in, or at risk of being in, the juvenile justice system.

(C) Are reentering the community from a youth correctional facility.

(D) Are in the child welfare system pursuant to Section 300, 601, or 602.

(E) Are at risk of institutionalization.

(e) (1) (A) Notwithstanding subdivision (a) of Section 5891, the allocations pursuant to subdivision (a) shall include funding for annual planning costs pursuant to Sections 5963.02 and 5963.03.

(B) The total of these costs shall not exceed 5 percent of the total of annual revenues received for the Local Behavioral Health Services Fund.

(C) The planning costs shall include funds for county mental health and substance use disorder programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process.

(2) (A) Notwithstanding subdivision (a) of Section 5891, the allocations pursuant to subdivision (a) may include funding to improve plan operations, quality outcomes, fiscal and programmatic data reporting pursuant to Section 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants.

(B) The total of the costs in subparagraph (A) shall not exceed 2 percent of the total of annual revenues received for the Local Behavioral Health Services Fund. For counties with a population of less than 200,000, the total of the costs in subparagraph (A) shall not exceed 4 percent of the total annual revenues received from the Local Behavioral Health Services Fund.

(C) A county may commence use of funding pursuant to this paragraph on July 1, 2025.

(D) Notwithstanding any other law, new costs to implement this article that exceed existing county obligations and are in excess of the funds provided by subparagraph (B) of paragraph (2) of subdivision (e) shall be evaluated by the State Department of Health Care Services for inclusion in the Governor's 2024–25 May Revision. The department shall consult with the California State Association of Counties and the County Behavioral Health Directors Association of California, no later than March 15, 2024, to evaluate the resources needed to implement this article.

(f) (1) Notwithstanding subdivision (a) of Section 5891, prior to making the allocations pursuant to subdivisions (a), (b), (d), and (e), funds shall be reserved for:

(A) State directed purposes consistent with the Behavioral Health Services Act, for the California Health and Human Services Agency, State Department of Health Care Services, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, the Behavioral Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency.

(B) The costs to assist consumers and family members so that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services.

(C) The costs for research and evaluation regarding the effectiveness of programs and services listed in subdivision (a) and achievement of the outcome measures and metrics pursuant to subdivision (d) of Section 5897.

(D) (i) The costs of the Department of Health Care Access and Information to implement a behavioral health workforce initiative. The cost for this initiative shall be a minimum of 3 percent of the total funds allocated pursuant to this subdivision.

(ii) This initiative shall be developed in consultation with stakeholders, including, but not limited to, behavioral health professionals, counties, behavioral health education and training programs, and behavioral health consumer advocates. The initiative shall focus on efforts to build and support the workforce to meet the need to provide holistic and quality services and support the development and implementation of strategies for training, supporting, and retaining the county behavioral health workforce and noncounty contracted behavioral health workforce, including efforts to increase the racial, ethnic, and linguistic diversity of behavioral health providers and increase access to behavioral health providers in geographically underserved areas.

(iii) A portion of the workforce initiative may focus on providing technical assistance and support to county contracted providers to implement and maintain workforce provisions that support the stabilization and retention of the broad behavioral health workforce.

(iv) A portion of the workforce initiative may focus on providing technical assistance and support to county and contracted providers to maximize the use of peer support specialists.

(E) The costs for the State Department of Public Health to provide population-based mental health and substance use disorder prevention programs. A minimum of 4 percent of the total funds allocated pursuant to this subdivision shall be distributed to the State Department of Public Health for this purpose. Of these funds, at least 51 percent shall be used for programs serving populations who are 25 years of age or younger. The State Department of Public Health shall consult with the State Department of Health Care Services and the Behavioral Health Services Oversight and Accountability Commission to ensure the provision of these programs.

(i) Population-based prevention programs are activities designed to reduce the prevalence of mental health and substance use disorders and resulting conditions.

(ii) Population-based prevention programs shall incorporate evidence-based promising or community-defined evidence practices and meet one or more of the following conditions:

(I) Target the entire population of the state, county, or particular community to reduce the risk of individuals developing a mental health or substance use disorder.

(II) Target specific populations at elevated risk for a mental health, substance misuse, or substance use disorder.

(III) Reduce stigma associated with seeking help for mental health challenges and substance use disorders.

(IV) Target populations disproportionately impacted by systemic racism and discrimination.

(V) Prevent suicide, self-harm, or overdose.

(iii) Population-based prevention programs may be implemented statewide or in community settings.

(iv) Population-based prevention programs shall not include the provision of early intervention, diagnostic, and treatment for individuals.

(v) Population-based prevention programs shall be provided on a schoolwide or classroom basis and may be provided by a community-based organization off campus or on school grounds.

(vi) School-based prevention supports and programs shall be provided at a school site or arranged for by a school on a schoolwide or classroom basis and shall not provide services and supports for individuals. These supports and programs may include, but are not limited to:

(I) School-based health centers, student wellness centers, or student wellbeing centers.

(II) Activities, including, but not limited to, group coaching and consultation, designed to prevent substance misuse, increase mindfulness, self-regulation, development of protective factors, calming strategies, and communication skills.

(III) Integrated or embedded school-based programs designed to reduce stigma associated with seeking help for mental health challenges and substance use disorders.

(IV) Student mental health first aid programs designed to identify and prevent suicide or overdose.

(V) Integrated training and systems of support for teachers and school administrators designed to mitigate suspension and expulsion practices and assist with classroom management.

(vii) Early childhood population-based prevention programs for children 0 to 5 years of age, inclusive, shall be provided in a range of settings.

(viii) Funding under this provision shall comply with Section 5891 and shall be used to strengthen population-based strategies and not supplant funding for services and supports for which ongoing funding is available through Children and Youth Behavioral Health Initiative or other sources.

(F) The Behavioral Health Services Act Innovation Partnership Fund as provided for in Section 5845.1. A maximum of twenty million dollars ($20,000,000) shall be deposited into the fund annually, for fiscal years 2026–27 to 2030–31, inclusive. Thereafter funding shall be determined through the annual budget act.

(G) At its discretion, the commission may utilize funding received in support of the Mental Health Wellness Act to support this section, consistent with subparagraph (F) of paragraph (2) of subdivision (g), and subdivision (h), of Section 5848.5.

(2) The costs for the purposes specified in paragraph (1) shall not exceed 10 percent of the total of annual revenues received for the State Behavioral Health Services Fund. The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(g) Each county shall place all funds received from the State Behavioral Health Services Fund in a local Behavioral Health Services Fund. The Local Behavioral Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future fiscal years.

(h) All expenditures for county behavioral health programs shall be consistent with a currently approved county integrated plan or annual update pursuant to Section 5963.02 or an intermittent update prepared pursuant to subdivision (c) of Section 5963.03.

(i) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) (A) The Controller shall revert funds by offsetting amounts from each monthly distribution to a county's Local Behavioral Health Service Fund pursuant to subdivision (c) of Section 5891, until the full amount of the reverted funds has been offset. The reverted funds shall be deposited into the Reversion Account for use, consistent with this section and Sections 5890, 5891 and 5891.5, as determined by the State Department of Health Care Services.

(B) Funds that have been reverted that are owed to a county as a result of an audit adjustment, or for other reasons, shall be paid from the Reversion Account. If the balance of funds in the Reversion Account is inadequate, funds owed to a county shall be offset from the monthly distributions to other counties pursuant to subdivision (c) of Section 5891, based on a methodology provided by the State Department of Health Care Services. Owed funds shall be paid to a county in the monthly distribution pursuant to subdivision (c) of Section 5891.

(C) If the State Department of Health Care Services withholds funds from a monthly distribution to a county pursuant to subdivision (e) of Section 5963.04, funds shall be reverted first and the remaining balance shall be withheld.

(3) Notwithstanding paragraph (1), funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(j) If there are revenues available in the fund after the State Department of Health Care Services has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, the department, in consultation with counties, shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the department's plan that furthers the purposes of this act.

(k) For purposes of this section, the following definitions shall apply:

(1) "Behavioral health services" means mental health services and substance use disorder treatment services, as defined in Section 5891.5.

(2) "Chronically homeless" means an individual or family that is chronically homeless, as defined in Section 11360 of Title 42 of the United States Code, or as otherwise modified or expanded by the State Department of Health Care Services.

(3) "Experiencing homelessness or are at risk of homelessness" means people who are homeless or at risk of homelessness, as defined in Section 91.5 of Title 24 of the Code of Federal Regulations, or as otherwise defined by the State Department of Health Care Services for purposes of the Medi-Cal program.

(4) "Outreach and engagement" means activities to reach, identify, and engage individuals and communities in the behavioral health system, including peers and families, and to reduce disparities. Counties may include evidence-based practices and community-defined evidence practices in the provision of activities.

(5) "Workforce education and training" includes, but is not limited to, the following for the county workforce:

(A) Workforce recruitment, development, training, and retention.

(B) Professional licensing and/or certification testing and fees.

(C) Loan repayment.

(D) Retention incentives and stipends.

(E) Internship and apprenticeship programs.

(F) Continuing education.

(G) Efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce.

(6) "Community-defined evidence practices" means an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(7) (A) "Eligible children and youth" means persons who are 25 years of age or under, including early childhood or transition age youth who do either of the following:

(i) Meet the criteria specified in subdivision (d) of Section 14184.402, notwithstanding age limitations.

(ii) Have a substance use disorder, as defined in subdivision (c) of Section 5891.5.

(B) Eligible children and youth are not required to be enrolled in the Medi-Cal program.

(8) (A) "Eligible adults and older adults" means persons who are 26 years of age or older who do either of the following:

(i) Meet the criteria specified in subdivision (c) of Section 14184.402.

(ii) Have a substance use disorder, as defined in subdivision (c) of Section 5891.5.

(B) Eligible adults and older adults are not required to be enrolled in the Medi-Cal program.

