SACRAMENTO STATE
COLLEGE OF CONTINUING EDUCATION

CALHHS BEHAVIORAL HEALTH AND TASK FORCE MEETING

MEETING SUMMARY

WEDNESDAY, JANUARY 17, 2024, 10 AM – 3 PM

MEETING SUMMARY PURPOSE

This document provides a summary of the Behavioral Health Task Force (BHTF) quarterly meeting held on January 17, 2024. This summary is an accompaniment to the presentation slide deck and meeting recordings, both available for review on the BHTF webpage along with other meeting materials.

Appendix A of this summary lists meeting attendees.

WELCOME & INTRODUCTIONS

The facilitation team responsible for supporting BHTF activities, Lead Facilitators Ariel Ambruster and Julia Csernansky of California State University Sacramento, welcomed attendees, introduced themselves, and encouraged participants to contact them with any questions regarding participation in the BHTF. This is the first BHTF hybrid quarterly meeting and all 2024 meetings will be hybrid.

Secretary Mark Ghaly, California Health and Human Services Agency (CalHHS), extended New Year wishes to participants and highlighted developments in the health and human services sector as one of the largest behavioral health transformations in decades. He shared that, contrary to worries this past fall, State leaders have found a way to maintain many behavioral health investments, both large and small, in the upcoming fiscal year budget.

Secretary Ghaly acknowledging the departure of Melissa Stafford-Jones, who recently left as Director of the Children Youth and Behavioral Health Initiative (CYBHI) to do other important work. The Agency has been fortunate to find the talented **Dr. Sohil Sud**, MD, MA, a UCSF-trained pediatrician and faculty member there, to fill those shoes. Yesterday, CYBHI announced the launch of two critical statewide platforms for virtual services for younger age groups, the BrightLife Kids and Soluna apps, to be demonstrated later in the meeting. He encouraging participants to explore and share the tools. In addition, he introduced **Dr. Anh Thu Bui**, Project Director of the 988-Crisis Care Continuum initiative, noting her decades of experience as a community psychiatrist, her expertise and commitment to the work.

A significant focus of the day's agenda is on behavioral health challenges within the justice system. Secretary Ghaly said that, working in San Francisco and Los Angeles, he experienced the pivotal role of early and compassionate intervention for individuals with serious behavioral

health needs who find themselves entangled in the justice system. There is room for improvement in the state's approach, there are new efforts such as the CalAIM Justice Involved Initiative and aspects of BH-CONNECT up for approval that could help people on the road to or currently in incarceration with support services, even housing. If support is packaged in the right way, people can successfully make the transition back to their communities, enjoying themselves and making their communities stronger. He stressed the importance of continually pushing for improvement. The BHTF has the right range of agency, sector, and stakeholder perspectives to dig in deeply on how to deliver for this population. He concluded with a call to collectively delve into the challenges of the justice intersection space, particularly with the recent launch of the justice initiative to ensure better support for those currently in correctional facilities and, crucially, to prevent others from entering such settings due to unmet behavioral health needs.

Deputy Secretary of Behavioral Health Stephanie Welch, CalHHS, acknowledged the renewed in-person engagement of the BHTF and emphasized how in-person interactions among the diverse BHTF membership can rebuild relationships and understanding of ground-level realities.

GETTING TO KNOW EACH OTHER – SPEED NETWORKING

Meeting attendees were invited to get to know each other through a brief networking exercise by sharing an answer to one of the two questions below:

1. *What encouraged you to become a part of the BHTF?*
2. *What is something you'd like others to know about you?*

JUSTICE-IMPACTED POPULATION: BEHAVIORAL HEALTH CHALLENGES AND OPPORTUNITIES – PANEL CONVERSATION

In her introduction, Deputy Secretary Welch noted that people who exit incarceration are most likely to die within the first two weeks. The State can take immediate steps. California was first to receive approval for the in-reach allowing incarcerated people to enroll in Medi-Cal 90 days before release, which will be a heavy lift to implement, as was closing the Department of Juvenile Justice. It will be a heavy lift as well to support youth in reintegration and recovery. She noted youth and justice-impacted populations are called out in policy as priority populations to support in reentry, so there is a lot of work ahead.

CALIFORNIA'S CURRENT LANDSCAPE OF JUSTICE INVOLVEMENT FOR INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS

Brenda Grealish, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH) said her organization has a broad scope, encompassing both state and local levels and looking

at various sectors including criminal justice, behavioral health, housing, employment, and social services. She shared statistics on the overrepresentation of individuals with behavioral health needs in jails and prisons: 10% of the general public has substance use disorder (SUD), but 80% of those in prison do; about 16% of the general population as any mental illness, versus 36% of incarcerated people. To reduce those discrepancies takes a collective, multi-system approach. She highlighted a CCJBH project to track medical enrollment of those released from state prisons revealing the length of time it takes to enroll, because of issues such as packets being mailed to people with unstable addresses. Regarding linking to services, data revealed challenges in penetration and engagement, particularly for those with co-occurring disorders. Focus groups indicate the low utilization is tied to insufficient education, stigma, and housing challenges, with 17% found to be unhoused, and three-fourths of those people identified as having a significant behavioral health need. A recurring focus of CCJBH is how to get these people into housing.

