

**CALIFORNIA HEALTH AND
HUMAN SERVICES AGENCY
Behavioral Health Task Force (BHTF)**

June 8, 2021

10:00 a.m. – 1:00 p.m.

Meeting Synopsis

BHTF Members Attending: Andrew Imparato, Disability Rights California; Ashley Zucker, Kaiser Permanente; Carmela Coyle, California Hospital Association; Carolina Valle, California Pan-Ethnic Health Network; Cathy Senderling-McDonald, County Welfare Directors Association (CWDA); Charles Bacchi, California Association of Health Plans; Christine Stoner-Mertz, California Alliance of Child & Family Services; Emma Hoo, Pacific Business Group on Health; Hector Ramirez, Disability Rights California; Jessica Cruz, NAMI California; Kim Lewis, National Health Law Program; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Lenore Anderson, Californians for Safety & Justice; Linnea Koopmans, Local Health Plans of California; Lishaun Francis, Children Now; Mandy Taylor, California LGBTQ Health & Human Services Network; Mary June Diaz, Service Employees International Union (SEIU); Michelle Cabrera, County Behavioral Health & Human Services Agency; Sarah Arnquist, Beacon Health Options; Seciah Aquino, Latino coalition for a Healthy California; Sonya Aadam, California Black Women's Health Project; Tanja Heitman, Santa Barbara County Probation Department; Tom Insel, Steinberg Institute; Virginia Hedrick, California Consortium for Urban Indian Health; Vitka Eisen, HealthRIGHT 360

BHTF Members Not Attending: Albert Senella, Tarzana Treatment Centers; Elizabeth Oseguera, California Primary Care Association; Jose Zavala, Fresno Unified School District; Marie Webber, University of California San Diego Health;

State Representatives Attending: Amanda Levy, Department of Managed Health Care; Benjamin Lin, Department of Aging; Brenda Grealish, Council on Criminal Justice & Behavioral Health; Daniel Lee, Department of Education; Jim Kooler, Department of Health Care Services; Jim Suennen, California Health & Human Services; Joe Xavier, Department of Rehabilitation; Kim Johnson, Department of Social Services; Kim McCoy Wade, Department of Aging; Mark Ghaly, California Health & Human Services; Mary Watanabe, Department of Managed Health Care; Matt Schueller, Office of the California Surgeon General; Nadine Burke Harris, Office of the Surgeon General; Rohan Radhakrishna, Department of Public Health; Sara Rogers, Department of Social Services; Stephanie Clendenin, Department of State Hospitals; Stephanie Welch, California Health & Human Services; Toby Ewing, Mental Health Services Oversight & Accountability Commission; Tomas Aragon, Department of Public Health; Will Lightbourne, Department of Health Care Services

State Representatives Not Attending: Tom Herman, California Department of Education

Below is a synopsis of the meeting and discussion. People are encouraged to review the presentation slides posted [online](#) for detailed presentation information.

Welcome, Roll Call, & Opening Comments – Stephanie Welch, Deputy Secretary of Behavioral Health, California Health & Human Services (CHHS)

Deputy Secretary called the meeting to order, thanked, and welcomed all attendees. After conducting roll-call of all members, she provided general housekeeping rules for this meeting. She reviewed the agenda and introduced Secretary Dr. Mark Ghaly for his presentation.

The Children and Youth Behavioral Health Initiative Proposal
Mark Ghaly, MD, MPH, Secretary, California Health & Human Services (CHHS)

Home and Community Based Spending Plan

After thanking Deputy Secretary, Stephanie Welch and the entire CHHS team as well as our stakeholders and partners for their hard work and organization, Secretary Ghaly stated that the budget's focus is on upstream opportunities to ensure that people in acute crisis have access to urgent care centers, emergency rooms, substance use disorder services in acuity, hospital beds, residential programs, etc. With regard to the Home and Community-Based Services (HCBS) proposal with a deadline of June 12, 2021 to submit to the Federal Government, the near \$3 billion enhanced federal funding pool has the potential to grow up to \$5.2 billion and will open doors to many positive things such as work related to school linkages and the ability to focus on services needed by young people and other vulnerable populations (e.g. individuals experiencing homelessness). The proposal is being circulated, and conversations are underway with legislative partners. This will also allow California to draw down additional federal dollars to make sure Medicaid beneficiaries with a health condition and people experiencing homelessness have access to important resources for wraparound housing services and the actual housing itself. The objective is to center on building up the community-based system.