(l) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 96. Section 5892.1 of the Welfare and Institutions Code is amended to read:

5892.1. (a) All unspent funds subject to reversion pursuant to subdivision (h) of Section 5892 as of July 1, 2017, are deemed to have been reverted to the fund and reallocated to the county of origin for the purposes for which they were originally allocated.

(b) (1) The department shall, on or before July 1, 2018, in consultation with counties and other stakeholders, prepare a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated pursuant to Section 5892.

(2) Prior to the preparation of the report referenced in paragraph (1), the department shall provide to counties the amounts it has determined are subject to reversion, and provide a process for counties to appeal this determination.

(c) (1) By July 1, 2018, each county with unspent funds subject to reversion that are deemed reverted and reallocated pursuant to subdivision (a) shall prepare a plan to expend these funds on or before July 1, 2020. The plan shall be submitted to the commission for review.

(2) A county with unspent funds that are deemed reverted and reallocated pursuant to subdivision (a) that has not prepared and submitted a plan to the commission pursuant to paragraph (1) as of January 1, 2019, shall remit the unspent funds to the state pursuant to paragraph (1) of subdivision (h) of Section 5892 no later than July 1, 2019.

(d) Funds included in the plan required pursuant to subdivision (c) that are not spent as of July 1, 2020, shall revert to the state pursuant to paragraph (1) of subdivision (h) of Section 5892.

(e) Notwithstanding subdivision (d), innovation funds included in the plan required pursuant to subdivision (c) that are not spent by July 1, 2020, or the end of the project plan approved by the Mental Health Service Oversight and Accountability Commission pursuant to subdivision (e) of Section 5830, whichever is later, shall revert to the state pursuant to subdivision (h) of Section 5892.

(f) (1) The requirement for submitting a report imposed under subdivision (b) is inoperative on July 1, 2022, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to subdivision (b) shall be submitted in compliance with Section 9795 of the Government Code.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5899.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in

accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 97. Section 5892.1 is added to the Welfare and Institutions Code, to read:

5892.1. (a) All unspent funds subject to reversion pursuant to subdivision (i) of Section 5892 as of July 1, 2017, are deemed to have been reverted to the fund and reallocated to the county of origin for the purposes for which they were originally allocated.

(b) (1) The department shall, on or before July 1, 2018, in consultation with counties and other stakeholders, prepare a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated pursuant to Section 5892.

(2) Prior to the preparation of the report referenced in paragraph (1), the department shall provide to counties the amounts it has determined are subject to reversion and provide a process for counties to appeal this determination.

(c) (1) By July 1, 2018, each county with unspent funds subject to reversion that are deemed reverted and reallocated pursuant to subdivision (a) shall prepare a plan to expend these funds on or before July 1, 2020. The plan shall be submitted to the commission for review.

(2) A county with unspent funds that are deemed reverted and reallocated pursuant to subdivision (a) that has not prepared and submitted a plan to the commission pursuant to paragraph (1) as of January 1, 2019, shall remit the unspent funds to the state pursuant to paragraph (1) of subdivision (i) of Section 5892 no later than July 1, 2019.

(d) Funds included in the plan required pursuant to subdivision (c) that are not spent as of July 1, 2020, shall revert to the state pursuant to paragraph (1) of subdivision (i) of Section 5892.

(e) Notwithstanding subdivision (d), innovation funds included in the plan required pursuant to subdivision (c) that are not spent by July 1, 2020, or the end of the project plan approved by the Behavioral Health Service Oversight and Accountability Commission pursuant to subdivision (e) of Section 5830, whichever is later, shall revert to the state pursuant to subdivision (h) of Section 5892.

(f) (1) The requirement for submitting a report imposed under subdivision (b) is inoperative on July 1, 2022, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to subdivision (b) shall be submitted in compliance with Section 9795 of the Government Code.

(g) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking further regulatory action, may implement, interpret, or make specific this section, Section 5899.1, and subdivision (h) of Section 5892 by means of all-county letters or other similar instructions until applicable regulations are adopted in accordance with Section 5898 or until July 1, 2019, whichever occurs first.

(2) The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

(h) This section shall be operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 98. Section 5892.3 is added to the Welfare and Institutions Code, to read:

5892.3. (a) There is hereby created a Behavioral Health Services Act Revenue Stability Workgroup to assess year-over-year fluctuations in tax revenues generated by the Behavioral Health Services Act, in recognition of the need for a reliable strategy for short- and long-term fiscal stability, commencing no later than June 30, 2024.

(b) The workgroup shall develop and recommend solutions to reduce Behavioral Health Services Act revenue volatility and to propose appropriate prudent reserve levels to support the sustainability of county programs and services.

(c) (1) The California Health and Human Services Agency and the State Department of Health Care Services shall jointly convene and lead the workgroup.

(2) Members of the workgroup shall serve without compensation. Members shall include representatives from the following entities:

(A) Behavioral Health Services Oversight and Accountability Commission.

(B) Legislative Analyst's Office.

(C) County Behavioral Health Director's Association of California.

(D) California State Association of Counties, including both urban and rural county representatives.

(3) The California Department of Finance may consult with the workgroup, as needed, to provide technical assistance.

(d) The workgroup shall review and analyze current and historical revenues generated pursuant to the Mental Health Services Act and the Behavioral Health Services Act and current and historical prudent reserve levels to develop the recommendations specified in

subdivision (b).

(e) On or before June 30, 2025, the California Health and Human Services Agency and the State Department of Health Care Services shall submit a report that includes its recommendations specified in subdivision (b) to the Legislature and the Governor's Office.

(f) The workgroup may meet as often as necessary, as determined by the members of the workgroup, until the workgroup is disbanded upon submission of the report specified in subdivision (b).

(g) Prudent reserve requirements specified in this subdivision may be changed, and requirements to mitigate Behavioral Health Services Act revenue volatility and improve fiscal stability may be developed, based upon recommendations made by the Behavioral Health Services Act Revenue Stability Workgroup pursuant to Section 5892.3.

(h) The California Health and Human Services Agency and the State Department of Health Care Services may jointly reconvene the workgroup, if at any point the recommended revenue volatility strategy and prudent reserve requirements no longer adequately support the sustainability of county programs and services given the year-over-year fluctuations in tax revenues generated by the Behavioral Health Services Act.

SEC. 99. Section 5892.5 of the Welfare and Institutions Code is amended to read:

5892.5. (a) (1) The California Housing Finance Agency, with the concurrence of the State Department of Health Care Services, shall release unencumbered Mental Health Services Fund moneys dedicated to the Mental Health Services Act housing program upon the written request of the respective county. The county shall use these Mental Health Services Fund moneys released by the agency to provide housing assistance to the target populations who are identified in Section 5600.3.

(2) For purposes of this section, "housing assistance" means each of the following:

(A) Rental assistance or capitalized operating subsidies.

(B) Security deposits, utility deposits, or other move-in cost assistance.

(C) Utility payments.

(D) Moving cost assistance.

(E) Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.

(b) For purposes of administering those funds released to a respective county pursuant to subdivision (a), the county shall comply with all of the requirements described in the Mental Health Services Act, including, but not limited to, Sections 5664, 5847, subdivision (h) of Section 5892, and 5899.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 100. Section 5892.5 is added to the Welfare and Institutions Code, to read:

5892.5. (a) (1) The California Housing Finance Agency, with the concurrence of the State Department of Health Care Services, shall release unencumbered Behavioral Health Services Fund moneys dedicated to the Mental Health Services Act housing program upon the written request of the respective county.

(2) The county shall use these Behavioral Health Services Fund moneys released by the agency to provide housing interventions pursuant to Section 5830.

(b) For purposes of administering those funds released to a respective county pursuant to subdivision (a), the county shall comply with all of the requirements described in the Behavioral Health Services Act, including, but not limited to, Section 5664, Section 5963.02, subdivision (g) of Section 5892, and Section 5963.04.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 101. Section 5893 of the Welfare and Institutions Code is amended to read:

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The fund shall be increased by its share of the amount earned on investments.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 102. Section 5893 is added to the Welfare and Institutions Code, to read:

5893. (a) In a year that the funds available exceed the amount allocated to counties, the excess funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) (1) All funds deposited into the Behavioral Health Services Fund shall be invested in the same manner that other state funds are invested.

(2) The fund shall be increased by its share of the amount earned on investments.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by voters at the March 5, 2024, statewide primary election.

SEC. 103. Section 5895 of the Welfare and Institutions Code is amended to read:

5895. (a) If any provisions of Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 104. Section 5897 of the Welfare and Institutions Code is amended to read:

5897. (a) Notwithstanding any other state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) The department shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its internet website any plans of correction requested and the related findings.

(f) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890), may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 that are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 105. Section 5897 is added to the Welfare and Institutions Code, to read:

5897. (a) (1) Notwithstanding any other state law, the State Department of Health Care Services shall implement the programs and services specified in subdivision (a) of Section 5892, and related activities, through contracts with a county or counties acting jointly.

(2) A contract may be exclusive and may be awarded on a geographic basis.

(3) For purposes of this section, a "county" includes a city receiving funds pursuant to Section 5701.5.

(b) (1) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of programs and services pursuant to subdivision (a) of Section 5892.

(2) The agreement may encompass all or part of these programs and services.

(3) An agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall contract with counties, or counties acting jointly pursuant to subdivision (a), through the county performance contract as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) (1) The department shall conduct program reviews of performance contracts to determine compliance, including compliance with Sections 5963.02 and 5963.04.

(2) Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) (1) If a county behavioral health department is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements and take administrative action, including, but not limited to, the temporary withholding of funds and the imposition of monetary sanctions pursuant to Section 5963.04.

(2) The department shall post plans of correction requested and the related findings on its internet website.