Ms. Grealish emphasized the pervasive stigma surrounding this population that erects barriers, infecting all sides, and urged BHTF members to think about ways to help address this. Service providers may turn away those seeking help, because they are viewed as being too behavioral, or because they are justice-involved. Among the justice-involved, there can be deep distrust in services, due to a long history of negative experiences. CCJBH has been promoting the use of peers here to help foster trust. She underscored the need for education, awareness, and stigma-busting. She concluded by urging BHTF Members to view their work through the lens of a justice-involved population, inquiring into how they can help benefit this population. Multi-system coordination, strengthening relationships across sectors, will be key, as will workforce expansion – to actually serve a seriously, mentally ill or co-occurring population is one of the highest needs, and it will take all hands on deck.

CCJBH links:

- Website
- Email

CALIFORNIA CALAIM 1115 DEMONSTRATION: JUSTICE INVOLVED INITIATIVE

Sydney Armendariz, Chief of the Justice Involved Reentry Services Branch, Department of Health Care Services, and lead on the CalAIM Justice-Involved Initiative, introduced the Initiative, part of the California CalAIM 1115 demonstration, which will test and evaluate the expectation that providing services to incarcerated Californians 90 days before release will avoid unnecessary use of more costly care. To provide context, she highlighted a 63% increase in incarcerated individuals in California with an active mental health case over the past decade

and a threefold drug overdose rate in California prisons compared to the nation. A stronger connection to Medicaid coverage during the reentry process has the potential to help individuals with behavioral health conditions maintain continuity of care, manage chronic conditions and access housing and employment.

Under federal law, Medicaid only covers inpatient hospital care for incarcerated people. In January 2023, California became the first state to receive 1115 waiver approval to provide the pre-release services. The State hopes with these services to bridge gaps, ensuring the person has a smooth transition back into the community still receiving the same level of continued care. Statewide goals include increasing medical coverage in the state; providing intervention and medications to reduce decompensation and deaths, and reduce emergency department visits and hospitalizations. The State aims to advance health equity, improve health outcomes, and serve as a national model. Under the Initiative, county correctional facilities must now provide Medicaid to incarcerated people and help them enroll in Medi-Cal before they are released. On January 1, enhanced care management for transitioning individuals went live. Between fall 2024 and fall 2026, all correctional facilities will launch 90-day pre-release services for eligible individuals. Ms. Armendariz also shared that funding to counties to stand up pre-release efforts may still be available from the Providing Access and Transforming Health (PATH) Capacity Building Program.

CalAim Justice-Involved Initiative links:

- Website
- PATH funding
- Ms. Armendariz's email: CalAIMJusticeAdvisoryGroup@dhcs.ca.gov.

CARING FOR OUR JUSTICE INVOLVED YOUTH AND FAMILIES - OYCR

Dr. Juan Carlos (JC) Argüello, DO, Chief Health Policy Officer of the Office of Youth and Community Restoration (OYCR), described the experiences of justice-involved youth, saying they may face challenges even prior to birth, through inadequate prenatal care. Many experience physical, psychological, or sexual abuse, as well as neglect. Approximately 70% of justice-involved youth have faced significant trauma in their lives, such as food insecurity or homelessness. They often face racial disparities, economic segregation, and exposure to violence, with about 90% survivors of violence or who witnessed violence in school. He emphasized that these environmental experiences might trigger epigenetic changes leading to mental illness.

Regarding mental health issues, justice-involved youth may experience attention deficit hyperactivity disorder (ADHD), conduct disorder, major depressive disorder, or post-traumatic stress disorder (PTSD). Substance use disorders are also common, affecting around 50% of the youth, often with parents suffering from addiction. Dr. Argüello touched upon the educational challenges faced by justice-involved youth, with about 48% below grade level in math and reading. He emphasized the importance of understanding neurodivergent disorders, such as autism and dyslexia, and tailoring services to the unique strengths and challenges of these individuals.

Dr. Argüello shared OYCR initiatives to address the unique needs of justice-involved youth, including the Stepping Home model, grants for less restrictive rehabilitative settings, and efforts to end the incarceration of girls. He also discussed the development of a Youth Advisory Board, a Youth Bill of Rights, and partnerships with organizations to provide comprehensive services and support. He underscored the importance of education, vocational training, family engagement, and the role of credible mentors in the lives of justice-involved youth. He urged BHTF members to consider justice-involved youth in their program development.

OYCR Links:

- Website
- Email
- See slides for a list of online resources

JUSTICE-IMPACTED POPULATION: BEHAVIORAL HEALTH CHALLENGES AND OPPORTUNITIES – GROUP DISCUSSION

BHTF Members were invited to ask questions about and discuss the presentations, verbally and in chat. Questions, answers, and comments follow.

- The PATH program is beneficial for those in local custody for at least 90 days. However, we are finding many individuals have repeated short stays of about 3 days for substance use or misdemeanor offenses and there isn't sufficient time to connect them with Medi-Cal and other services. How can we connect and support these individuals?
    - Ms. Armendariz referenced the Justice-Involved Initiative policy guide and its short-term model (in Section 8), which aims to achieve as much as possible in a short time. The goal is to initiate the application process, screenings, and essential services, and get through as much as possible, even if the individual stays for a short duration. She offered to provide further assistance and suggested reaching out for additional support.