The Child & Youth Behavioral Health Initiative Proposal

The goal of this proposal is to transform California's children and youth behavioral system for young people ages 0 - 25 and create a system that is world-class and upstream-focused with a special focus on the young people where disparities were seen. It includes building on the adolescent substance use disorder (SUD) treatment system for the state and ensuring young people in crisis have places to go for treatment located close to their networks, communities, and loved ones. Young people should no longer use the doors of the justice system, school discipline, or school failure to access behavioral health treatment systems. Utilizing the "By Youth, For Youth" concept, young people are empowered to take control of their own mental health as individuals and as a community. Combined with the HCBS initiative, this proposal will focus on building up and improving workforce, program, and facilities components in the State of California. CHHS Agency will ensure coordination across departments, the state, and multiple systems. Stakeholders will be invited and encouraged to participate in opportunities

to provide input. . CHHS will work with subject-matter experts, creating robust youth voice that will support youth engagement. CHHS will also be responsible to manage the evaluation component that will assess not only programs and outcomes but the processes used to implement the initiative.

Member Questions/Comments

HECTOR RAMIREZ, Disability Rights California: This proposal is really appreciated along with the comments concerning cultural proficiency rather than competency moving forward. As a Latino Native American person in LA County with a disability, the light at the end of the tunnel didn't come for us. To survive, we either had to acknowledge the impact trauma has had on young people and that it will continue in future generations or pretend as though nothing happened. I am grateful for the focus of this plan to tackle our youth who continue to struggle significantly to access basic services. I would like to encourage the use of people from our communities when selecting mentors. These individuals know about our deep cultural traditions. They will know the proper way to provide information to our young people. This is equally true for disabled individuals. With regard to evaluation, the element of accountability is missing. For example, we have experienced a significant barrier to continual division as it relates to the lack of services being made available in Spanish and the lack of disability accommodations. The proposal is not clear about how past mistakes will be mitigated. Because we are not a part of the decision-making process, a level of accountability is needed to ensure that current known disparities do not continue. We are looking for change.

Dr. Ghaly responds: Yes, we do need to speak more about accountability in the evaluation process and have regular conversations with our stakeholder groups to hold us responsible. We also need to be transparent and inform people about processes and services or explain why they aren't happening.

KIM LEWIS, National Health Law Program: We appreciate the vision of the agency and for all of the departments who made the investment in behavioral health services. This is a critical and historic moment in our country. So many services in both Medicaid and private insurance are really starved and access is really challenging. Having an equity focus is very important. Medicaid has an entitlement that may provide certain young people an additional leg up. However, it falls short in many ways especially when it comes to SUD services. We want to ensure that this is looked at innovatively. Just as community-based care, wrap-around services, child and family teaming are really crucial components of what works for the behavioral and mental health systems, we need to apply them in the SUD arena as well. We can learn from these lessons and move them across instead of fitting kids in behavioral or mental health diagnosis in order to get these types of services. We hope that the focus on evidenced-based practices (EBPs) is broadened because some EBPs have a historic racial bias. Studies are not often conducted on Black, Indigenous, and People of Color (BIPOC). For that reason alone, it is a mistake to solely rely on EBPs. Mental health services in the public arena demonstrate that wrap-around and other community practices are also an important part of the system. We can learn from that. We should look at what's working, why it's working, and use that as a litmus

test. Finally, a suggestion was made to put statewide data showing who is getting what now. Despite the challenge of this undertaking, it is very important. If the data is not there to begin with, you are operating in the dark concerning what is needed, where it's needed, and who's giving what to whom. Medicaid has a set of services, and private insurance is a very different structure even with parity. There is a very low bar in terms of what is available there. It has to begin with what the picture looks like in California and how we are seeing and identifying mapping.