(f) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, the Behavioral Health Services Oversight and Accountability Commission and the California Health and Human Services Agency to implement programs and services set forth in subdivision (a) of Section 5892 and programs pursuant to Part 3.1 (commencing with Section 5820) may be awarded in the same manner that contracts are awarded pursuant to Section 5814, and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 that are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

(h) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by voters at the March 5, 2024, statewide primary election.

SEC. 106. Section 5898 of the Welfare and Institutions Code is amended to read:

5898. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 107. Section 5898 is added to the Welfare and Institutions Code, to read:

5898. (a) (1) The State Department of Health Care Services shall develop regulations, as necessary, to implement this act.

(2) Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

(b) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 108. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) (1) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report.

(2) The instructions shall include a requirement that the county certify the accuracy of this report.

(3) With the exception of expenditures and receipts related to the capital facilities and technology needs component described in paragraph (6) of subdivision (d), each county shall adhere to uniform accounting standards and procedures that conform to the Generally Accepted Accounting Principles prescribed by the Controller pursuant to Section 30200 of the Government Code when accounting for receipts and expenditures of Mental Health Services Act (MHSA) funds in preparing the report.

(4) Counties shall report receipts and expenditures related to capital facilities and technology needs using the cash basis of accounting, which recognizes expenditures at the time payment is made.

(5) Each county shall electronically submit the report to the department and to the Mental Health Services Oversight and Accountability Commission.

(6) The department and the commission shall annually post each county's report in a text-searchable format on its internet website in a timely manner.

(b) The department, in consultation with the commission and the County Behavioral Health Directors Association of California, shall revise the instructions described in subdivision (a) by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.

(c) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of MHSA funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(d) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.

(2) Prevention and early intervention strategies.

(3) Innovative projects.

(4) Workforce education and training.

(5) Adults and older adults systems of care.

(6) Capital facilities and technology needs.

(e) If a county does not submit the annual revenue and expenditure report described in subdivision (a) by the required deadline, the department may withhold MHSA funds until the reports are submitted.

(f) A county shall also report the amount of MHSA funds that were spent on mental health services for veterans.

(g) By October 1, 2018, and by October 1 of each subsequent year, the department shall, in consultation with counties, publish on its internet website a report detailing funds subject to reversion by county and by originally allocated purpose. The report also shall include the date on which the funds will revert to the Mental Health Services Fund.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 109. Chapter 3 (commencing with Section 5963) is added to Part 7 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 3. Behavioral Health Modernization Act

Article 2. Behavioral Health Planning and Reporting

5963. (a) It is the intent of the Legislature that this article establish the Integrated Plan for Behavioral Health Services and Outcomes, which each county shall develop every three years to include all of the following:

(1) A demonstration of how the county will utilize various funds for behavioral health services to deliver high-quality, culturally responsive, and timely care along the continuum of services in the least restrictive setting from prevention and wellness in schools and other settings to community-based outpatient care, residential care, crisis care, acute care, and housing services and supports.

(2) A demonstration of how the county will use Behavioral Health Services Act funds to prioritize addressing the needs of those who meet both of the following:

(A) Chronically homeless, experiencing unsheltered homelessness, or are at risk of homelessness, are incarcerated or at risk of being incarcerated, are reentering the community from prison, jail, or a correctional facility, or at risk of institutionalization, conservatorship, or are in the child welfare or adult protective system.

(B) The criteria for eligible adults and older adults, as defined in Section 5892, or for eligible children and youth, as defined in Section 5892.

(3) A demonstration of how the county will strategically invest in early intervention and advancing behavioral health innovation.

(4) A demonstration of how the county has considered other local program planning efforts in the development of the integrated plan to maximize opportunities to leverage funding and services from other programs, including federal funding, Medi-Cal managed care, and commercial health plans.

(5) A demonstration of how the county will support and retain a robust, diverse county and noncounty contracted behavioral health workforce to achieve the statewide and local behavioral health outcome goals.

(6) A development process in partnership with local stakeholders.

(7) A set of measures used to track progress and hold counties accountable in meeting specific outcomes and goals of the integrated plan, including outcomes and goals that reduce disparities.

(8) Information for the state to consider, if necessary, to recommend changes to the county's integrated plan or requiring sanctions to a county's Behavioral Health Services Act funding as a result of a county not meeting its obligations or state outcome metrics.

(b) For purposes of this article, the following definitions apply:

(1) "Chronically homeless" means an individual or family that is chronically homeless, as defined in Section 11360 of Title 42 of the United States Code, or as otherwise modified or expanded by the State Department of Health Care Services.

(2) "Department" means the State Department of Health Care Services.

(3) "Experiencing homelessness or are at risk of homelessness" means people who are homeless or at risk of homelessness, as defined in Section 91.5 of Title 24 of the Code of Federal Regulations, or as otherwise defined by the department.

(4) "Integrated plan" means the Integrated Plan for Behavioral Health Services and Outcomes required by this section.

(c) Notwithstanding any other law, new and ongoing county and behavioral health agency administrative costs to implement this article and Section 14197.71, any costs for plan development required under this article that exceed the amounts set forth in subparagraph (B) of paragraph (1) of subdivision (e) of Section 5892, and any costs for reporting required by this article that exceed the amounts set forth in subparagraph (B) of paragraph (2) of subdivision (e) of Section 5892, shall be included in the Governor's 2024–25 May Revision. The State Department of Health Care Services shall consult with the California State Association of Counties and the County Behavioral Health Directors Association of California no later than March 15, 2024, to estimate the resources needed to implement this article and Section 14197.71.

5963.01. (a) A county shall work with each Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, that covers residents of the county on development of the managed care plan's population needs assessment.

(b) A county shall work with its local health jurisdiction on development of its community health improvement plan.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

5963.02. (a) (1) Each county shall prepare and submit an integrated plan and annual updates to the Behavioral Health Services Oversight and Accountability Commission and the department.

(2) All references to the three-year program and expenditure plan mean the integrated plan.

(3) Each county's board of supervisors shall approve the integrated plan and annual updates by June 30 prior to the fiscal year or years the integrated plan or update would cover.

(4) A county shall not use the integrated plan to demonstrate compliance with federal law, state law, or requirements imposed by the department related to programs listed in subdivision (c).

(b) (1) Each section of the integrated plan and annual update listed in subdivision (c) shall be based on available funding or obligations under Section 30025 of the Government Code and corresponding contracts for the applicable fiscal years and in accordance with established stakeholder engagement and planning requirements as required in Section 5963.03.

(2) A county shall consider relevant data sources, including local data, to guide addressing local needs, including the prevalence of mental health and substance use disorders, the unmet need for mental health and substance use disorder treatment in the county, behavioral health disparities, and the homelessness point-in-time count, in preparing each integrated plan and annual update, and should use the data to demonstrate how the plan appropriately allocates funding between mental health and substance use disorder treatment services.

(3) A county shall consider the population needs assessment of each Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, that covers residents of the county in preparing each integrated plan and annual update.

(4) A county shall consider the community health improvement plan of the local health jurisdiction for the county in preparing each integrated plan and annual update.

(5) A county shall stratify data to identify behavioral health disparities and consider approaches to eliminate disparities, including, but not limited to, promising practices, models of care, community-defined evidence practices, workforce diversity, and cultural responsiveness in preparing each integrated plan and annual update.

(6) A county shall report and consider the achievement of defined goals and outcomes measures of the prior integrated plan and annual update, in addition to other data and information as specified by the department pursuant to Section 5963.05, in preparing each integrated plan and annual update.

(7) A county with a population greater than 200,000 shall collaborate with the five most populous cities in the county, managed care plans, and continuums of care to outline respective responsibilities and coordination of services related to housing interventions described in Section 5830.

(8) A county shall consider input and feedback into the plan provided by stakeholders, including, but not limited to, those with lived behavioral health experience, including peers and families.

(c) The integrated plan and annual updates shall include a section for each of the following:

(1) (A) Community mental health services provided pursuant to Part 2 (commencing with Section 5600).

(B) Programs and services funded from the Behavioral Health Services Fund pursuant to Section 5890, including a description of how the county meets the requirements of paragraph (7) of subdivision (b).

(C) Programs and services funded by the Projects for Assistance in Transition from Homelessness grant pursuant to Sections 290cc-21 to 290cc-35, inclusive, of Title 42 of the United States Code.

(D) Programs and services funded by the Community Mental Health Services Block Grant pursuant to Sections 300x to 300x-9, inclusive, of Title 42 of the United States Code.

(E) Programs and services funded by the Substance Abuse Block Grant pursuant to Sections 300x-21 to 300x-35, inclusive, of Title 42 of the United States Code.

(F) Programs and services provided pursuant to Article 5 (commencing with Section 14680) of Chapter 8.8 of Part 3 of Division 9 and Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9.

(G) Programs and services provided pursuant to Article 3.2 (commencing with Section 14124.20) of Chapter 7 of Part 3 of Division 9.

(H) Programs and services provided pursuant to Section 14184.401.

(I) Programs and services funded by distributions from the Opioid Settlements Fund established pursuant to Section 12534 of the Government Code.

(J) Services provided through other federal grants or other county mental health and substance use disorder programs.

(2) A budget that includes the county planned expenditures and reserves for the county distributions from the Behavioral Health Service Fund and any other funds allocated to the county to provide the services and programs set forth in paragraph (1). The budget shall also include proposed adjustments pursuant to the requirements set forth in paragraph (c) of Section 5892.

(3) (A) A description of how the integrated plan and annual update aligns with statewide behavioral health goals and outcome measures, including goals and outcome measures to reduce identified disparities, as defined by the department in consultation with counties, stakeholders, and the Behavioral Health Services and Oversight Accountability Commission, pursuant to Section 5963.05.

(B) Outcome measures may include, but are not limited to, measures that demonstrate achievement of goals to reduce homelessness among those eligible for housing interventions pursuant to Section 5830 and measures that demonstrate reductions in the number of people who are justice-involved in the county and who are eligible adults or older adults, as defined in Section 5892, or eligible children and youth, as defined in Section 5892.