- Is the 63% growth in people with mental illness in jails over the past 10 years due to criminal justice reforms, leading to a higher proportion of inmates with mental health disorders? The increased incarceration despite efforts to decriminalize behavioral health issues is surprising.
    - Ms. Armendariz mentioned that the statistic is from an article by California Health Policy Strategies, analyzing the period between 2009 and 2019 and may be a bit outdated. You may be correct – it could be things are working, but not within the timeframe studied.
    - Secretary Welch said it is difficult for those with serious mental illnesses to be incarcerated, and they may respond to the experience with behavior that is perceived as problematic through a public safety lens. People in public safety say they are not seeing that the behavioral health sector is prioritizing this population. She would like the group to discuss why we are not making the desired progress.
- Being a member of the LGBTQ community was not mentioned in the discussion about reasons for youth incarceration. Family discrimination and rejection have significant impacts on LGBTQ youth, leading to homelessness and engaging in survival crimes. About 20% of incarcerated youth are LGBTQ, and LGBTQ adults are three times more likely to be incarcerated than their heterosexual counterparts. In references offered today, he did not see recommendations for LGBTQ cultural competency training for prison officials or for mental health providers within the prison system. Post-release programs work with policing agencies and DHCS and then get formerly incarcerated into services, and there was no mention of the triggering effect of interacting with policing agencies for many in the LGBTQ community due to past negative experiences. Is there data being collected on LGBTQ individuals being incarcerated? Are there plans for LGBTQ cultural competency training at all levels, from incarceration to reentry, including interactions with homeless shelters? And if there are no such plans, who is being engaged to address the needs of this vulnerable population?
    - Dr. Argüello said the speaker is absolutely right, this is extremely important, and he should have included that OYCR is beginning to work with UCLA to conduct a literature search on effective interventions for LGBTQ+ youth in the system. They will also look to incorporate the WPATH (World Professional Association of Transgender Health) guidelines, and they will build interventions and a project as technical assistance to their partners.
    - Ms. Grealish appreciated the recommendations – these are issues the Council can discuss. Regarding stratifying data by sexual orientation and gender identity

(SOGI), she will see where the DHCS is in collecting that data, and the Council can absolutely bring that stratification into its data sets.

- The waiver will open opportunities to improve outcomes. There is an important intersection between lack of housing and the overrepresentation of individuals with mental health and substance use needs in the criminal justice system. Nevada County sees a very high overlap between people in the homeless services system and those in the criminal justice system. The challenges faced in housing individuals diverted from the criminal justice system, especially high-utilizers or frequent flyers, are the difficulty in finding housing, and viable placements with sufficient staffing and support, which aligns with the earlier point about challenges in housing individuals and workforce issues.
    - Ms. Grealish underscored the significance of the housing issue, saying it aligns with her everyday work experiences.
- A key challenge in engaging people with substance use disorders is the historical approach of making individuals feel bad by emphasizing the negative consequences of substance use. This approach may not be the most effective in healthcare. In other health contexts, such as diabetes care, the focus is on care rather than making patients feel bad. There needs to be a shift toward harm reduction, a broader approach to healthcare. It is important change the narrative around substance use, moving away from stigmatizing language and toward a more compassionate and supportive model of care. This shift requires a systemic change at both the local and state levels, involving justice partners and fostering a community-wide conversation.
- All the work being done to track and ensure the successful integration of individuals into communities upon release is appreciated. With the challenge of mailing packets when individuals may not have stable addresses, is work underway to instead use tech-driven approaches, given increasing access to cell phones?
    - Ms. Grealish said DHCS is actively working on a solution, particularly for the 90-day in-reach program, aiming for an auto-assignment for qualified individuals before release to eliminate concerns about packet issues. Efforts are also underway within the Division of Adult Parole Operations, specifically the Behavioral Health Reintegration Clinical Team, to support individuals in picking up where they left off in prison. The transitional case management program is involved in this process to address the interim period until the 90-day in-reach program is fully implemented.
    - Ms. Armendariz emphasized that a part of the Justice Involved Initiative is to have a pre- or pre-and-post-release care manager. Ideally, the same person would help facilitate the re-entry process, ensuring that individuals have their

appointments set up and receive the necessary information. The goal is to reduce challenges related to tasks like sending out packets or expecting individuals to search for services on their own. This initiative is at the heart of their efforts, although it hasn't started yet, with a two-year timeline until the end of 2026 to get it underway. The intention is to mitigate challenges in the re-entry process.

- The question at the center of the health equity issue is there are things that almost everyone experiences in life, such as addiction, but why is it mainly black and brown people who face challenges and disproportionate impacts in getting addicted, accessing treatment, and going to jail because of addiction issues? There needs to be a deeper inquiry about why and what happens before they need a pre-release program. How involved is California Department of Education in these conversations, as you can't have this conversation without looking at the specifics in the school-to-prison pipeline around suspensions and expulsions, to get at some of the root causes.
    - Dr. Argüello agreed it is extremely important to understand the "why." OYCR is looking at how sometimes school policies and procedures can force young people into the justice system, and has hired an education subject matter expert, Dr. Michael Massa, to look at this issue more closely.
    - Ms. Grealish said the Council has a juvenile justice work group that looks at student behavioral health. Sometimes youth can only express themselves by their behaviors and that is an opportunity to wrap around that youth in the best way and address their needs. The Council seeks to also help at-promise youth, to get upstream before issues arise. It also has legislation recommendations. She expressed openness to this conversation and loved the thinking to guide their work.

