California Alliance
Empowering lives. Enriching futures.

October 19, 2022

Marlies Perez
Chief, Community Services Division
Department of Health Care Services

RE: Behavioral Health Bridge Housing Program Feedback

Dear Chief Perez:

On behalf of the California Alliance of Child and Family Services, representing 160+ nonprofit community-based organizations serving children, youth, and families across the state, we respectfully submit comments and feedback on the new $1.5 billion Behavioral Health Bridge Housing Program, approved in Fiscal Year 2022-23 state budget. While this funding is to be prioritized for the CARE Court population, we believe this new investment is a critical opportunity to make change in the lives of unaccompanied youth with behavioral health conditions. Unaccompanied youth up to 24 comprise 8% of the total number of individuals experiencing homelessness in California, according the to 2021 Point-in-Time (PIT) count. PIT methodology tends to under count this population, so the true population level is likely higher. A significant portion of this population have serious behavioral health challenges and we believe that a portion of the Behavioral Health Bridge Housing funding should be designed and targeted to address youth homelessness. Please find below specific recommendations on how to maximize this investment for unaccompanied youth with serious behavioral health conditions.

• **Set aside 10% for youth and transition age youth experiencing homelessness.** We recommend that the Department of Health Care Services issue guidance requiring counties to set aside 10% of the funding to be dedicated to unaccompanied youth up to age 25. According to national research conducted at Chapin Hall at the University of Chicago, 29% of homeless youth report substance use problems, 69% report mental health problems, 33% are former foster youth, and 50% had been involved in the juvenile justice system. We believe that the behavioral health bridge housing program should follow the lead of the Homeless Emergency Aid Program (HEAP) and Homeless, Housing, Assistance and Prevention Program (HHAP) and dedicate a portion of the funding to unaccompanied youth.

• **Recommend coordination with Department of Housing and Community Development on requirements to align with Homekey.** The California Alliance recommends DHCS coordinate with the Department of Housing and Community Development to align program requirements so that agencies can leverage multiple opportunities at the same time including Project Homekey. Project Homekey allows local governments to acquire and rehabilitate a variety of settings including hotels, motels, and vacant apartment buildings to provide individuals with housing and services. We believe these two important programs can be utilized together to expand the opportunities to provide housing and supports to vulnerable Californians experiencing homelessness with significant behavioral health conditions.

• **Require onsite mental health services—beyond what Medi-Cal offers.** Critical to the success of this program is to provide mental health services to individuals in need on-site. Our members find particularly for youth turning 21, once the EPSDT benefit stops and the individual is in the adult system, that there is "cliff" that occurs that can lead to destabilization. Particularly for a youth experiencing homelessness, there needs to be a trauma-informed approach that meets the youth where they are at and assists them to achieve stability in

their life and assistance in navigating systems. This goes beyond what Medi-Cal can offer, although Medi-Cal Specialty Mental Health Services can and should be leveraged wherever possible.

• **Fund variety of settings that best match youth.** Our members, which operate transitional housing programs for current and former foster youth, report that the most successful living setting for transition age youth is settings without roommates with onsite services. Issues can and do arise in shared housing settings, particularly around pets and having the ability to fund a variety of single occupancy sites are helpful. This could include duplexes, fourplexes, tiny-homes, studio apartments, etc. However, we highly encourage that there be onsite behavioral health services, including the ability to fund a space where behavioral health services can occur.

• **Encourage counties to partner with local CBOs.** We request that DHCS encourage counties to partner with their local community-based organizations to provide housing and services. Our members are experts in children and youth serving systems, have expertise in providing housing to unaccompanied youth experiencing homelessness, and are embedded within the communities that need housing and services. We believe these strengths benefit counties when they partner with us.

• **Housing First.** Our providers experience barriers with certain components of Housing First, which can make it difficult to run an effective program that serves transition aged youth—the primary barrier is including not being able to require program participation. Transitional Housing Programs include supportive services to assist transition age youth to develop skills to transition to independent living, which includes meeting educational goals, obtaining employment, and learning financial management, relationship, and daily living skills. The program includes social workers who meet with the program clients to assist them. We recommend that DHCS be flexible in their interpretation of Housing First for the Behavioral Health Bridge Housing program to be able to incorporate and leverage other funding for recovery residences and for transitional housing programs.

• **Recommend not using Coordinated Entry System.** Our members recommend that the Department of Health Care Services not utilize the Coordinated Entry System (CES) as one of the requirements for entry into Behavioral Health Bridge Housing Program. We find on the ground that CES and the prioritization methodology leads to transition aged youth having to wait till they are chronically homeless to receive housing and assistance when we know that this population is at high risk of experiencing chronic homelessness and we should be intervening earlier. It has led to situations of vacant units that could be used to serve individuals. We believe there should be a clinical assessment to match individuals into clinically enriched housing and consider youth that have had system involvement, both child welfare and juvenile justice, and prioritize those youth.

If you have any questions regarding our recommendations, please feel free to reach out to me at trinde@cacfs.org or (916) 225-3861.

Sincerely,

Tyler Rinde

Tyler Rinde
Deputy Director of Child Welfare Policy

CC: Tyler Sadwith, Deputy Director, Behavioral Health, DHCS
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