MARY JUNE DIAZ, SEIU California: This meeting is very important for SEIU California. Thank you, Dr. Ghaly and CHHS staff, for all of the work done. Our public sector workers are community members who know their communities and have dedicated themselves to serve their communities. Any behavioral health proposals that do not explicitly include recognition or investments in public health workers is problematic especially since we have seen this challenged repeatedly. It is also alarming that much of this proposed funding may be outside of existing public sector programs and contracted out. We look forward to working with you and the legislature to ensure there are responsible contracting standards that all entities should meet, especially if they will be allocated precious taxpayer dollars. This is an unprecedented opportunity to fund our public sector workers that have been challenged for 1-1/2 years by COVID-19 but also years' worth of underinvestment and divestment from the state. We are willing partners and open to communication. We understand there is a tight turnaround specifically to the budget items presented, but it would be remiss of us not to highlight our public sector workers and any new initiatives that are being undertaken in the new few days.

Dr. Ghaly responds: We often have vacancies because workers aren't available. The broad scaling up will help to get people to fill those vacancies. There is a lot of clear benefit to this point.

CHRISTINE STONER MERTZ, California Alliance of Child & Family Services: Many thanks to Secretary Ghaly and the team. We are thrilled to be a part of this moment and to help move this forward. As we consider building up a children's behavioral health system, the foster care system is dealing with the implementation of the Family First Prevention Services Act (FFPSA). Our Short Term Residential Therapeutic Programs (STRTPs) are looking to be considered Institutions of Mental Diseases (IMDs). This issue is an existential threat to many of these organizations, and it must be addressed. In this larger behavioral health effort, there is an opportunity to think about how to work together to engage them, make adjustments and transform. We want to ensure that those organizations do not close as we build something else.

Dr. Ghaly responds: There is definitely an opportunity to transform the entirety of this system. This is a long-standing conversation where the same question has been asked in different ways. We do need to use this opportunity to potentially reconsider certain existing conversations that seem to be tracking in one direction. Perhaps this will change the direction. There are others with a similar change in trajectory, but I do think that this is one we have to acknowledge as soon as we can.

MICHELLE CABRERA, County Behavioral Health Directors Association: Thank you Health and Human Services Agency for the amazing scale of this behavioral health investment and the particular attention both to the county behavioral health safety net, children and youth, and the substance use disorder components. Far too long SUD has been a trailer or an afterthought. We cannot only have mental health conversations any more. We look forward to building out those SUD counselors in a way that aligns the certifying body and modernizes the take on SUD. We have medically necessary vital life-saving services that sit outside of insurance markets as private pay services. This is partly due to insurance not stepping to the plate as fully as it could or should. As we are building out new capacity, structure, and workforce capacity, we need to be very mindful of that. In county behavioral health, we have somewhat been an all-payers system working side-by-side with schools to serve children. The price of admission for county behavioral health to be on school campuses has been that we serve all children regardless of pair. We want to acknowledge that unique role that county behavioral health and our contracted community-based organization partners have played on school campuses. Finally, on the infrastructure proposal, there are gaps and needs with regard to treatment facilities particularly with the sub-acute levels of care. We also need to be thoughtful and intentional about how we align our housing investments because it is hard to compete locally for scarce-housing resources for county behavioral health clients, particularly individuals with higher-end needs. While the scarcity element is going away, the impulse to prioritize other sub-populations are there. We would like to see how housing efforts line up as part of the overall community-based treatment and prevention framework.

Dr. Ghaly responds: In the HCBS proposal, linking potential housing supports and housing itself more tightly to the Medicaid system and Medicaid managed care, we will need to capitalize on real connection points to ensure that individuals experiencing homelessness with serious behavioral health and serious medical conditions are prioritized. This may not exactly address what you speak of, but it does begin to have that conversation in a very deliberate way.

LE ONDRE CLARK HARVEY, California Council of Community Behavioral Health Agencies: For years, workforce has been the number one issue and policy priority for our community based organizations. It's good to see that there is focus and conversation around diversifying the workforce and mostly that there is investment there. With that being said, our community based organizations are really concerned and interested in how that is structured and funded particularly as we talk about schools and the investment there. What will the training requirements and supervision for behavioral health at school sites look like? How will it roll out? What will be the process by which community based organizations receive referrals and reimbursement? These are things we are monitoring and hope to hear more about. We also want to ensure that community based organizations are a part of the subject-matter expert group and that the voices of all stakeholders are included at that table.