- It is very important to establish connections before release, to identify individuals early, especially those with short turnaround times, who might still have active managed care plans. There needs to be early identification by the right people, as individuals may already be engaged with community partners or clinics. Medication changes during incarceration are particularly crucial, and we need to avoid delays upon release. A person-centered approach is important, giving options, not dictating, and ensuring equity so that individuals are motivated to follow through with choices after release.
- A BHTF member expressed interested in understanding more about the initiation of pre-release services, potential impacts on release dates due to service unavailability or delays, and the availability of Black mental health providers for Black inmates.

- The increased prevalence of mental disorders and substance use disorders could be attributed to the rise in enhanced assessment capacity in jail/prison settings, thereby addressing past under-reporting.
- What components of the initiative are available for incarcerated older adults?
- It is important to engage education partners in initiatives, especially considering the significant educational needs of incarcerated youth and adults.
- How much is a multi-system approach being used to addressing juvenile justice mental health issues, coordinating across schools, foster care, and healthcare and addressing youth needs? And also moving the place of services from juvenile justice systems to the community?
- Will care managers be employees of the managed care company or staff of the county mental health plan?
- Given the health impact of the criminal legal system, why do people have to go to carceral settings to receive services, and why do these settings receive the majority of funds for implementing pre-release services? Who are the vendors listed as increasing justice system health equity capacity, and do they have the expertise needed?
- About seven years ago, California prisons had the highest opioid death rate among the nation's prisons and jails, then Medication-Assisted Treatment (MAT) reduced opioid-caused deaths quickly by 60%. MAT was provided by primary care providers, a strategy rarely considered for community behavioral health systems.
- Regarding the earlier discussion of racial equity, it's important to directly address root causes like racism and systemic racism, as well as their consequences.

988-CRISIS POLICY ADVISORY GROUP UPDATE

Dr. Anh Thu Bui, Project Director of 988-Crisis Care Continuum, CalHHS, updated the BHTF on the newly launched 988-Crisis Policy Advisory Group (PAG) and sought member input on the initiative's work. Assembly Bill 988 (AB 988) in 2022 established the 988 fund to collect fees from phone lines to support the operations of 988 centers and related crisis services and created the 988 Technical Advisory Board to work on interoperability between 988, 911, and behavioral health crisis services. The goal is a California-specific unified platform for 988 interoperability with 911. The legislation also requires CalHHS to develop a five-year implementation plan by the end of 2024.

The Policy Advisory Group, launched in December, will advise CalHHS in developing the plan recommendations. Six workgroups will launch soon to address the 14 required topics outlined in AB 988. These workgroups will delve into areas such as a comprehensive assessment of the behavioral health crisis services system, 988 standards and guidance, integration with the crisis care continuum, data and metrics, strategic communications, and funding sustainability. Dr. Bui

inviting BHTF members to join and participate in the workgroups and contribute their expertise and resources. A key part of the plan process will be seeking to involve specific populations of focus, such as justice-involved individuals, tribes, urban Indians, BIPOC communities, LGBTQ+ groups, and others facing barriers to access. The Policy Advisory Group includes seven BHTF members, and Dr. Bui invited Task Force members and attendees to participate in workgroups and plan development:

- To volunteer for a Workgroup, complete the "Workgroup Statement of Interest Questionnaire"
- Sign up for updates on the 988-Crisis process and information about upcoming engagement opportunities (e.g. focus groups, surveys) by emailing AB988Info@chhs.ca.gov
- More information here or email here AB988Info@chhs.ca.gov

BHTF MEMBER INPUT ON 988-CRISIS POLICY ADVISORY GROUP WORK

Dr. Bui sought focused input from BHTF Members to help support the work of the 988-Crisis Policy Advisory Group.

POPULATIONS OF FOCUS – WHO IS MISSING?

To expand the effort's reach, BHTF members were asked to consider what populations of focus might be missing from those outlined in the Behavioral Health Crisis Care Continuum – particularly populations experiencing high rates of suicide, substance use disorder, overdose/overdose deaths, or who face inequities in the behavioral health system.
BHTF members, verbally and in chat, recommended:

- Justice-impacted individuals and those reentering justice systems
- Rural communities, which tend toward higher rate of suicide
- Unhoused individuals
- College-aged students and ensuring integration of 988 with campus safety departments
- White, middle-aged males (American Foundation for Suicide Prevention's 2017 report indicated this population is 70% of those who engaged in and completed suicide)
- Members of law enforcement and members of the medical professions have unique characteristics in regard to the way that crises need to be handled
- Active military
- Perinatal populations and maternal postpartum health – 23% of perinatal deaths are preventable
- Deaf community

- Disabled community
- Undocumented individuals, in particular those recently arrived and those seeking asylum
- Individuals in transition from active to veteran status
- Foster youth

HOW TO ENGAGE OR "GO TO" POPULATIONS OF FOCUS

Dr. Bui asked BHTF members how to reach and meet these populations. She offered an open invitation for ongoing thoughts and advice on how to engage all populations effectively. Verbal and chat comments, questions, and discussion are summarized below.

