Chad Costello, CASRA Executive Director
Address to the 2021 Fall Conference
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Back in the pandemic "before times", CASRA's Fall and Spring in-person conferences were an opportunity for like-minded travelers to come together and share information, approaches and practices, and as important, or maybe even more important, to come away with a feeling of what they were doing was part of a righteous cause. An opportunity to reenergize, so that they could go back and hold true to recovery values and principles and maintain hope, even while being asked to pay homage to the Medi-Cal gods through documentation and other requirements that were both burdensome in time and devoid of spirit. Although I am confident that the knowledge part of that equation will be realized due to the wonderful presenters you will encounter during the Conference, I think all of us have to admit that we miss the side conversations in the hallways between sessions and over lunch.

The Fall and Spring Conferences were also when CASRA membership would get together to talk about the past year, the current policy and programmatic landscape and the opportunities and challenges that laid ahead. So, I hope you will allow me to take up a few moments of your valuable time to do that, even though CASRA's official annual meeting isn't for another month.

CASRA currently counts 29 member organizations, which is a bit fewer than ten years ago, though some of that loss is due to consolidation of organizations, some of that loss, I fear, may be due to increasing incongruence between CASRA's mission and theirs. It is also satisfying to know that CASRA's mission remains appealing. Since last fall, CASRA has welcomed two new organizations as provisional members, Mental Health Association of San Francisco and the Mental Wellness Center in Santa Barbara. We hope to welcome another organization to the CASRA family in the coming weeks.

CASRA continues to train and educate those currently providing service as evidenced by those of you joining us today, and through ongoing peer provider trainings for San Mateo County and CASRA member organizations. We've thrown our hat into what is a large CalMHSA ring to possibly take advantage of additional Certified Peer Provider training opportunities as a result of last year's passage of SB 803, and we are working with CASRA organizations who are taking on the difficult challenge of billing Medi-Cal for the first time – also an outgrowth of SB 803. We are excited to partner with CalHOSA this Spring to help create a curriculum for high school teachers that will assist them in better identifying and meeting the needs of students in their classes while at the same time helping them and their students to create a supportive environment in the classroom, and hopefully guide those students who are interested into a career in behavioral health. I am thrilled to once again be closely working with my longtime colleague and friend, Joe Ruiz, CASRA's Director of Training and Education, who is as committed to CASRA's mission as anyone, and has decades of experience in translating mission into action at the practice level. He and CASRA's dedicated

Conference Committee Members are responsible for the wonderful lineup of speakers and presentations you get to enjoy today and over the following two Tuesdays – so thank you to Joe and the Committee and of course to our presenters.

… and now onto what for me was the more difficult part of this presentation to prepare – the current policy and advocacy landscape, some plans for the upcoming year and some predictions, about which I have to be very careful, because after all, this is being recorded. This section was difficult to prepare simply because there is just. So. Much. Happening. I'll do my best not to get too wonky in the next few minutes, but we'll see how that goes.

In my 25 years working in CBOs in public behavioral health in California, I have never seen so much interest, attention and money directed at behavioral health. I was around for the passage of the Mental Health Services Act in 2004, and yes Sara, wherever you are, you beat me by 18 signatures for the most gathered by any person in the State to get that initiative on the ballot – I'm still bitter about coming in second on that one. The MHSA and the billions of additional funding it has provided over the past 17 years, I think helped to financially save the public behavioral health system in California and has been instrumental in moving portions of that system toward a recovery-focused vision. The MHSA is still vital and important and is the envy of many other state's public behavioral health systems. It is still a very good idea.

…and then along came the 2021-22 budget process. The initial State budget forecasts in the Fall of 2020 were scary, piled on top of the already terrifying estimated $56 billion, with a "B" State predicted budgetary shortfall from the previous Spring. By the release of the Governor's initial State budget in January of this year, pandemic-related revenue shortfalls were predicted to continue long into 2021, 2022 & 2023, but were not as dire as previously thought and pandemic-related expenses had not been as high as predicted, but there was talk of cuts, some serious to local county behavioral health and other safety-net budgets. Initiatives such as Cal-AIM, which had been put on hold the previous year due to the pandemic, looked to be dead in the water for the foreseeable future.