VITKA EISEN, HealthRIGHT 360: This is an amazing vision for upstream services, but we cannot deliver on it if we cannot consider worker compensation. We can do loan repayment, all kinds of earn-and-learn, and lots of supports, but the compensation for workers in the field (whether they work in public or private sectors) is insufficient. It doesn't attract workers into the pipeline. Fundamentally, it is about worker pay and worker equity. Regarding substance use, many of our workers are diversified often drawn from people with lived experience, yet have the lowest rates of pay. We need to recognize that we either have to lower our expectation of the number of people that we will serve so that we can stretch the same dollars, or we need to grow that pie because there is a critical worker shortage at all levels from front-line clinicians up to psychiatrists.

Dr. Ghaly responds: Yes, this is a huge issue that will be demanded of us to address because otherwise, it is a vision without a reality. We will be having that conversation and look forward to many of you being a part of it.

ANDREW IMPARATO, Disability Rights, California: We serve young people between the ages 16 – 25 many of which are starting out as adults. Regarding workforce issues related to our young people, this is an opportunity for them to learn how to talk about their lived experience as an asset and a strength to prospective employers. It also is an opportunity for them to learn how to ask for accommodations and to learn about their rights in the workplace. I encourage us to think of young people as workers and not just individuals in the behavioral health system and how we can help them to break into the labor force and feel comfortable asking for the things they need to be successful.

Dr. Ghaly responds: It is amazing how we predict how many people with behavioral health conditions can be identified early in life, yet we fail to do it. When we do, let's prepare for a different arc to their life in the future. This means not just managing the symptoms and the illness, but creating opportunities and participate in all the things they need to partake in to lead successful lives as young adults. This is a very complicated but important piece that we will all need to work together to bring up concerns and ideas.

LISHAUN FRANCIS, Children Now: Unless we are very clear about the groups that we are going to impact, the activities that we align to support those groups, and the outcomes that we want, accountability is going to be hard. As a state, this is going to be a problem because we still are not clear about what we want along racial, ethnic, LGBTQ lines, etc. The overarching goal desired to come from this taskforce is to be very specific and clear on what it is that we want and how we plan to align to support these groups.

Roadmap for Resilience: A Cross-Sector Approach to Addressing ACEs and Toxic Stress
Dr. Nadine Burke Harris, MD, MPH, FAAP, California Surgeon General

This presentation is about the Kaiser and CDC study on Adverse Child Experiences (ACEs) and Toxic Stress as a modifiable risk factor for behavioral health risks and the opportunities available to intervene early. Preventing ACEs and development of the toxic stress response could reduce a large number these negative outcomes. All primary care and behavioral health providers are encouraged to become ACEs-aware certified by going to the ACEs-aware website, taking the training, and attesting. The goal is to get as many of our primary care providers and behavioral health providers trained on how to screen for ACEs. Within the ACEs-aware initiative, there are a lot of resources available to provide guidance and instructions for individuals at low-, intermediate-, or high-risk for the toxic stress response. The [California Surgeon General's report](#) on ACEs, toxic stress, and health can be accessed at the Office of the Surgeon General's website. One promotion on the website worth taking a look at is, "[Let's make our state of care ACEs aware.](#)" Also, the [ACE Number Story](#) highlights the individuality of how someone's ACEs may be impacting them is unique, reflects the biology and the science of individual differences, but also hopeful. Finally, "[The Me You Can't See](#)" is a television network series on Apple TV that was coproduced by Oprah Winfrey and Prince Harry. It is a really powerful series about replacing the shame surrounding mental health with wisdom, compassion, and honesty. Public education is key to help people recognize, seek, and accept care. It is an important role in prevention.

Questions/Comments

WESLEY MUKOYAMA, Cultural Competence Chairperson and member of the Behavioral Health Board of Santa Clara: My first comment is that Asian-American females having the highest rate of suicide. Secondly, regarding depression and prevention, why isn't faith-based spirituality included? This is very important to African-American, Latino, and Asian-American communities because only a small percentage of people within this group of people seek mental health help.