- There is frustration that, despite marginalized communities' consistent desire for complete removal of police officers from crisis care, and agreement on that, there is a reversion to a sanitized co-responder model involving police. This leads to an erosion of community goodwill and trust in institutions and a feeling that public opinions are solicited but repeatedly ignored. As a youth, this is frustrating that promises of "decarcerating crisis care" were not upheld.
- There are barriers to reaching out to foster youth involved with the Family Urgent Response System because of the program's proposed State budget cuts. How can we engage the foster youth population around crisis response, as there are placement stability issues that can escalate to 911 response and the need is to de-escalate, prevent, and do early intervention. The State can tap into the ongoing conversations among county workers and families about not only preventing crisis but also rolling out mobile response systems.
- A BHTF member echoed concerns about police involvement in mental health crisis response and people of color, and Blacks in particular, dying disproportionately in such situations. Taun Hall's son Miles died at the hands of the police after the family had cooperated with and informed police of his mental illness. A next step is specific state guidance, transparent uniform standards around when police are to be involved in crisis response.
- A BHTF member asked for clarification of Advisory Group and workgroup roles and the engagement structure.
    - Dr. Bui shared that the main Policy Advisory Group comprises around 40 members. Six workgroups will focus on in-depth exploration of topics outlined by AB 911. The workgroups consist of both Advisory Group members and individuals from the public who are not part of the main group. The workgroup purpose is to provide detailed input, including research and recommendations,

directly to the Advisory Group. All these efforts contribute to the formation of recommendations for the 5-Year Implementation Plan and facilitate a more thorough examination of specific aspects of the initiative.

- Carmen Katsarov of CalOptima Health offered to connect the initiative with youth advisory groups across different regions of California, as they have been helpful in discussing potential solutions.
- The 988 process could benefit from the wealth of existing local processes across California, including Mental Health Services Act planning processes and behavioral health boards and commissions that reflect community input about prevention and funding for local crisis response. An issue often arising in those discussions is families' difficulty accessing basic outpatient services. While acknowledging California's expansion beyond the 988 model to look at crisis prevention, there remains the issue of adequate basic care and services. The Hall family was commercially insured but did not have access to the degree of services they needed. Groups like NAMI coach families to use 911 or law enforcement to get into the county system through involuntary treatment, laying these issues at the door of the county behavioral health system. However, it is important for the BHTF to look at the root issues upstream for a more comprehensive prevention strategy.
- The 988 implementation legislation was not without disagreement between the Legislature and the Administration, so involving a legislator or staff in the process in some way would help build buy-in for proposals emerging from the group.
    - In response, Deputy Secretary Welch said Assemblymember Bauer-Kahan is on the Advisory Group, but she can explore more ways to involve legislative perspectives in the process and appreciates the active participation of legislative staff on the BHTF.
- Thinking about the need to broaden the focus to incorporate experience on the substance use crisis, members of grassroots harm reduction groups can provide tremendous on-the-ground knowledge of the user community and its crisis experience.
- A BHTF member echoed the concern about budget cuts to the Family Urgent Response System. Regarding foster youth and justice-involved youth, we need to reach out to local grassroots organizations with no current involvement in the mental health system and make sure they are engaged and providing input. Regarding integrated services, it will be important to use relationships with schools and school boards to develop the recommendations, as schools are often put in the position of needing to contact law enforcement in handling youth behavioral issues.
- COVID and the resulting increased demand for mental health services, especially in underserved communities and the LGBTQ+ community, has prompted senior-serving

community non-profits to offer mental health services. There is lack of sufficient and culturally competent services. Staff and clients of these organizations could participate in focus groups.

- Approach leadership of community organizations serving very vulnerable populations to help create opportunities for listening sessions to gather input from those who may be hesitant to participate in formal forums. Also, members of the Public Defenders Association of California and the District Attorney's Association of California are very interested in reducing community interactions with the criminal justice system and it would be good to get their input.
- The topic of the interaction between law enforcement and 988 has arisen multiple times. Can you clarify if there has been a decision regarding the co-response model or if we are still exploring it? Knowing that answer matter could impact the advice that BHTF members provide.
    - Dr. Bui said that topic relates to the Medi-Cal mobile crisis benefit, but the plan is far beyond that. 988 was implemented on a national level, but states assume responsibility for it at the state level and certainly talk about what their role as a state will be. The State has not made any decisions about what needs to be done as a state. There are many models of mobile crisis response, including co-responder models in different communities, and what statewide standards would look like. The recommendations staff put together will need to be thought about, considering both local needs and the broader State-level vision for the future.
    - Secretary Welch said that, in an earlier meeting on 988, several BHTF members not here today had talked about their passion, and the message was not “let’s not have law enforcement response," it was “let’s make sure people don’t inappropriately experience crisis, let’s find innovative ways to use peers and other people to support people to prevent crisis.” This is maybe a reframe, but she wanted to acknowledge that other perspective. This is a plan and set of recommendations and an incredible opportunity to do a lot of work and have these conversations and look toward the future, to build out our behavioral health system.
- It’s important to take a step back. We are talking about how to connect callers to a national suicide prevention hotline to a broader crisis care system. There are a number of steps and problems: number one, we historically have not had a really robust, fully funded and supported, discrete to behavioral crisis response system. We have had a patchwork of some mobile crisis available sometimes, and co-response models, and a sprinkle of this and that. Next, yay, California, we passed the tax, and now we have to

figure out what to do next, and the road to a comprehensive crisis system will take time and resources beyond what has currently been put on the table. What I hear people talk about is beyond our current emergency response system for everything else. It's not connected to EMS and fire and police. And historically, I would argue one note of caution: We do not have a good track record on well-resourced behavioral health unique stand-alone systems. It's going to take a lot of time and intentional thought about how we fill those gaps. The mobile crisis benefit, which just launched, the county behavioral health system, is also a patchwork as well. One decision that I know that has been made, around the technical advisory committee for 988/911, is to look at procuring a vendor to create a platform to route calls back and forth between 988 and 911. And under Medi-Cal, that Medi-Cal won't reimburse for police officers involved in mobile crisis response. Those are two decisions in regard to law enforcement that have already have been made at the State policy level. The degree that law enforcement has any involvement at all is a bigger question, because, look at EMS, 911 more broadly, but that's a good conversation obviously for us to have.