By the time the May budget revision was drafted, things had moved from "it could have been much worse", to "wow, things are actually pretty good". Revenues were not nearly as horrible as thought, just delayed. It was a bit hard to believe especially since we were very much still in the middle of living our shared pandemic reality. As May concluded, things went from good to gooder, meaning not only should future cuts be off the table, but the Administration was also planning on reinstating funding that had been cut the previous year. State agencies and departments that just a few months before were looking at mothballing programs, were now sent scrambling to propose revised budgets and implement new programs on an accelerated schedule. CalAIM went from frozen to fast track in a matter of weeks. Then by the end of July, billions in federal money was placed on the table, turning what had been a deficit of tens of billions of dollars just the previous Fall into a projected budget surplus of $85 billion. In addition to suffering revenue whiplash, I blew a gasket trying to do

a budget analysis on the 21-22 budget and just had to sit tight until the folks on the inside of government could pull together all of the pockets of money into a digestible list, which has happened, more or less.

Like lots of people, I have a side hustle – mine is teaching. I like to ask my first year MSW policy students a simple question. If a bill says if you have "x" amount of dollars, then you can do "y", how much of "y" gets done if "x" is zero? The answer is zero – simple enough, and I ask that to try and make the point that policy ideas, even great ones absent funding don't come to fruition, so budget is policy.

OK – a question for all of you…. How much of "y" gets done if "x" is $85 billion(ish) dollars? The answer - it depends on the person or people who are now in charge of figuring out what "x" is because the people who usually figure out at least part of "x", the Legislature, didn't have time to do that this time around. In other words, I have never seen so much money with so few words attached to it.

This is what the next few months is all about, creating the rules, regulations, policies, procedures, and practices for turning very broad policy concepts with a ton of money behind them into buildings, services, and as many CASRA organizations know all too well, the thousands of people needed to accomplish those tasks, because the first word in human services is human.

Certainly, behavioral health was not allocated the entirety of that $85 billion, but I gotta say we did pretty darn good. Depending on how broadly you define the public behavioral health system and the funding that impacts it, somewhere between $13 billion and $15 billion is headed our way over the next couple of years (what's a couple billion between friends?). Whether it's the Children's Mental Health Initiative at around $4.4 billion total, or the $2.2 billion for badly needed behavioral health infrastructure or the now fully funded CalAIM initiative with $4 billion over the next three years, the small community of behavioral health policy nerds, of which I am happy to be a part, are going to be very busy. This isn't to mention the development of local crisis response systems as a part of the implementation of the 988 crisis lines, the state legislation for which will be taken up again in the new year, and if the current language stays intact would do much to hold private insurance's feet to the behavioral health parity fire. Hmmnnnn… Kaiser paying for FSP services for their members who need it – imagine that?

In a word? Opportunity, OK two words would be better - tremendous opportunity

Going back to CalAIM. This message is for our friends at the Department of Health Care Services. CalAIM is fully funded. You have assured us that CalAIM will do many things. Address our documentation burden concerns. At some point relieve us from the ridiculousness of cost settlements and the unyielding pursuit of the almighty billable minute. Provide for a definition of medical necessity that is consistent and doesn't demand that we rush to clinical conclusions prior to

having the information necessary to support those conclusions. There are a few more assurances I won't mention here. These are enormous challenges to be sure, but the greater challenge will be stepping up to your role and responsibility to tell the 59 county, city and county-city public mental health plans that when it comes to documentation, the floor you set at the state needs to be both the floor AND the ceiling in each and every plan. You need to demand that the counties share the new promised flexibility in funding that you are giving them with all of their CBO partner organizations, including CASRA organizations.

Now onto the elephant in the room, and the elephant is in the room because the person who usually watches the elephant called in sick and the two positions who might otherwise have covered for the elephant attendant have remained unfilled for the past six months.

I'm taking about workforce, workforce, workforce and unlike conjuring Beetlejuice, saying it three times will not make it appear.