(4) A description of how the integrated plan aligns with local goals and outcome measures for behavioral health, including goals and outcome measures to reduce identified disparities.

(5) The programs and services specified in paragraph (1) shall include descriptions of efforts to reduce identified disparities in behavioral health outcomes.

(6) A description of the data sources considered to meet the requirements specified in paragraph (2) of subdivision (b).

(7) A description of how the county has considered the unique needs of LGBTQ+ youth, justice-involved youth, child welfare-involved, justice-involved adults, and older adults in the housing intervention program pursuant to Part 3.2 (commencing with Section 5830) and Full Service Partnership program pursuant to Part 4.1 (commencing with Section 5887).

(8) A description of its workforce strategy, to include actions the county will take to ensure its county and noncounty contracted behavioral health workforce is well-supported and culturally and linguistically concordant with the population to be served, and robust enough to achieve the statewide and local behavioral health goals and measures. This description shall include how the county will do all of the following:

(A) Maintain and monitor a network of appropriate, high-quality, culturally and linguistically concordant county and noncounty contracted providers, where applicable, that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs.

(B) Meet federal and state standards for timely access to care and services, considering the urgency of the need for services.

(C) Ensure the health and welfare of the individual and support community integration of the individual.

(D) Promote the delivery of services in a culturally competent manner to all individuals, including those with limited English proficiency and diverse cultural and ethnic backgrounds and disabilities, regardless of age, religion, sexual orientation, and gender identity.

(E) Ensure physical access, reasonable accommodations, and accessible equipment for individuals with physical, intellectual and developmental, and mental disabilities.

(F) Select and retain all contracted network providers, including ensuring all contracted providers meet minimum standards for license, certification, training, experience, and credentialing requirements.

(G) Ensure that the contractor’s hiring practices meet applicable nondiscrimination standards and demonstrate best practices in promoting diversity and equity.

(H) Adequately fund contracts to ensure that noncounty contracted providers are resourced to achieve the behavioral health goals outlined in their contract for the purposes of meeting statewide metrics.

(I) Conduct oversight of compliance of all federal and state laws and regulations of all contracted network providers.

(J) Fill county vacancies and retain county employees providing direct behavioral health services, if applicable.

(9) A description of the system developed to transition a beneficiary's care between the beneficiary's mental health plan and their managed care plan based upon the beneficiary's health condition.

(10) Certification by the county behavioral health director, that ensures that the county has complied with all pertinent regulations, laws, and statutes, including stakeholder participation requirements.

(11) Certification by the county behavioral health director and by the county chief administration officer or their designee that the county has complied with fiscal accountability requirements, as directed by the department, and that all expenditures are consistent with applicable state and federal law.

(d) The county shall submit its integrated plan and annual updates to the department and the commission in a form and manner prescribed by the department.

(e) The department shall post on its internet website, in a timely manner, the integrated plan submitted by every county pursuant to this section.

(f) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

5963.03. (a) (1) Each integrated plan shall be developed with local stakeholders, including, but not limited to, all of the following:

(A) Eligible adults and older adults, as defined in Section 5892.

(B) Families of eligible children and youth, eligible adults, and eligible older adults, as defined in Section 5892.

(C) Youths or youth mental health or substance use disorder organizations.

(D) Providers of mental health services and substance use disorder treatment services.

(E) Public safety partners, including county juvenile justice agencies.

(F) Local education agencies.

(G) Higher education partners.

(H) Early childhood organizations.

(I) Local public health jurisdictions.

(J) County social services and child welfare agencies.

(K) Labor representative organizations.

(L) Veterans.

(M) Representatives from veterans organizations.

(N) Health care organizations, including hospitals.

(O) Health care service plans, including Medi-Cal managed care plans as defined in subdivision (j) of Section 14184.101.

(P) Disability insurers.

(Q) Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes.

(R) The five most populous cities in counties with a population greater than 200,000.

(S) Area agencies on aging.

(T) Independent living centers.

(U) Continuums of care, including representatives from the homeless service provider community.

(V) Regional centers.

(W) Emergency medical services.

(X) Community-based organizations serving culturally and linguistically diverse constituents.

(2) (A) (i) A county shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health and substance use disorder policy, program planning, and implementation, monitoring, workforce, quality improvement, health equity, evaluation, and budget allocations.

(ii) Stakeholders shall include sufficient participation of individuals representing diverse viewpoints, including, but not limited to, representatives from youth from historically marginalized communities, representatives from organizations specializing in

working with underserved racially and ethnically diverse communities, representatives from LGBTQ+ communities, victims of domestic violence and sexual abuse, and people with lived experience of homelessness.

(iii) A county may provide supports, including, but not limited to, training and technical assistance, to ensure stakeholders, including peers and families, receive sufficient information and data to meaningfully participate in the development of integrated plans and annual updates.

(B) A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interest and any interested party who has requested a copy of the draft plan.

(b) (1) The behavioral health board established pursuant to Section 5604 shall conduct a public hearing on the draft integrated plan and annual updates at the close of the 30-day comment period required by subdivision (a).

(2) Each adopted integrated plan and update shall include substantive written recommendations for revisions.

(3) The adopted integrated plan or update shall summarize and analyze the recommended revisions.

(4) The behavioral health board shall review the adopted integrated plan or update and make recommendations to the local mental health agency, local substance use disorder agency, or local behavioral health agency, as applicable, for revisions.

(5) The local mental health agency, local substance use disorder agency, or local behavioral health agency, as applicable, shall provide an annual report of written explanations to the local governing body and the department for substantive recommendations made by the local behavioral health board that are not included in the final integrated plan or update.

(6) A county may provide training to ensure stakeholders receive sufficient information and data to meaningfully participate in the development of integrated plans and annual updates.

(c) (1) A county shall prepare annual updates to its integrated plan and may prepare intermittent updates.

(2) In preparing annual and intermittent updates:

(A) A county is not required to comply with the stakeholder process described in subdivisions (a) and (b).

(B) A county shall post on its internet website all updates to its integrated plan and a summary and justification of the changes made by the updates for a 30-day comment period prior to the effective date of the updates.

(d) For purposes of this section, "substantive recommendations made by the local behavioral health board" means a recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local behavioral health board that has established a quorum.

(e) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

5963.04. (a) (1) Annually, counties and Medi-Cal behavioral health delivery systems, as defined in subdivision (i) of Section 14184.101, shall submit the County Behavioral Health Outcomes, Accountability, and Transparency Report to the department.

(2) This report shall include the following data and information that shall be submitted in a form, manner, and in accordance with timelines prescribed by the department:

(A) The county's annual allocation of state and federal behavioral health funds, by category.

(B) The county's annual expenditure of state and federal behavioral health funds, by category.

(C) The amounts of annual and cumulative unspent state and federal behavioral health funds, including funds in a reserve account, by category.

(D) The county's annual expenditure of county general funds and other funds, by category, on mental health or substance use disorder treatment services.

(E) The sources and amounts spent annually as the nonfederal share for Medi-Cal specialty mental health services and Medi-Cal substance use disorder treatment services, by category.

(F) All administrative costs, by category.

(G) All contracted services, and the cost of those contracted services, by category.

(H) Information on behavioral health services provided to persons not covered by Medi-Cal, including, but not limited to, those who are uninsured or covered by Medicare or commercial insurance, by category.

(I) Other data and information, which shall include, but is not limited to, information on spending on children and youth, service utilization data, performance outcome measures across all behavioral health delivery systems, and data and information pertaining to populations with identified disparities in behavioral health outcomes, as specified by the department. This shall include data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts. Other data and information may include the number of people who are eligible adults and older adults, as defined in Section 5892, who are incarcerated, experiencing homelessness, inclusive of the availability of housing, the number

of eligible children and youth, as defined in Section 5892, who access evidence based early psychosis and mood disorder detection and intervention programs.

(J) Data and information on workforce measures and metrics, including, but not limited to, all of the following:

(i) Vacancies and efforts to fill vacancies.

(ii) The number of county employees providing direct clinical behavioral health services.

(iii) Whether there is a net change in the number of county employees providing direct clinical behavioral health services compared to the prior year and an explanation for that change.

(b) The department shall establish metrics, in consultation with counties, stakeholders, and the Behavioral Health Services Oversight and Accountability Commission to measure and evaluate the quality and efficacy of the behavioral health services and programs listed in paragraph (1) of subdivision (c) of Section 5963.02. The metrics shall be used to identify demographic and geographic disparities in the quality and efficacy of behavioral health services and programs listed in paragraph (1) of subdivision (c) of Section 5963.02.

(c) Each county's board of supervisors shall attest that the County Behavioral Health Outcomes, Accountability, and Transparency Report is complete and accurate before it is submitted to the department.

(d) Each year, the department shall post on its internet website a statewide County Behavioral Health Outcomes, Accountability, and Transparency Report.

(e) (1) The department may require a county or Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, to revise its integrated plan or annual update pursuant to Section 5963.02 if the department determines the plan or update fails to adequately address local needs pursuant to paragraph (2) of subdivision (b) of Section 5963.02.

(2) The department may impose a corrective action plan or require a county or Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, to revise its integrated plan or annual update pursuant to Section 5963.02 if the department determines that the county or delivery system fails to make adequate progress in meeting the metrics established by the department pursuant to subdivision (b).

(3) (A) (i) If a county or Medi-Cal behavioral health delivery system fails to submit the data and information specified in subdivision (a) by the required deadline, or as otherwise required by the department, fails to allocate funding pursuant to Section 5892, or fails to follow the process pursuant to Section 5963.03, the department may impose a corrective action plan, monetary sanctions, or temporarily withhold payments to the county or Medi-Cal behavioral health delivery system, pursuant to Section 14197.7.