- It's incumbent upon us to lean in to the process and sign up for the workgroups. This is not a set-it-and-forget-it opportunity, but a once-in-a-lifetime baseline around the services that we are looking forward to providing throughout the state. As an active participant in the data workgroup, data matters from a culturally affirming practice perspective, and from a tracking who-is-getting-what-services perspective. If you see a workgroup you'd like to be involved in, let them know, because this has been an incredibly collaborative process.
- About 7-8 years ago, the Rand Corporation conducted a study of the usage of California that would be prudent to review. Also, RAND Corporation research on California's Suicide Hotlines.
- Outreach to local County BH/MH Advisory Boards, which represent important constituencies; and consumer run clubhouses.
- Jenny Bayardo invited the 988 process to utilize the California Behavioral Health Planning Council's Systems and Medicaid Committee and/or the Council's Quarterly meeting.
- The 988 response system can be perfectly designed, but if the local referral resources (where the individual in need resides) are lacking in effective crisis response assistance, what then?
- The UC System offered to help host meetings to engage college-aged populations. UC has a Student Mental Health Oversight Committee and Behavioral Health Community of Practice that includes mobile crisis response.

- Host town halls with local LGBTQ CBOs where community members and LGBTQ advocates can gather in a safe space and share their experiences and needs. Also, KII have been helpful when asking what is needed to LGBTQ-specific mental health providers who work at LGBTQ centers. Ensure facilitators are members of their respective communities as they will understand what is being said and can empathize with community members.
- Is there collaboration with the California Office of Community Partnerships and Strategic Communications (CA-OPSCS) and the statewide Trusted Messenger campaigns they implement?
- Contact LGBTQ Community Centers – they are good places to have a focus group and to reach all generations.
- As California rolls out a more comprehensive crisis response system, it will require a workforce component regarding training (e.g. best practices; co-occurring capacity; law enforcement partnership). We are woefully under-resourced to fill out these essential roles.

REVIEW AND DEBRIEF LUNCH AND LEARN: STREET MEDICINE

Brett Feldman, MSPAS, PA-C, Director of USC Street Medicine, said support from CalHHS has allowed the method of care to make more progress spreading across California in the last two years than in the previous 15, elevated from a fringe movement to a legitimate part of the healthcare continuum, recognizing the people they serve as being worthy of being cared for. In the last year, the number of California programs has risen from 25 to 55. Street medicine seeks to provide the unsheltered with the same quality of care on the street as that expected in a brick-and-mortar clinic. Central to its mission is not only the provision of medical care but also the establishment of a genuine connection through understanding and compassion. Services extend beyond the basics to medication dispensing, lab work, ultrasounds, and EKGs. Mr. Feldman said the work is done through walking rounds from a pickup truck, allowing the team to avoid the constraints of fixed sites or mobile units and meet individuals in their own environment, on the street or in an encampment, intentionally shifting the power dynamic to prioritize their comfort and needs. Continuity of care, by following people from the hospital to the street, has reduced readmissions at one hospital from 30% to 10%. Housing rates are 30-40% for those they treat. Challenges include a scarcity of street psychiatrists, so the primary care members of a team have tried to train themselves to practice at the highest scope they can. Crisis management is effective and needs to be scaled up from its current small scale.

Joseph Becerra, Community Health Worker, Certified Addiction Treatment Counselor, USC Street Medicine, highlighted the effectiveness of having a street psychiatrist as a part of their team, leading to increased openness among patients.

Mr. Feldman shared key challenges and opportunities for growth: grappling with how delegated models limit access to medically necessary services, training street medicine PCPs in street behavioral health for mild to moderate illness, and the need for sustainable funding.

- Link to view a recording of Lunch and Learn – Street Medicine.
- For more information: visit the USC Street Medicine website.

BHTF MEMBER DISCUSSION

- Along with providing street medicine, how do you interact with the behavioral health agencies in order to provide housing and other social services? How does it fit into the whole system?
    - Mr. Feldman said that all of their patients are patients of USC, so the approach is 100% integrated into the healthcare system. He and his colleagues are working to add referrals to housing, which has not yet been allowed, but try to bring patients as close as possible to housing, including getting all of their documents together. They work very closely with Los Angeles County Department of Mental Health. Their challenge is the number of unhoused people who need those services, so they have chosen to focus on the most severely mentally ill who might need to be conserved. Even within that focused population, they don't have enough capacity to meet the need. Because of that, the Street Medicine program has hired its own psychiatrists.
- With the growing number of people over 50 on the streets in California, how are you working with the Department of Aging in Los Angeles, as people will need aging services and aging mental health services?
    - Mr. Feldman shared that approximately 40% of the program's patients are over 55, and this percentage appears to increase each year. The program has a close collaboration with the National Center for Elder Abuse within their department and the Center for Aging. When somebody is experiencing homelessness, it tends to overshadow other descriptors. For example, the Center for Aging or the regional center will communicate that they don't typically provide homeless services, and they can reconnect with that person once they are housed. But the Street Medicine program is concerned that the lack of services during previous housing experiences could contribute to individuals ending up on the streets. So there are opportunities for collaboration with various organizations. Another example: the program is trying to involve women's rights organizations as over 90% of females experiencing homelessness are sexually assaulted. He stressed the

importance of helping them understand that homelessness doesn't have to overshadow other critical issues.