Dr. Burke Harris responds: One of the challenges we face with regard to the discussion of spirituality is that evidentiary standards must be met. There are different ways that studies are structured and evaluated. Although there are promising studies and literature on spirituality, it fails to meet the standard to include into the Surgeon General report. This is why this data has not been presented.

SONIA YOUNG AADAM, CEO, California Black Women's Health Project: I respect this work greatly, sometimes I'm troubled because I don't see enough emphasis on race and ethnicity particularly with the African-American community around ACEs. Even the new promotion demonstrates 62% of Californians experience one ACE, but we know that those numbers are substantially higher for our community. It often seems that this body of work is a broad public reach campaign. This is important, but we have a crucial life and death issue as it relates to behavioral and mental health, toxic stress and the ACEs experience for the African-American community and our children. As a black organization, seeing those extremely high numbers and that it is being promoted publicly as something that is there for everyone makes it difficult to see that we are not highlighting the significant disparities in ACEs, and how toxic stress is

really rooted in racism. When we look at ACEs, we don't see racism called out. I do support this work, and I'm glad that the work around our youth is being done, but without being deliberate and intentional about emphasizing the extreme connection between toxic stress and ACEs that is happening to our children, it is a struggle to see how such an amazing impact will be measured as it relates to the unprecedented behavioral health expansion investment. Will the measurement fail to address that this issue is rooted in racism and contributes significantly to the conditions that our youth are experiencing?

Dr. Burke Harris responds: A part of the ACEs aware initiative have some intentionality to highlight, for example, racism as a risk factor for toxic stress. In order to breakthrough transformation investments that are truly healing, it will require not focusing on one population. In saying that, we do look at the dose of adversity a specific community experiences. For example, in the African-American community, we look at those things that have been passed down for generations. It takes a level of analysis and rigor to evaluate the amount of generational adversity that may be carried on epi-genetic markers in order to dictate investments in treatments. My focus is getting to efficacy and what will be effective in healing our people. In the ACEs aware initiative, we launched the health equity series to specifically talk about racism as a risk factor for toxic stress, but we also talk about other types of discrimination as factors of toxic stress. It is true that the dose is different based on the experience, circumstance, historical/generational nature. However, the goal is to solve it for all of us and to provide solutions and strategies that are tailored to the specific experiences in our communities and not mutually exclusive. We have to do both.

TOMAS ARAGON, Director, Department of Public Health: Thank you for your amazing work. Everything you are talking about are issues across all schools. Support is greatly needed for children who have difficulty regulating their emotions. This is very exciting and should have a huge impact.

LISHAUN FRANCIS, Associate Director, Children Now: We have been early supporters of the work that you are doing. A lot of people, especially in California, are comfortable talking about racism broadly. When it comes to racism, we need to be specific in the context that is being discussed. As an example, when screening for ACEs, one of the things they will come into contact with is medical racism and its historical impact. Conversations with providers need to be not just about racism but about the relationship that consumers have to the medical system. We need to have conversations also about racism in the K-12 grade environment. This will build trust as we acknowledge where our people have been harmed in the past and inform them of the direction we are currently pursuing. It will also impact our understanding of how to respond to youth and consumers.

Dr. Burke Harris responds: Using COVID-19 vaccinations as an example to this very topic, the breakdowns show 90% of eligible Caucasians in California have at least received one vaccine. The percentages are in the 40s for African-Americans and Latinos. That demonstrates

how the history of medical racism continues to kill people when they don't trust and sign up for a life-saving vaccine. We have a lot of work to do.

CAROLINA VALLE, Policy Director, CA Pan Ethnic Health Network: One of the issues we have been thinking a lot about is the cost delivery collaboration that needs to happen around addressing and reducing ACEs in the next generation for both kids and adults. How are you thinking about that piece? There is a lot that can be managed in the primary care setting when it comes to clients or patients that need services outside of the primary care setting. What have been some of the themes that come up among the primary care providers that you work with? Also, how will they collaborate with systems outside of their control such as the behavioral health system? Has the need for primary care provider training come up around connecting patients that do need some counseling or do need some additional support with their health plan services?