Workforce has been the single greatest challenge for CASRA agencies and the behavioral health system at large for many, many years. The pandemic has been and continues to be yet another stress test in a long line of stress tests for you, your supervisors and your organizations. Our somewhat reduced turnout for this conference is in part due to the fact that when you have Program Directors covering for Supervisors who are working double shifts to fill in for unfilled positions, attending a conference, even one where you like the topics and need the CEUs, just isn't possible.

The public behavioral health system certainly isn't the only sector feeling the burden of the lack of humans to do the work, the armada of fully loaded container ships I can see in in Long Beach harbor when I go on my runs is testament to that, but behavioral health CBO's and in particular CASRA organizations face unique staffing challenges even when compared to the county behavioral health entities with whom we all contract. The workforce story of our county partners is not our story exactly, but both stories are important to fully know and understand if we are to step up to take advantage of the opportunities presented by all that funding, I mentioned a few moments ago. We operate in a high-touch, person intensive field, which means we need people. We need to hold onto the ones we have, make better use of them, and find a whole bunch of new people who want to do this stuff.

Do we need prescribers? Yes, it's been that way since the dawn of time, and no one yet has figured out how to meaningfully address that issue. We've tried to make it easier for nurse practitioners to prescribe, and there is a bill that will be taken up once again in the new year that has this as its goal. So, if that can overcome the opposition of the California Medical Association, we will get a few more prescribers sooner rather than later. Here's an idea, maybe stop having meds always be the gold standard for mental health treatment? Controversial? Maybe?

Do we need licensed clinicians? Yep, also been an issue ever since I can remember. Maybe if we used all those folks at the top of their license and got the counties to realize that a clinical license is not tantamount to audit armor, we would make better use of a scarce resource that will probably get scarcer despite loan repayment programs. If anyone can convince the Cal State system to build another campus, please be my guest.

But what about Certified Peer Providers, Parent Partner Advocates and Family Partners? Won't they save us? They will continue to have a transformational impact on the system if SB 803 is implemented correctly. The State and counties need to set the rate for peer services no lower than those for Case Management and/or Mental Health Services (T1017 & H2015 if I remember my service codes correctly?). Supervisors, who will hopefully often also be peers themselves need to recognize, understand and respect the important and different roles that peers can and should play in the lives of those with whom they partner. But no, even if SB 803 is implemented correctly, there will not be enough peers to fill all the needed positions and roles that our current and future system demand.

On hopeful note, I think CASRA agencies have the secret for addressing the workforce shortage/crisis/end times whatever works for you. That secret is our use of folks with AA/BA degrees, and high school diplomas. To be sure we don't have enough of these folks either, but CASRA organizations have been smart enough to make full use of the tremendous flexibility contained within California's Medicaid reimbursement structure and our county partners haven't. Instead of acquiescing to what are often ridiculous mandates to replace fully competent staff who don't happen to have a license with someone else who does, we need to work together to get the State to tell counties to knock it off – they aren't doing anyone – including those we serve, a favor. They are making it more difficult for us to open new programs or just operate the ones we currently have. How is the system going to be able to take advantage of all of the new opportunities afforded us in this year's budget if we aren't allowed to utilize all of our human resources?

My message to the counites is that as your partners in providing care, we are telling you that you need to get smarter and stop shooting yourself, hell, all of us in the foot with ridiculous staffing expectations and documentation requirements. For rural counties in which the county is often the only game in town, the licensed folks aren't coming. You need to make better use of who is there. The folks with AAs, BAs, GEDs, who can do the work because they know their communities and they would know the people they would serve if you would just let them.

My message to the several State Departments who are slated to receive some portion of the hundreds of millions of dollars in behavioral health workforce funding that was part of this year's budget, spend it wisely. To quote the statistician and management guru W. Edwards Deming, or was it Paul Batalden, or Arthur Jones? (really its quite the Wikipedia rabbit hole there) "Every system is perfectly designed to get the results it gets". If we keep doing the same things we have been

doing when it comes to workforce we will continue to have a workforce crisis – we have to be the solution to our own problem.

Spend the money on pipeline programs to bring in new people to the field. Support industry partnerships between community colleges and CBOs who can provide intern sites, help with curriculum development and potential instructors. Community colleges are everywhere, even in rural areas. You can find the diversity so desperately needed in our workforce at your local community college – trust me, it's there.