- San Francisco has a pilot program where Department of Aging Services can be brought in once someone is placed. It would also be helpful to make shelters more age friendly. I encourage continued efforts to collaborate.
- What is the role of funding from the Department of Public Health (DPH) on your work?
    - Mr. Feldman said his program is still in the process of figuring that out.
- Is there a definitive staffing pattern, both locally and nationally? Do you provide medication-assisted treatment, particularly Naloxone? Regarding social services, there would need to be a wide array provided, and I'd imagine they would constitute a significant portion of the bundle of services.
    - Dr. Feldman agreed. The team does provide not only Naloxone, but also Suboxone, and the new long acting injectables. He outlined their model, which involves training primary care staff to handle mild to moderate cases, with a psychiatrist serving in a consultant role for more severe cases. However, he noted that this model hasn't been widely propagated due to a shortage of psychiatrists on the street.
- In an exchange via chat, a BHTF member asked how the Street Medicine team acquires drugs for its purposes, if that is through a provider license. This is an issue because, although DHCS supports street medicine, the Board of Pharmacy has indicated to Community Health Center-owned pharmacies not to use their drugs for street medicine efforts.
    - Mr. Feldman said yes, via a provider license, which is allowed under a physician dispensing law.

UPDATES ON CYBHI

Dr. Sohil Sud, MD, MA, new Director of CYBHI, expressed his enthusiasm for engaging with the BHTF as thought partners in moving upstream and exploring innovative ways of early and frequent interaction with youth. In framing the introduction of two new online behavioral health platforms offering coaching and resources to children and youth, he noted that young people don't live in doctor's offices, but in their homes, schools, and communities, and they also spend a significant amount of time online. These platforms offer an alternative to Google and aim to guide them in understanding their emotions and to offer appropriate triage in communities and during crises.

Sheela Abucay Kamara, Behavioral Health Digital and Operations Section Chief, DHCS, said the two platforms launched on January 1, 2024 offer free, app-based behavioral health services and

wellness supports, irrespective of insurance. One platform, "BrightLife Kids" by vendors Brightline is for parents and caregivers with children aged 0 to 12. The second, "Soluna" by Kooth is focused on youth and young adults aged 13 to 25. They provide professional coaching through in-app chats or video visits, access to educational content, age-tailored articles, videos, podcasts, and stories. Clinically validated assessments, care navigation services, peer communities, and crisis and safety protocols are also features. Over 300 youth and parents across the state offered feedback as the apps were developed. Ms. Kamara shared demos of each:

- Bright Life Kids demo video
- Soluna demo video

BHTF MEMBER DISCUSSION

BHTF Members were invited to ask questions and offer comments on the CYBHI updates.

- What is Soluna tool access like for students transitioning from ages 25 to 26, or does access get cut off when they turn 26?
    - In response, Ms. Kamara clarified that the app's cutoff is contingent on user input for the date of birth. There is hope resources will be available for those who are 26 and won't be able to access the app; also, this age group may include parents who can access BrightLife Kids.
- For educational institutions, is there a way to obtain data and analytics from the tool to better serve students?
    - In response, Ms. Kamara highlighted DHCS' robust data monitoring protocols to ensure the apps are directing to the right resources.
- Is it possible to customize the tool, such as mapping in local campus and community resources?
    - Ms. Kamara emphasized the presence of a free care navigation capability allowing users to locate resources based on zip codes or areas.
- Thank you to the State for building on the initial investments in CalHOPE, a program established during the pandemic through federal grant funds in collaboration with counties and peers.
- How are these new platforms layering on existing resources through schools, such as BrainPOP and Care Solace, and how parents should view them: as additional or potentially replacing the current tools? And what mechanisms are in place to ensure appropriate referrals to the correct delivery systems through these platforms, recognizing historical challenges in achieving accurate referrals?

  - In response, Ms. Kamara and Dr. Sud clarified that the new services should be seen as additional resources rather than replacements for existing services. They emphasized the unique aspect of these platforms, providing one-on-one coaching support and care navigation services accessible at hand, offering immediate assistance during times when reaching other support services might take longer. The intention is to complement the current systems and provide an extra layer of support for all California children, youth, and families.
  - Dr. Sud said the navigation is a work in progress, tricky to implement and will look different for different social groups. He welcomed ongoing feedback on the best ways to deploy the tools.
- (Via chat) Is there a marketing plan for these platforms that includes influencers popular with youth? Is there a formal evaluation component.

BHTF MEMBER UPDATES

BHTF Members were invited to share updates and announcements related to their work:

- Virginia Wimmer, California Department of Veterans Affairs (CalVet), announced the launch of a survey specifically for women veterans that will enable the Department to better serve them based on their needs and preferences. She encouraged women veterans to participate in the survey and others to spread the word to women veterans they know. The confidential survey takes between 10 to 20 minutes to complete and will remain open through the spring. She urged those who haven't received it to reach out directly to her so she can provide the link.

PUBLIC COMMENT

Members of the public were invited to share comments and questions.