Dr. Burke Harris responds: This has been a big issue we have been working on for many months. Some of it has to do with roles and accountability. The network of care grow map is approximately 80 pages. It's about how to create closed-loops systems of accountability, communication, roles, and how we all support each other to obtain a good outcome for patients. Sometimes we lay out guidelines, and sometimes we learn-as-we-go while refining & correcting. We also hope to share information to improve the quality and the efficacy of this work.

CATHY SENDERLING-MCDONALD, Executive Director, County Welfare Directors Association (CWDA): What advice or suggestions would you give for organizations like ours on how we can amplify and share those messages as well as use them within our organizations and the communities that we serve? Do you have any thoughts or examples that would help to get this going?

Dr. Burke Harris responds: A lot of these materials are being shared through social media. There is a social media toolkit for both the ACEs Aware and Numbers Story. Many people are embedding this work in the trainings or community education they provide. The Numbers Story is intended to be used as public education material. Within the Numbers Story, specific information can be searched to find information that will provide help sought after (e.g. parenting with ACEs). These are a few suggestions on how to incorporate this information into your client- or patient-facing materials. Also, in your network channels, make clinicians, providers, and any educational or promotional organizations aware of these resources.

STEPHANIE WELCH, CHHS Deputy Secretary: Perhaps we can get some of this information on our website. On the next agenda item, due to time constraints, the Department of Managed Health Care will present a few announcements and highlights about the work they are doing in implementing MH parity reforms. A full report will be given at the next scheduled meeting in September.

Department of Managed Healthcare Update

MARY WATANABE, Director

- 1) Help is needed on the implementation of the SB855 which significantly expands access to behavioral health services particularly around mental health parity. We will be working on regulations. Anyone interested to work with us, please send an email to [Amanda Levy](#).
- 2) In the Governor's budget last year, we received approval to conduct targeted focused behavioral health investigations of commercial health plans. More about this will be shared in the future.
- 3) We are interested in the consumer's experience in navigating the healthcare system, where the barriers are, and highlighting the differences between commercial and MediCal coverage. The first five health plans we will be reviewing include: Community Care Health Plan, Inc., Sutter Health Plan (Sutter Health Plus), Cigna HealthCare of California, Inc., Contra Costa County Medical Services (Contra Costa Health Plan), and Ventura County Health (Ventura County Health Care Plan). We welcome input from anyone who has experience or knows of people who have experience with those plans. Email boxes are set up for enrollees and will also be placed in the chat feature. Providers are encouraged to engage with us and share information. We look forward to continuing to work with taskforce members as well as members of the public that is interest to work with the Department of Managed Healthcare.

STEPHANIE WELCH, CHHS Deputy Secretary: Introduced BHTF members and Chairpersons of the Behavioral Health Action Coalition, Carmela Coyle and Jessica Cruz to present their report. From this report, thoughts can be formulated about how to leverage this information and partner in a united effort.

Behavioral Health Action: Elevate. Educate. Innovate
Carmela Coyle, President & CEO, California Hospital Association & Jessica Cruz, CEO, NAMI California

For the past three years, this coalition consisting of 50+ statewide organizations have come together to work toward a common path in an effort to elevate, educate, and innovate areas of behavioral healthcare. To build leaders in the policy area, the group has engaged various influential leaders who have willingly shared the stories they have experienced and have committed to help move our efforts forward. The Coalition has created and released, [The BHA Blueprint for Behavioral Health](#). This blueprint is a resource that provides a vision and a set of activities to focus our work. It is available online at www.behavioralhealthaction.org. Also worthwhile viewing is the video, ["Flipping the triangle"](#). It emphasizes the need to invest in prevention and early detection. [The Behavioral Health Action website](#) has another video and a lot of valuable information to review.

STEPHANIE WELCH, CHHS Deputy Secretary: The YouTube link will be posted on our website after the meeting. It may take a while to post these materials as we have to ensure they are ADA compliant.