Spend the workforce money on programs to help take advantage of an important and largely untapped part of a potential workforce. Those with criminal backgrounds who currently can't pass background checks because of some long-ago offense that isn't related to the work they could do for us. That's a twofer – help address a workforce crisis and support social justice through employment. What about folks who have retired from the field? Maybe they don't want to come back as a full-time supervisor, but could you make use of a seasoned 10 hour a week care coordinator?

I'm going to switch gears again and move into what might come off as me being a bit angry, but really the feeling from my side is passion. This has to do with the confounding of homelessness and mental illness.

Overly simplistic narratives for complex problems yield suboptimal solutions. Homelessness is a very complex problem that has been many decades in the making. To suggest that untreated mental illness is the primary or even most important cause of the homelessness crisis is to ignore decades of inequality, lack of opportunity, and racism. If mental illness is an equal opportunity disease, and mental illness is the most important causal factor for homelessness then why is it that Blacks make up a hugely disproportionate number of those considered homeless? Relaxing involuntary outpatient commitment standards as happened again this year in the Legislature, building large numbers of involuntary inpatient beds which may happen as a result of the behavioral health infrastructure money I mentioned earlier, and as has been suggested, the re-introduction of legislation that ultimately would lead to the possibility of forced physical health treatment as part of LPS conservatorships. In fact, there is talk of an LPS ballot initiative in the not-too-distant future, which I have little doubt would be marketed as a solution to the homelessness crisis. This is a terribly blunt instrument to effect change on something as nuanced as LPS.

These are all behavioral health solutions to something that is not, at its core, a behavioral health problem.

The root cause of homelessness is poverty and let's face it poverty if far from equally distributed. Since we are generally loath to give poor people money, then we need to give them housing, not as a reward for navigating a many years long obstacle course of programmatic impediments, but as a

right. Lack of a safe place to call home and to be part of a community is generally bad for one's mental health, but this doesn't support the assertion of a causal link between mental illness and homelessness, rather it is a call to action to offer people a place to call home. As a state, California will more than likely experience an increase in homelessness in the coming year, but this will not be due to an increase in mental illness, it will be the result of a somewhat delayed economic reality associated with the pandemic. Those who have been protected by eviction moratoriums will no longer be protected and if they can't come up with the rent, they will lose their housing and may then become homeless. This will no doubt impact their mental health, but this an effect and not a cause.

As always, CASRA's purpose is to serve the interests of our member organizations, programs, staff and most important, the interests of those served by those organizations, programs and staff. I also think that CASRA has a duty to serve the interests of social justice, even when the issue may not directly impact a member agency's book of business or the specific constituency they currently serve. I think this puts CASRA in a unique and I hope valuable place. I remember when being asked to describe why my previous organization should belong to multiple associations. I broke it down to needing to have a "why", a "what", and a "how" to be able to continue to do this important work. You didn't need to find all three in the same place, but you did need to find all them someplace. That particular organization, which had its roots in advocacy already had a pretty solid "why" before it came across CASRA, but the "why" of CASRA blended very well with its own. That same organization had sorta figured out a good portion of the "what", but through CASRA found a group of experienced sister organizations that could consult and sometimes console as it continued with its own programmatic development. I think the real benefit for that particular organization when it came to being a CASRA member was coming across a clear articulation of the "how" of social rehabilitation, being able to learn the application of its values and principles from experienced, like-minded travelers and to share in the comradery of embracing an approach that truly put the people we served at the center of everything we were doing.

I thank each and every one for you for keeping the people at the center of the work you do, day in and day out, and for taking the time today and over the following two Tuesdays to learn a bit more about the "how". I know you'll find it informative and applicable, but more than that I hope that despite not being face-to-face, you will connect with your colleagues via chat, exchange email addresses and phone numbers and that you be open to reconnecting with any and all of those vital "why", "how" and "what" aspects of your work as a supporter, ally, friend, teacher, mentor, healer and member of the CASRA family.

3350 E 7th Street, #509, Long Beach, CA 90804 Phone:(562) 343-2621