(ii) Subject to the guidance issued pursuant to Section 5963.05, if a county's actual expenditures of its allocations from the Behavioral Health Services Fund significantly varies from its budget in Section 5963.02, the department may impose a corrective action plan, monetary sanctions, or temporarily withhold payments to the county pursuant to Section 14197.7.

(iii) Notwithstanding subdivision (o) of Section 14197.7, temporarily withheld payments shall be withheld from the Behavioral Health Services Fund.

(B) (i) Notwithstanding subdivision (q) of Section 14197.7, monetary sanctions collected pursuant to this section shall be deposited in the Behavioral Health Services Act Accountability Fund, which is hereby created in the State Treasury.

(ii) Subject to the department's guidance issued pursuant to Section 5963.05, all monies in the Behavioral Health Services Act Accountability Fund shall be continuously appropriated and allocated and distributed to the county that paid the monetary sanction upon the department's determination that the county has come into compliance.

(C) The department shall temporarily withhold amounts it deems necessary to ensure the county or Medi-Cal behavioral health delivery system comes into compliance.

(D) The department shall release the temporarily withheld funds when it determines the county or Medi-Cal behavioral health delivery system has come into compliance.

(f) This section shall be read in conjunction with, and apply in addition to, any other applicable law that authorizes the department to impose sanctions or otherwise take remedial actions against a county and Medi-Cal behavioral health delivery system.

(g) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

5963.05. (a) Notwithstanding Chapter 3.5 (commencing Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific the amendments made pursuant to this act by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking further regulatory action.

(b) By July 1, 2033, the department shall adopt regulations necessary to implement, interpret, or make specific the amendments made pursuant to this act in accordance with the requirements of Chapter 3.5 (commencing Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) (1) For purposes of implementing this act, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, including contracts to implement new or change existing information technology systems.

(2) Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems made pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, Part 2 (commencing with Section 12100) of Division 2 of the Public Contract Code, the Statewide Information Management Manual, and the State Administrative Manual and shall be exempt from the review or approval of any division of the Department of General Services or the Department of Technology.

(d) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

5963.06. (a) The California State Auditor shall, no later than December 31, 2029, issue to the Governor, the Legislature, the Senate and Assembly Committees on Health, the Assembly Committee on Housing and Community Development, and the Senate Committee on Housing, a comprehensive report on the progress and effectiveness of the implementation of the Behavioral Health Services Act.

(b) The California State Auditor shall conduct the audit required pursuant to subdivision (a) every three years thereafter with the final audit due on or before December 31, 2035. The final report shall include final findings, conclusions, and recommendations on the topics addressed in the previous reports.

(1) The California State Auditor shall make their reports available to the public.

(2) The California State Auditor shall make every effort to provide affected entities with an opportunity to reply to any facts, findings, issues, or conclusions in their reports with which the department may disagree.

(c) The audit conducted pursuant to this section shall include an assessment of the following:

(1) The impact of the policy changes of the Behavioral Health Services Act on the overall delivery of behavioral health services in California.

(2) The timeliness and thoroughness of guidance issued and training and technical assistance provided to impacted entities by the state as it transitions from the existing behavioral health system of care to the reforms envisioned pursuant to this act.

(3) The implementation of the Behavioral Health Services Act by each of the primary entities involved in the transition and implementation, including, but not limited to, the California Health and Human Services Agency, State Department of Health Care Services, Department of Health Care Access and Information, State Department of Public Health, Behavioral Health Services Oversight and Accountability Commission, counties, and county behavioral health directors.

(4) How counties demonstrate progress towards meeting the statewide behavioral health goals and outcome measures developed pursuant to subparagraph (A) of paragraph (3) of subdivision (c) of Section 5963.02.

(5) The fiscal and programmatic aspects of the Behavioral Health Services Act, including reserve levels, reversion activity, services and system outcomes, workforce training, workforce capacity, number of individuals served, number of individuals receiving services, number of individuals receiving housing interventions, as reported to the department by counties.

(6) The revised Behavioral Health Services Act allocations pursuant to paragraphs (1), (2), and (3) of subdivision (a) of Section 5892, gaps in service, and trends in unmet needs.

(7) The degree to which the inclusion of substance use disorders, substance use disorder treatment services, and substance use disorder personnel into the Behavioral Health Services Act has impacted the system of behavioral health care and the degree to which inclusion in the Behavioral Health Services Act has been initially successful.

(8) The effectiveness and outcomes achieved through the population-based prevention programs developed and implemented by the State Department of Public Health.

(9) The effectiveness and compliance by the counties with the revised reporting requirements under the act that added this section.

(10) The department’s oversight of the revised Integrated Plan for Behavioral Health Services and Outcomes and County Behavioral Health Outcomes, Accountability, and Transparency Report, including the use of corrective action plans or sanctions, or both.

(11) The coordination and collaboration occurring throughout the transition period between, but not limited to, the California Health and Human Services Agency, State Department of Health Care Services, Behavioral Health Services Oversight and Accountability Commission, counties, and county behavioral health directors, and an identification of areas of improvement if warranted.

(12) Recommendations on any changes or improvements indicated by the audit pursuant to this section.

(d) (1) The California Health and Human Services Agency, State Department of Health Care Services, counties, and Behavioral Health Services Oversight and Accountability Commission staff shall cooperate with all requests of the California State Auditor to the extent such information is available and the State Department of Health Care Services, counties, and Behavioral Health Services Oversight and Accountability Commission shall provide data, information, and case files as requested by the California State Auditor to perform all of their duties, to the extent that information is available.

(2) The California State Auditor may also provide in its reports, additional information to either the department or the Legislature at their discretion or at the request of either the department or the Legislature.

(e) The California State Auditor shall, in making its recommendations, indicate the predicted quickest method of implementing those recommendations, including, but not limited to, regulatory or statutory changes.

(f) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(g) This section shall become inoperative on June 30, 2036, and, as of January 1, 2037, is repealed.

SEC. 110. Section 14197.7 of the Welfare and Institutions Code is amended to read:

14197.7. (a) Notwithstanding any other law, if the director finds that any entity that contracts with the department for the delivery of health care services (contractor), including a Medi-Cal managed care plan or a prepaid health plan, fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause, the director may terminate the contract or impose sanctions as set forth in this section. Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor reporting to the department.

(b) The director may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits, investigations, contract compliance reviews, quality improvement system monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, health plan rating systems, fair hearing decisions, complaints from beneficiaries and other stakeholders, whistleblowers, and contractor self-disclosures.

(c) Except when the director determines that there is an immediate threat to the health of Medi-Cal beneficiaries receiving health care services from the contractor, at the request of the contractor, the department shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the contractor. The department shall present evidence at the hearing showing good cause for the termination. The department shall assign an administrative law judge who shall provide a written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing. Reasonable notice of the hearing shall be given to the contractor, Medi-Cal beneficiaries receiving services through the contractor, and other interested parties, including any other persons and organizations as the director may deem necessary. The notice shall state the effective date of, and the reason for, the termination.

(d) In lieu of contract termination, the director shall have the power and authority to require or impose a plan of correction and issue one or more of the following sanctions against a contractor for findings of noncompliance or good cause, including, but not limited to, those specified in subdivision (a):

(1) Temporarily or permanently suspend enrollment and marketing activities.

(2) Require the contractor to suspend or terminate contractor personnel or subcontractors.

(3) Issue one or more of the temporary suspension orders set forth in subdivision (j).

(4) Impose temporary management consistent with the requirements specified in Section 438.706 of Title 42 of the Code of Federal Regulations.

(5) Suspend default enrollment of enrollees who do not select a contractor for the delivery of health care services.

(6) Impose civil monetary sanctions consistent with the dollar amounts and violations specified in Section 438.704 of Title 42 of the Code of Federal Regulations, as follows:

(A) A limit of twenty-five thousand dollars ($25,000) for each determination of the following:

(i) The contractor fails to provide medically necessary services that the contractor is required to provide, under law or under its contract with the department, to an enrollee covered under the contract.

(ii) The contractor misrepresents or falsifies information to an enrollee, potential enrollee, or health care provider.

(iii) The contractor distributes directly, or indirectly through an agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information.

(B) A limit of one hundred thousand dollars ($100,000) for each determination of the following:

(i) The contractor conducts any act of discrimination against an enrollee on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(ii) The contractor misrepresents or falsifies information that it furnishes to the federal Centers for Medicare and Medicaid Services or to the department.

(C) A limit of fifteen thousand dollars ($15,000) for each beneficiary the director determines was not enrolled because of a discriminatory practice under clause (i) of subparagraph (B). This sanction is subject to the overall limit of one hundred thousand dollars ($100,000) under subparagraph (B).

(e) Notwithstanding the monetary sanctions imposed for the violations set forth in paragraph (6) of subdivision (d), the director may impose monetary sanctions in accordance with this section based on any of the following:

(1) The contractor violates any federal or state statute or regulation.

(2) The contractor violates any provision of its contract with the department.

(3) The contractor violates any provision of the state plan or approved waivers.

(4) The contractor fails to meet quality metrics or benchmarks established by the department. Any changes to the minimum quality metrics or benchmarks made by the department that are effective on or after January 1, 2020, shall be established in advance of the applicable reporting or performance measurement period, unless required by the federal government.

(5) The contractor fails to demonstrate that it has an adequate network to meet anticipated utilization in its service area.

(6) The contractor fails to comply with network adequacy standards, including, but not limited to, time and distance, timely access, and provider-to-beneficiary ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan or contract, and that are posted in advance to the department's internet website.

(7) The contractor fails to comply with the requirements of a corrective action plan.

(8) The contractor fails to submit timely and accurate network provider data.

(9) The director identifies deficiencies in the contractor's delivery of health care services.

(10) The director identifies deficiencies in the contractor's operations, including the timely payment of claims.