Member Questions/Comments

STEPHANIE WELCH, CHHS Deputy Secretary: Because of the rapid changes that have occurred recently, my challenge is how to steer this group and to partner with all of our amazing directors as well as many of you who are eager to participate. The feedback received about the children's initiative is very valuable. CHHS will be leading a number of initiatives as we enter the new fiscal year. Currently, we are in a position where we, as a state, could make an even larger investment in behavioral health. We need to be able to look at what we're currently doing and ensure that it is consistent with our values and goals. We are conducting assessments and thinking about We have a renewed commitment to focus and leverage this group on topic(s) it is best suited for. We also want to explore best methods in partnering with other groups such as the Behavioral Health Action Coalition, Child Welfare Council, the MH Oversight and Accountability Commission, and all of our Departments. There are so many things that the Behavioral Health Action Coalition can do that we may not be able to do. They have an important role to identify and engage with the legislative leadership. One of the great things about this report is that measurable goals are identified. Litmus tests results can reveal whether or not we are going in the right direction.

CARMELA COYLE, President & CEO, California Hospital Association: In the history of California, we are at a moment in our collective effort to make a difference in behavioral health. It will take all of us coming together and finding those places we can work together. We had a tremendous opportunity to leverage not only the expertise but the guidance of Dr. Tom Insel. This notion of measurable metrics is hard. The Behavioral Health Action Coalition stands ready to help in any way we can and leverage public/private partnership. This is a huge undertaking in the absolute right moment in time.

SONYA YOUNG-AADAM, CEO, California Black Women's Health Project: We are so excited about future possibilities and the potential to flip the triangle. We are focused and dedicated to give more attention and investment of time and energy into expanding opportunities in the prevention arena and for community-based organizations to be situated where we live. This work provides the greatest chance for there to be an integration and alignment between work that is happening in communities and with behavioral healthcare systems. There are gaps that need to be filled. There are opportunities for that work to be done in closer alignment and for it to be effective in racial/ethnic populations, LGBTQ, and other marginalized communities. The California Black Women's Health Project is happy to partner and support any of these opportunities.

CAROLINA VALLE, California Pan-Ethnic Health Network: In thinking about the taskforce and the work that we need to do, we are at a critical moment concerning what behavioral health

needs to look like. For CPEHN, it's about how we actually concretely implement an anti-racist framework in behavioral health across our delivery system. We need to ask ourselves, what are the core components of a racial equity framework? The data piece is very important and that we understand how our delivery system is performing. How are counties doing? How are health and commercial plans doing? Then, we need to set some outcomes because it is a core part of racial equity. Discussions also need to include data and accountability, different types of behavioral health interventions i.e. community-defined practices, different approaches to efficacy, and challenging old-ways of thinking. Oftentimes this leads us to the topic of integration. We need to revisit what integration means. We often think of this as centering a health plan, but there are lots of different types of integration and collaborative care that can help it happen. We need to think bigger about what is available to us and what we can do so that people are getting the care that they need when they need it. We also need to update our standards for cultural linguistic competence. It's been 20 years since we've done it, and there's so much we have learned in the last 20 years around this subject. We need to tackle that problem.

HECTOR RAMIREZ, Disability Rights California: This presentation is really good and will reinforce those things that we have repeatedly discussed on the Behavioral Health Taskforce. In order for this particular body to move forward, we need to assess how the state has delivered services during the pandemic, how things are going right now, and how to provide recovery. In both our current system and in our communities, we need to redo behavioral health solutions. We are in desperate need to have both ACEs and trauma-informed services explained. Our people go to agencies and often come out feeling even more stressed due to limited or inappropriate services offered. This needs to change. We should move away from focusing on cultural linguistic proficiency. It hasn't worked. The focus should be on measurable and achievable outcomes. Everything is pragmatic and new terms are presented that basically mean the same thing. In the end, we need to show that the people are getting the help they really need. Because we continue to use the same strategies, we know the barriers we will face. Stakeholders that receive services need to be involved and provide input on how to make them appropriate to the communities.