- **Stacie Hiramoto, Director of REMHDCO, the Racial and Ethnic Mental Health Disparities Coalition** said the hybrid meeting format worked very well for her. Ms. Hiramoto raised concerns about a Request for Applications related to CYBHI on local-level public education and change campaigns administered by the Department of Public Health that was released on December 1. REMHDCO, the California Reducing Disparities Project, and other major state-level behavioral health organizations did not hear about the RFA until the week of the webinar on it and days before the letter of intent was due. The second webinar's notice was given less than 24 hours before its occurrence, which was the day before the letter of intent deadline. Their understanding was that the project aims to serve historically underserved, unserved, and inappropriately served populations, including priority populations like African American, Asian Pacific Islander,

Latinx, Native American, and LGBTQ+ communities. REMHDCO appreciates that aim but is concerned there was not adequate outreach and notice to local organizations serving these communities and fears few organizations made the Jan. 16th deadline. They hope the matter is reviewed and, if few applications are received, that extraordinary measures are taken to ensure the set-aside funding reaches the intended underserved populations.

NEXT STEPS & CLOSING

Deputy Secretary Welch thanked BHTF members and stakeholders for joining the meetings and for sharing their valuable input. She acknowledged previous BHTF member recommendations to discuss the implementation of mental health parity, workforce and supportive employment, and encouraged participants to continue providing comments and feedback in the meeting evaluation, including on the new hybrid meeting structure, and on ways to support BHTF members in sharing information with each other. She emphasized the importance of making the meetings more informative for the participants.

Upcoming Lunch and Learn:

- March 6, 2024

Upcoming Quarterly Meeting Dates (all will be hybrid):

- April 10, 2024
- August 28, 2024
- November 13, 2024

For more information, please visit the BHTF website.

APPENDIX A. MEETING ATTENDEES

STATE REPRESENTATIVES AND BHTF MEMBERS

Chair: Mark Ghaly, Secretary, CalHHS
Dr. Tomas Aragon, CDPH
Dr. Juan Carlos Arguello, OYCR
Michelle Baass, DHCS
Jenny Bayardo, BHPC
Mareva Brown, Senate
Stephanie Clendenin, DSH
Susan DeMarois, Aging
Brenda Grealish, CCJBH
Kim Johnson, DSS
Genie Kim, UCOP
Elizabeth Landsberg, HCAI
Meghan Marshall, CIC Homelessness
Dr. Diana Ramos, Surgeon General
Rebecca Ruan-O'Shaughnessy, CCC
Kim Rutledge, DOR
Dr. Sohil Sud, CYBHI
Marjorie Swartz, Senate
Mary Watanabe, DMHC
Virginia Wimmer, CalVet
Jackie Wong, First 5
Sonya Aadam, CBWHP
Marcy Adelman, Comm on Aging
Alfredo Aguirre, LBHC
Laura Arnold, SBC Public Defender
William Arroyo, MCHAP
Charles Bacchi, CAHP
Kirsten Barlow, CHA
Phebe Bell, Nevada County BH Dept
Grant Boyken, Shatterproof
Dannie Ceseña, CA LGBTQ HHSN
Le Ondra Clark Harvey, CCCBHA
Theresa Comstock, CALBHB/C
Steve Dilley, Veterans Art Project
Michelle Doty Cabrera, CBHDAC
Ruby Fierro, CPOC
Anita Fisher, NAMI California
Lisa Fortuna, Psy/Neuro, UC Riverside
Lishaun Francis, Children Now
Leticia Galyean, Seneca Family of Agencies
Cynthia Jackson Kelartinian, Heritage Clinic
Carmen Katsarov, CalOptima Health
Karen Larsen, Steinberg Institute
Robb Layne, CAADP
Michael Lombardo, CalHHS Advisor
Stephanie Moon, LACDHS Housing/Health
Elizabeth Oseguera, CPCA
Justin Peglowski, Indian Health Services
Paul Rains, CommonSpirit Health System
Allison Rodriguez, CommuniCare Health Cen
Albert M. Senella, Tarzana Treatment Cen
Miguel Serricchio, Didi Hirsch
Christine Stoner-Mertz, CACFS
Zofia Trexler, Disability Rights California
Gary Tsai, LAC DPH SA Prevention/Control
Dawan Utecht, Telecare Corporation
Carolina Valle, CPEHN
Jasmine Young, National Health Law Program
Shaina Zurlin, CCAH

PANELISTS AND PRESENTERS

- Brenda Grealish*, Executive Officer, Council on Criminal Justice and Behavioral Health
- Sydney Armendariz, Chief of Justice Involved Re-Entry Services, Department of Health Care Services CalAIM Justice-Involved Initiative
- Juan Argüello*, Chief Health Policy Officer, Office of Youth and Community Restoration
- Dr. Anh Thu Bui, Project Director of 988-Crisis Care Continuum, California Health and Human Services
- Brett Feldman and Joseph Becerra, USC Street Medicine

* Also BHTF Member

- Sheela Abucay Kamara, Behavioral Health Digital and Operations Section, Office of Strategic Partnerships, DHCS
- Dr. Sohil Sud*, MD, MA, Director, CYBHI

CALHHS AND FACILITATION TEAM

Stephanie Welch, MSW. Deputy Secretary of Behavioral Health, CalHHS
Josephine Baca, CalHHS

Thomas Haas, CalHHS
Ariel Ambruster, CSU Sacramento
Julia Csernansky, CSU Sacramento