(11) The contractor fails to comply with reporting requirements, including, but not limited to, those set forth in Section 53862 of Title 22 of the California Code of Regulations.

(12) The contractor fails to timely and accurately process grievances or appeals.

(f) (1) Monetary sanctions imposed pursuant to subdivision (e) may be separately and independently assessed and may also be assessed for each day the contractor fails to correct an identified deficiency. For a deficiency that impacts beneficiaries, each beneficiary impacted constitutes a separate violation. Monetary sanctions shall be assessed in the following amounts:

(A) Up to twenty-five thousand dollars ($25,000) for a first violation.

(B) Up to fifty thousand dollars ($50,000) for a second violation.

(C) Up to one hundred thousand dollars ($100,000) for each subsequent violation.

(2) For monetary sanctions imposed on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), the department shall calculate a percentage of the funds attributable to the contractor to be offset per month pursuant to paragraphs (2) to (4), inclusive, of subdivision (n) until the amount offset equals the amount of the penalty imposed pursuant to paragraph (1).

(g) When assessing sanctions pursuant to this section, the director shall determine the appropriate amount of the penalty for each violation based upon one or more of the following nonexclusive factors:

(1) The nature, scope, and gravity of the violation, including the potential harm or impact on beneficiaries.

(2) The good or bad faith of the contractor.

(3) The contractor's history of violations.

(4) The willfulness of the violation.

(5) The nature and extent to which the contractor cooperated with the department's investigation.

(6) The nature and extent to which the contractor aggravated or mitigated any injury or damage caused by the violation.

(7) The nature and extent to which the contractor has taken corrective action to ensure the violation will not recur.

(8) The financial status of the contractor, including whether the sanction will affect the ability of the contractor to come into compliance.

(9) The financial cost of the health care service that was denied, delayed, or modified.

(10) Whether the violation is an isolated incident.

(11) The amount of the penalty necessary to deter similar violations in the future.

(12) Any other mitigating factors presented by the contractor.

(h) Except in exigent circumstances in which there is an immediate risk to the health of beneficiaries, as determined by the department, the director shall give reasonable written notice to the contractor of the intention to impose any of the sanctions authorized by this section and others who may be directly interested, including any other persons and organizations as the director may deem necessary. The notice shall include the effective date for, the duration of, and the reason for each sanction proposed by the director. A contractor may request the department to meet and confer with the contractor to discuss information and evidence that

may impact the director's final decision to impose sanctions authorized by this section. The director shall grant a request to meet and confer prior to issuance of a final sanction if the contractor submits the request in writing to the department no later than two business days after the contractor's receipt of the director's notice of intention to impose sanctions.

(i) Notwithstanding subdivision (d), the director shall terminate a contract with a contractor that the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(j) (1) The department may make one or more of the following temporary suspension orders as an immediate sanction:

(A) Temporarily suspend enrollment activities.

(B) Temporarily suspend marketing activities.

(C) Require the contractor to temporarily suspend specified personnel of the contractor.

(D) Require the contractor to temporarily suspend participation by a specified subcontractor.

(2) The temporary suspension orders shall be effective no earlier than 20 days after the notice specified in subdivision (k).

(k) Prior to issuing a temporary suspension order, or temporarily withholding funds pursuant to subdivision (o), the department shall provide the contractor with a written notice. The notice shall state the department's intent to impose a temporary suspension or temporary withhold, and specify the nature and effective date of the temporary suspension or temporary withhold. The contractor shall have 30 calendar days from the date of receipt of the notice to file a written appeal with the department. Upon receipt of a written appeal filed by the contractor, the department shall, within 15 days, set the matter for hearing, which shall be held as soon as possible, but not later than 30 days after receipt of the notice of hearing by the contractor. The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense. The temporary suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. The department shall stay imposition of a temporary withhold, pursuant to subdivision (o), until the hearing is completed and the department has made a final determination on the merits.

(l) (1) Except as provided in paragraph (2), a contractor may request a hearing in connection with any sanctions applied pursuant to subdivision (d) or (e) within 15 working days after the notice of the effective date of the sanctions has been given, by sending a letter so stating to the address specified in the notice. The department shall stay collection of monetary sanctions upon receipt of the request for a hearing. Collection of the sanction shall remain stayed until the effective date of the final decision of the department.

(2) With respect to mental health plans, the due process and appeals process specified in paragraph (4) of subdivision (b) of Section 14718 shall be made available in connection with any contract termination actions, temporary suspension orders, temporary withholds of funds pursuant to subdivision (o), and sanctions applied pursuant to subdivision (d) or (e).

(m) Except as otherwise provided in this section, all hearings to review the imposition of sanctions, including temporary suspension orders, the withholding or offsetting of funds pursuant to subdivision (n), or the temporary withholding of funds pursuant to subdivision (o), shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(n) (1) If the director imposes monetary sanctions pursuant to this section on a contractor, except for a contractor described in paragraphs (2) to (4), inclusive, the amount of the sanction may be collected by withholding the amount from capitation or other associated payments owed to the contractor.

(2) If the director imposes monetary sanctions on a contractor that is funded from the Mental Health Subaccount, the Mental Health Equity Subaccount, the Vehicle License Collection Account of the Local Revenue Fund, or the Mental Health Account, the director may offset the monetary sanctions from the respective account. The offset is subject to paragraph (2) of subdivision (q).

(3) If the director imposes monetary sanctions on a contractor that is funded from the Behavioral Health Subaccount of the Local Revenue Fund 2011, the director may offset the monetary sanctions from that account from the distribution attributable to the applicable contractor. The offset is subject to paragraph (2) of subdivision (q).

(4) If the director imposes monetary sanctions on a contractor that is funded from any other mental health or substance use disorder realignment funds from which the Controller is authorized to make distributions to the contractor, the director may offset the monetary sanctions from these funds if the funds described in paragraphs (2) and (3) are insufficient for the purposes described in this subdivision, as appropriate. The offset is subject to paragraph (2) of subdivision (q).

(o) (1) Whenever the department determines that a mental health plan or any entity that contracts with the department to provide Drug Medi-Cal services has violated state or federal law, a requirement of this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), or any regulations, the state plan, or a term or condition of an approved waiver, or a provision of its contract with the department, the department may temporarily withhold payments of federal financial participation and payments from the accounts listed in paragraphs (2) to (4), inclusive, of subdivision (n). The department shall temporarily withhold amounts it deems necessary to ensure the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services promptly corrects the violation. The department shall release the temporarily withheld funds when it determines the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services has come into compliance.

(2) A mental health plan, or any entity that contracts with the department to provide Drug Medi-Cal services, may appeal the imposition of a temporary withhold pursuant to this subdivision in accordance with the procedures described in subdivisions (k) and

(m). Imposition of a temporary withhold shall be stayed until the effective date of the final decision of the department.

(p) This section shall be read in conjunction with, and apply in addition to, any other applicable law that authorizes the department to impose sanctions or otherwise take remedial action upon contractors.

(q) (1) Notwithstanding any other law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), shall be deposited into the General Fund for use, and upon appropriation by the Legislature, to address workforce issues in the Medi-Cal program and to improve access to care in the Medi-Cal program.

(2) Monetary sanctions imposed via offset on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraphs (2) to (4), inclusive, of subdivision (n). The department shall notify the Department of Finance of the percentage reduction for the affected county. The Department of Finance shall subsequently notify the Controller, and the Controller shall redistribute the monetary sanction amount to nonsanctioned counties based on each county's prorated share of the monthly base allocations from the realigned account. With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the applicable account or accounts that are attributable to the contractor in a given month. If the department is not able to collect the full amount of monetary sanctions imposed on a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected.

(r) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(2) By July 1, 2025, the department shall adopt any regulations necessary to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(s) This section shall be implemented only to the extent that any necessary federal approvals have been obtained and that federal financial participation is available.

(t) For purposes of this section, "contractor" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(u) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 111. Section 14197.7 is added to the Welfare and Institutions Code, to read:

14197.7. (a) (1) Notwithstanding any other law, if the director finds that an entity that contracts with the department for the delivery of health care services (contractor), including a Medi-Cal managed care plan or a prepaid health plan, fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause, the director may terminate the contract or impose sanctions as set forth in this section.

(2) Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor reporting to the department.

(b) The director may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits, investigations, contract compliance reviews, quality improvement system monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, health plan rating systems, fair hearing decisions, complaints from beneficiaries and other stakeholders, whistleblowers, and contractor self-disclosures.

(c) (1) Except when the director determines there is an immediate threat to the health of Medi-Cal beneficiaries receiving health care services from the contractor, at the request of the contractor, the department shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the contractor.

(2) The department shall present evidence at the hearing showing good cause for the termination.

(3) The department shall assign an administrative law judge who shall provide a written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing.

(4) (A) Reasonable notice of the hearing shall be given to the contractor, Medi-Cal beneficiaries receiving services through the contractor, and other interested parties, including any other person and organization the director may deem necessary.

(B) The notice shall state the effective date of, and the reason for, the termination.

(d) In lieu of contract termination, the director shall have the power and authority to require or impose a plan of correction and issue one or more of the following sanctions against a contractor for findings of noncompliance or good cause, including, but not limited to, those specified in subdivision (a):

(1) Temporarily or permanently suspend enrollment and marketing activities.

(2) Require the contractor to suspend or terminate contractor personnel or subcontractors.

(3) Issue one or more of the temporary suspension orders set forth in subdivision (j).

(4) Impose temporary management consistent with the requirements specified in Section 438.706 of Title 42 of the Code of Federal Regulations.

(5) Suspend default enrollment of enrollees who do not select a contractor for the delivery of health care services.

(6) Impose civil monetary sanctions consistent with the dollar amounts and violations specified in Section 438.704 of Title 42 of the Code of Federal Regulations, as follows:

(A) A limit of twenty-five thousand dollars ($25,000) for each determination of the following:

(i) The contractor fails to provide medically necessary services that the contractor is required to provide, under law or under its contract with the department, to an enrollee covered under the contract.