Public Comments

WESLEY MUKOYAMA, Cultural Competence Chairperson and member of the Behavioral Health Board of Santa Clara: Having been on the board off and on for 38 years, I understand how mental health has evolved. After not seeing payments toward prevention, I'm glad to see that this is happening with the Behavioral Health Action program. I don't agree with Dr. Burke Harris in terms of spirituality. Spirituality is one way to collaborate particularly with ethnic communities where it is evident that these individuals experiencing depression go first to their faith leaders. For this reason, it should be included. I'm also concerned that PTSD and SMI are not considered. It is only in our County that serious illness is considered because we have so many immigrants and refugees in Santa Clara County. Thirty-eight percent of our population

consists of Asian-Pacific Islanders and twenty-eight percent are Latino. So we have a majority minority population in our County and I do think that faith-based organizations is one collaboration that will best reach out to this population. I'm really impressed with the work of the Behavioral Health Action Coalition, but in my opinion, in order to grasp the cultural aspects of mental health within our communities, you have to go through faith-based organizations.

LINDA COPELAND, Developmental Pediatrician and New Medical Director of Contra Costa Health Plan: With regard to Dr. Ghaly's point of needing to expand the workforce. There was mention to increase psychiatrists. I have been trained in a lot of what psychiatry does, and I can tell you that Developmental Pediatricians are underutilized. That could help expand the workforce as well as networking with Behavioral Health Providers who have trained in behavioral analysis. I think they are partners in this. They definitely have experience with developmental disabilities. To echo what Wesley says, a number of counselors in faith-based organizations are actually trained mental health counselors. It is a legitimate point.

ANANDITA, Psychologist in the Riverside county area, Behavioral Health Commission: I really enjoyed and learned a lot today from the meeting. I work with homeless youth and families. This is a very vulnerable population. A lot of families don't want to report homelessness because they are afraid of their children being taken away or getting systems involved. The other issue is minor unaccompanied youth who cannot sign permission for services. What are we doing in terms of interagency collaboration to serve this vulnerable population?

Stephanie Welch responds: As an agency, we are looking internally at the immediate issue of supporting our unaccompanied youth. There is a significant focus proposed in the May revise to address and prevent family homelessness as well as a separate component that's specific to transition age youth and young people who are homeless.

KAREN VICARI, Parents Anonymous – Re: Child and Youth Behavioral Health Initiative, it feels a little like we're trying to treat youth behavioral health. The ACES presentation brings to light adverse child experiences often happen in the home. Protective factors that mitigate ACES also happen in the home. There are so many aspects of youth mental health that relate to parents (e.g. parental resilience, knowledge of parenting and child development, etc.) We would love to see a little focus in the initiative on family strengthening. Our programs are evidence-based. We have strong evidence that family strengthening improves youth and parent mental health, reduces domestic violence, mitigates ACES, prevents ACES, and so much more. To fully address youth behavioral health, we also have to provide services to parents.

KENNA CHIC, Disability Rights California: My question is related to the youth behavioral health initiative. I fully support this and believe that the focus on youth between ages 0 – 25 is really important and also expansive enough to include people who are very early in their careers. Given that this would take several years to implement, would it possible during that time to include the class of 2020. In a lot of the work that I have done, I've noticed that the class of 2020 is one of those age groups that have been especially impacted by the pandemic as they

were all kicked off campus during that time. A lot of them moved back with their parents or were starting their careers. There has been a lot of studies focusing on their employment or rather lack of employment during that time and especially how this would impact the rest of their lives. A lot of the studies have examined economic implications, but it is important to address the behavioral health implications. There are rising rates of depression, suicide, and just a general lack of hope for the Class of 2020. I just wanted to bring this up in case there is consideration toward this. As of right now, the oldest people in the class of 2020 would be around 24 years old. If this initiative takes some time to implement, they would have aged out of 0 – 25 eligibility. I want to hear your thoughts about this.

Stephanie Welch responds: I do think we have an incredible opportunity to reach out to these particular young people. You are correct about the impact that COVID-19, it has had a disproportionately significant impact to young people under the age of 30. We are eager to get together with partners to discuss recruiting this particular population if they are interested in this work. Not only have they had experiences that could bring tremendous value to the work that needs to be done, but there might be people in that group that may not have considered behavioral health as a part of their career and may now be interested to try. We will continue to think through creative strategies to reach the transition age youth population. Because they are not all on campus, we need to think through some good strategies to reach out. One method might involve doing it through their employers.

Adjourn