(ii) The contractor misrepresents or falsifies information to an enrollee, potential enrollee, or health care provider.

(iii) The contractor distributes directly, or indirectly through an agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information.

(B) A limit of one hundred thousand dollars ($100,000) for each determination of the following:

(i) The contractor conducts an act of discrimination against an enrollee on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or a practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(ii) The contractor misrepresents or falsifies information that it furnishes to the federal Centers for Medicare and Medicaid Services or to the department.

(C) A limit of fifteen thousand dollars ($15,000) for each beneficiary the director determines was not enrolled because of a discriminatory practice under clause (i) of subparagraph (B). This sanction is subject to the overall limit of one hundred thousand dollars ($100,000) under subparagraph (B).

(e) Notwithstanding the monetary sanctions imposed for the violations set forth in paragraph (6) of subdivision (d), the director may impose monetary sanctions in accordance with this section based on any of the following:

(1) The contractor violates a federal or state statute or regulation.

(2) The contractor violates a provision of its contract with the department.

(3) The contractor violates a provision of the state plan or approved waivers.

(4) The contractor fails to meet quality metrics or benchmarks established by the department. Any changes to the minimum quality metrics or benchmarks made by the department that are effective on or after January 1, 2020, shall be established in advance of the applicable reporting or performance measurement period, unless required by the federal government.

(5) The contractor fails to demonstrate that it has an adequate network to meet anticipated utilization in its service area.

(6) The contractor fails to comply with network adequacy standards, including, but not limited to, time and distance, timely access, and provider-to-beneficiary ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan, or contract and that are posted in advance to the department's internet website.

(7) The contractor fails to comply with the requirements of a corrective action plan.

(8) The contractor fails to submit timely and accurate network provider data.

(9) The director identifies deficiencies in the contractor's delivery of health care services.

(10) The director identifies deficiencies in the contractor's operations, including the timely payment of claims.

(11) The contractor fails to comply with reporting requirements, including, but not limited to, those set forth in Section 53862 of Title 22 of the California Code of Regulations.

(12) The contractor fails to timely and accurately process grievances or appeals.

(f) (1) Monetary sanctions imposed pursuant to subdivision (e) may be separately and independently assessed and may also be assessed for each day the contractor fails to correct an identified deficiency. For a deficiency that impacts beneficiaries, each beneficiary impacted constitutes a separate violation. Monetary sanctions shall be assessed in the following amounts:

(A) Up to twenty-five thousand dollars ($25,000) for a first violation.

(B) Up to fifty thousand dollars ($50,000) for a second violation.

(C) Up to one hundred thousand dollars ($100,000) for each subsequent violation.

(2) For monetary sanctions imposed on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), the department shall calculate a percentage of the funds attributable to the contractor to be offset per month pursuant to paragraphs (2) to (4), inclusive, of subdivision (n) until the amount offset equals the amount of the penalty imposed pursuant to paragraph (1).

(g) When assessing sanctions pursuant to this section, the director shall determine the appropriate amount of the penalty for each violation based upon one or more of the following nonexclusive factors:

(1) The nature, scope, and gravity of the violation, including the potential harm or impact on beneficiaries.

(2) The good or bad faith of the contractor.

(3) The contractor's history of violations.

(4) The willfulness of the violation.

(5) The nature and extent to which the contractor cooperated with the department's investigation.

(6) The nature and extent to which the contractor aggravated or mitigated any injury or damage caused by the violation.

(7) The nature and extent to which the contractor has taken corrective action to ensure the violation will not recur.

(8) The financial status of the contractor, including whether the sanction will affect the ability of the contractor to come into compliance.

(9) The financial cost of the health care service that was denied, delayed, or modified.

(10) Whether the violation is an isolated incident.

(11) The amount of the penalty necessary to deter similar violations in the future.

(12) Other mitigating factors presented by the contractor.

(h) (1) Except in exigent circumstances in which there is an immediate risk to the health of beneficiaries, as determined by the department, the director shall give reasonable written notice to the contractor of the intention to impose any of the sanctions authorized by this section and others who may be directly interested, including any other persons and organizations the director may deem necessary.

(2) The notice shall include the effective date for, the duration of, and the reason for each sanction proposed by the director.

(3) A contractor may request the department to meet and confer with the contractor to discuss information and evidence that may impact the director's final decision to impose sanctions authorized by this section.

(4) The director shall grant a request to meet and confer prior to issuance of a final sanction if the contractor submits the request in writing to the department no later than two business days after the contractor's receipt of the director's notice of intention to impose sanctions.

(i) Notwithstanding subdivision (d), the director shall terminate a contract with a contractor that the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(j) (1) The department may make one or more of the following temporary suspension orders as an immediate sanction:

(A) Temporarily suspend enrollment activities.

(B) Temporarily suspend marketing activities.

(C) Require the contractor to temporarily suspend specified personnel of the contractor.

(D) Require the contractor to temporarily suspend participation by a specified subcontractor.

(2) The temporary suspension orders shall be effective no earlier than 20 days after the notice specified in subdivision (k).

(k) (1) Prior to issuing a temporary suspension order, or temporarily withholding funds pursuant to subdivision (o), the department shall provide the contractor with a written notice.

(2) The notice shall state the department's intent to impose a temporary suspension or temporary withhold and specify the nature and effective date of the temporary suspension or temporary withhold.

(3) The contractor shall have 30 calendar days from the date of receipt of the notice to file a written appeal with the department.

(4) Upon receipt of a written appeal filed by the contractor, the department shall, within 15 days, set the matter for hearing, which shall be held as soon as possible but not later than 30 days after receipt of the notice of hearing by the contractor.

(5) The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense.

(6) The temporary suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days of the close of the record for the matter.

(7) The department shall stay imposition of a temporary withhold, pursuant to subdivision (o), until the hearing is completed and the department has made a final determination on the merits within 60 days of the close of the record for the matter.

(l) (1) A contractor may request a hearing in connection with sanctions applied pursuant to subdivision (d) or (e) within 15 working days after the notice of the effective date of the sanctions has been given by sending a letter so stating to the address specified in the notice.

(2) The department shall stay collection of monetary sanctions upon receipt of the request for a hearing.

(3) Collection of the sanction shall remain stayed until the effective date of the final decision of the department.

(m) Except as otherwise provided in this section, all hearings to review the imposition of sanctions, including temporary suspension orders, the withholding or offsetting of funds pursuant to subdivision (n), or the temporary withholding of funds pursuant to subdivision (o) shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(n) (1) If the director imposes monetary sanctions pursuant to this section on a contractor, except for a contractor described in paragraphs (2) to (5), inclusive, the amount of the sanction may be collected by withholding the amount from capitation or other associated payments owed to the contractor.

(2) If the director imposes monetary sanctions on a contractor that is funded from the Mental Health Subaccount, the Mental Health Equity Subaccount, the Vehicle License Collection Account of the Local Revenue Fund, or the Mental Health Account, the director may offset the monetary sanctions from the respective account. The offset is subject to paragraph (2) of subdivision (q).

(3) If the director imposes monetary sanctions on a contractor that is funded from the Behavioral Health Subaccount of the Local Revenue Fund 2011, the director may offset the monetary sanctions from that account from the distribution attributable to the applicable contractor. The offset is subject to paragraph (2) of subdivision (q).

(4) If the director imposes monetary sanctions on a contractor that is funded from another mental health or substance use disorder realignment fund from which the Controller is authorized to make distributions to the contractor, the director may offset the monetary sanctions from these funds if the funds described in paragraphs (2) and (3) are insufficient for the purposes described in this subdivision, as appropriate. The offset is subject to paragraph (2) of subdivision (q).

(5) (A) If the director imposes monetary sanctions pursuant to subdivision (e) of Section 5963.04, the director may offset the monetary sanctions from the Behavioral Health Services Fund from the distribution attributable to the applicable contractor.

(B) With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the Behavioral Health Services Fund that are attributable to the contractor in a given month.

(C) If the department is not able to collect the full amount of monetary sanctions imposed on a contractor in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected. The offset is subject to paragraph (3) of subdivision (q).

(o) (1) (A) Whenever the department determines that a mental health plan or an entity that contracts with the department to provide Drug Medi-Cal services has violated state or federal law, a requirement of this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), or any regulations, the state plan, a term or condition of an approved waiver, or a provision of its contract with the department, the department may temporarily withhold payments of federal financial participation and payments from the accounts listed in paragraphs (2) to (4), inclusive, of subdivision (n).

(B) The department shall temporarily withhold amounts it deems necessary to ensure the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services promptly corrects the violation.

(C) The department shall release the temporarily withheld funds when it determines the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services has come into compliance.

(2) (A) A mental health plan or an entity that contracts with the department to provide Drug Medi-Cal services may appeal the imposition of a temporary withhold pursuant to this subdivision in accordance with the procedures described in subdivisions (k) and (m).

(B) Imposition of a temporary withhold shall be stayed until the effective date of the final decision of the department.

(p) This section shall be read in conjunction with, and apply in addition to, any other applicable law that authorizes the department to impose sanctions or otherwise take remedial action upon contractors.

(q) (1) Notwithstanding any other law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), shall be deposited into the General Fund for use and, upon appropriation by the Legislature, to address workforce issues in the Medi-Cal program and improve access to care in the Medi-Cal program.

(2) (A) Monetary sanctions imposed via offset on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraphs (2) to (4), inclusive, of subdivision (n).

(B) The department shall notify the Department of Finance of the percentage reduction for the affected county.

(C) The Department of Finance shall subsequently notify the Controller, and the Controller shall redistribute the monetary sanction amount to nonsanctioned counties based on each county's prorated share of the monthly base allocations from the realigned account.

(D) With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the applicable account or accounts that are attributable to the contractor in a given month.

(E) If the department is not able to collect the full amount of monetary sanctions imposed on a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected.

(3) Monetary sanctions imposed via offset on a contractor pursuant to subdivision (e) of Section 5963.04 shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraph (5) of subdivision (n).

(r) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking any further regulatory action.

(s) This section shall be implemented only to the extent that necessary federal approvals have been obtained and that federal financial participation is available.

(t) For purposes of this section, "contractor" means an individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries or other individuals receiving behavioral health services, as applicable, pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(10) Chapter 2 (commencing with Section 5650) of Part 2 of Division 5, solely for purposes of imposition of corrective action plans, monetary sanctions, or temporary withholds pursuant to subdivision (e) of Section 5963.04.

(11) Section 12534 of the Government Code.

(u) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 112. Section 14197.71 is added to the Welfare and Institutions Code, to read:

14197.71. (a) The department may, at its discretion, align relevant terms of its contract with a Medi-Cal behavioral health delivery system with the terms of its contract with a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, for those requirements that apply to both entities. Requirements that apply to both entities include, but are not limited to, all of the following:

(1) Organization and administration of the plan, including key administrative staffing requirements.

(2) Financial information.

(3) Information systems.

(4) Quality improvement systems.

(5) Utilization management.

(6) Provider network.

(7) Provider compensation arrangements.

(8) Provider oversight and monitoring.

(9) Access and availability of services, including, but not limited to, reporting of waitlists for behavioral health services or attesting to no waitlists.

(10) Care coordination and data sharing.

(11) Member services.

(12) Member grievances and appeals data.

(13) Reporting requirements.

(14) Other contractual requirements determined by the department.

(b) The department shall establish minimum quality metrics to measure and evaluate the quality and efficacy of services and programs covered under Medi-Cal behavioral health delivery systems.

(c) (1) Each Medi-Cal behavioral health delivery system shall report annually to the county board of supervisors on utilization, quality, patient care expenditures, and other data as determined by the department.

(2) The board of supervisors shall annually submit an attestation to the department that the county is meeting its obligations to provide realigned programs and services pursuant to clauses (i), (iv), and (v) of subparagraph (B) of paragraph (16) of subdivision (f) of Section 30025 of the Government Code.

(d) (1) Notwithstanding any other state or local law, including, but not limited to, Section 5328 of this code and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health, social services, housing, and criminal justice information, records, and other data with and among the department, other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, as defined in subdivision (j) of Section 14184.101, Medi-Cal behavioral health delivery systems, as defined in subdivision (i) of Section 14184.101, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, shall be permitted to the extent necessary and consistent with federal law.

(2) The department shall issue guidance identifying permissible data-sharing arrangements.

(e) For purposes of this section, the term "Medi-Cal behavioral health delivery system" means an entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits pursuant to Section 14184.400 and Chapter 8.9 (commencing with Section 14700) or a county Drug Medi-Cal Organized Delivery System pilot authorized under the CalAIM Terms and Conditions and described in Section 14184.401 or authorized under the Medi-Cal 2020 Demonstration Project Act pursuant to Article 5.5 (commencing with Section 14184).

(f) This section shall be implemented only to the extent that necessary federal approvals have been obtained and federal financial participation is available and not otherwise jeopardized.

(g) The department shall implement this section no later than January 1, 2027.

SEC. 113. Section 14707.5 of the Welfare and Institutions Code is amended to read:

14707.5. (a) It is the intent of the Legislature to develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services that will improve outcomes at the individual and system levels and will inform fiscal decisionmaking related to the purchase of services.

(b) The State Department of Health Care Services, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, shall create a plan for a performance outcome

system for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under the age of 21 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

(1) Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature. This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.

(2) In developing a plan for a performance outcomes system for EPSDT mental health services, the department shall consider the following objectives, among others:

(A) High-quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law.

(B) Information that improves practice at the individual, program, and system levels.

(C) Minimization of costs by building upon existing resources to the fullest extent possible.

(D) Reliable data that are collected and analyzed in a timely fashion.

(3) At a minimum, the plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and, timelines for implementation at the provider, county, and state levels.

(c) The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

(d) The State Department of Health Care Services shall propose how to implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

(e) Commencing no later than February 1, 2014, the department shall convene a stakeholder advisory committee comprised of advocates for and representatives of, child and youth clients, family members, managed care health plans, providers, counties, and the Legislature. The committee shall develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and supports. The committee shall also review health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans, among others. The committee shall make recommendations to the department regarding performance and outcome measures that will contribute to improving timely access to appropriate care for Medi-Cal eligible beneficiaries.

(1) The department shall incorporate into the performance outcomes system established pursuant to this section the screenings and referrals described in this subdivision, including milestones and timelines, and shall provide an updated performance outcomes system plan to all fiscal committees and the appropriate policy committees of the Legislature no later than October 1, 2014.

(2) The department shall propose how to implement the updated performance systems outcome plan described in paragraph (1) no later than January 10, 2015.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 114. Section 14707.5 is added to the Welfare and Institutions Code, to read:

14707.5. (a) It is the intent of the Legislature to develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services that will improve outcomes at the individual and system levels and will inform fiscal decisionmaking related to the purchase of services.

(b) The State Department of Health Care Services, in collaboration with the California Health and Human Services Agency and in consultation with the Behavioral Health Services Oversight and Accountability Commission, shall create a plan for a performance outcome system for EPSDT mental healthservices provided to eligible Medi-Cal beneficiaries under the age of 21 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

(1) (A) Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature.

(B) This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.

(2) In developing a plan for a performance outcomes system for EPSDT mental health services, the department shall consider the following objectives, among others:

(A) High-quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law.

(B) Information that improves practice at the individual, program, and system levels.

(C) Minimization of costs by building upon existing resources to the fullest extent possible.

(D) Reliable data that is collected and analyzed in a timely fashion.

(3) At a minimum, the plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and timelines for implementation at the provider, county, and state levels.

(c) The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

(d) The State Department of Health Care Services shall propose how to implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

(e) (1) (A) Commencing no later than February 1, 2014, the department shall convene a stakeholder advisory committee comprised of advocates for, and representatives of, child and youth clients, family members, managed care health plans, providers, counties, and the Legislature.

(B) The committee shall develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and supports.

(C) The committee shall also review health plan screenings for mental health, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans, among others.

(D) The committee shall make recommendations to the department regarding performance and outcome measures that will contribute to improving timely access to appropriate care for Medi-Cal eligible beneficiaries.

(2) The department shall incorporate into the performance outcomes system established pursuant to this section the screenings and referrals described in this subdivision, including milestones and timelines, and shall provide an updated performance outcomes system plan to all fiscal committees and the appropriate policy committees of the Legislature no later than October 1, 2014.

(3) The department shall propose how to implement the updated performance systems outcome plan described in paragraph (2) no later than January 10, 2015.

(f) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 115. (a) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific the amendments made pursuant to this measure by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking further regulatory action.

(b) By July 1, 2033, the State Department of Health Care Services shall adopt regulations necessary to implement, interpret, or make specific the amendments made pursuant to this measure, except for the additions of Article 3 (commencing with Section 5964) of Chapter 3 and Chapter 4 (commencing with Section 5965) of Part 7 of Division 5 of the Welfare and Institutions Code, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) (1) For purposes of implementing this measure, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, including contracts to implement new or change existing information technology systems.

(2) Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems made pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Chapter 5 (commencing with Section 19130) of the Part 2 of Division 5 of Title 2 of the Government Code, Part 2 (commencing with Section 12100) of Division 2 of the Public Contract Code, the Statewide Information Management Manual, and the State Administrative Manual and shall be exempt from the review or approval of any division of the Department of General Services or the Department of Technology.

SEC. 116. The provisions of this act are severable. If any provision of this act or its application is held invalid or unconstitutional by a decision of a court of competent jurisdiction, such decision shall not affect the validity of the remaining portions or applications of this act. The Legislature declares that it would have enacted this act and each portion thereof not declared invalid or unconstitutional without regard to whether any other portion of this act or its application thereof would be subsequently declared invalid or unconstitutional.

SEC. 117. This act shall take effect on January 1, 2025, upon approval by the voters of the amendments to the Mental Health Services Act at the March 5, 2024, statewide primary election.

SEC. 118. (a) Sections 1, 2, 14, 15, 18 to 23, inclusive, 28 to 30, inclusive, 35 to 40, inclusive, 42 to 44, inclusive, 49 to 59, inclusive, 62 to 64, inclusive, 73 to 81, inclusive, 86 to 95, inclusive, 98 to 100, inclusive, 103 to 112, inclusive, 116, and 117 of this act and Section 4 of the Behavioral Health Infrastructure Bond Act, as set forth in Assembly Bill 531 of the 2023–24 Regular Session, shall be submitted to the voters at the March 5, 2024, statewide primary election, and shall appear on the ballot as a single measure, in accordance with provisions of the Government Code and the Elections Code governing the submission of a statewide measure to the voters.

(b) Notwithstanding Sections 13115 and 13117 of the Elections Code or any other law, the single measure described in subdivision (a), shall be placed as the first measure on the March 5, 2024, statewide primary election ballot and shall be designated as "Proposition 1."

(c) Notwithstanding Sections 13115 and 13117 of the Elections Code or any other law, all other measures proposed by the Legislature at the 2023–24 Regular Session for submission to the voters at the March 5, 2024, statewide primary election, shall immediately follow Proposition 1 and be designated on the statewide primary election ballot as the next in order numerically pursuant to Section 13117 of the Elections Code.

SEC. 119. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

To protect the health and safety of the state's most vulnerable individuals by providing critical housing, mental health, and substance use disorder treatment services within this state, it is necessary for this act to take effect immediately.