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CALHHS BEHAVIORAL HEALTH AND TASK FORCE MEETING
Meeting Summary
TUESDAY, JUNE 14, 2022, 10AM – 3PM

SUMMARY PURPOSE

This document provides a summary of key input provided by Behavioral Health Task Force (BHTF) members. 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 contains notes from each breakout group discussion. Appendix B includes additional input shared throughout the meeting via chat. Appendix C provides links related to the Office of Health Care Access and Information's work on behavioral health workforce, as it relates to the Children and Youth Behavioral Health Initiative (CYBHI) and beyond.

WELCOME & INTRODUCTION OF NEW MEMBERS

WELCOME

Secretary Mark Ghaly, California Health and Human Services (CalHHS), welcomed BHTF members and members of the public. He noted that the State continues to advance many important behavioral health efforts and initiatives, from Community Assistance, Recovery, and Empowerment (CARE) Court to the CYBHI to the Crisis Care Continuum (CCC) and the proposed budget for next year continues to advance this focus on behavioral health. Secretary Ghaly expressed his appreciation for the perspectives and input that BHTF members and public participants bring to the BHTF meetings, which helps the State move the needle on behavioral health.

INTRODUCTION OF NEW BHTF MEMBERS

Deputy Secretary of Behavioral Health Stephanie Welch, CalHHS, introduced two new BHTF members. An-Chi Tsou is the new representative to the BHTF for the Service Employees International Union (SEIU). Rebecca Ruan-O'Shaughnessy is the Executive Vice Chancellor for Educational Services for the California Community Colleges Chancellor's Office.

FINAL BHTF CHARTER AND ENGAGEMENT

Orit Kalman, Senior Facilitator, California State University, Sacramento, Consensus and Collaboration Program, noted that the 2022 BHTF Charter was finalized after the March BHTF meeting, with input from BHTF members. Ms. Kalman noted the facilitation team's commitment to grounding BHTF engagement in the group's shared goals, as well as upholding the group's Guiding Principles and Commitments for Engagement.

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CRISIS CARE CONTINUUM AND 988

Deputy Secretary Welch gave an overview of the State's development of a Crisis Care Continuum Plan (CCC-P). Information shared during the May 17, 2022 BHTF Lunch and Learn session, as well as presentations provided by CalHOPE and BHTF members during the meeting, provided a foundation for BHTF discussions on CCC-related work during the afternoon portion of the BHTF meeting.

Deputy Secretary Welch shared about the need for developing a CCC and how a crisis-specific continuum fits within a comprehensive behavioral health continuum of care. A crisis care continuum can be conceived of as a system of care covering three categories that link to one another: crisis prevention, crisis response, and crisis stabilization. The CCC should be accessible to anyone, at any time, and in any place. Prevention within a CCC is more specific than general behavioral health prevention; it refers to community-based interventions specifically related to preventing suicide or mental health and substance use crises. Crisis response services support individuals while they are in crisis and can include hotlines and mobile crisis teams. Within the CCC-P, stabilization refers to support services to move people from being in crisis to reaching more stability; it does not cover long-term post-crisis care.

Deputy Secretary Welch reviewed data from a crisis care system in southern Arizona showing that such a system can significantly decrease reliance on the most restrictive, costly, and traumatizing ways of addressing behavioral health crises, such as use of jail, emergency department, and inpatient treatment. The system in Arizona resolved 80% of crises over the phone via a crisis line, 71% were resolved in the field by mobile crisis teams, 68% of individuals in crisis were discharged to the community, and 85% remain stable in community-based post-crisis care. Such a system can build on existing foundations in communities around the state.

In California, a Department of Health Care Services (DHCS) behavioral health needs assessment includes multiple findings that inform development of the CCC-P. For example, law enforcement and emergency departments are often relied upon even when they would not be necessary, simply because there may be no alternatives. A continuum of crisis services addresses such issues, and there is broad interest around the state in expanding crisis supports and services as well as connections between them.

The transition from the National Suicide Prevention Lifeline 800 number to 988 will expand the focus of the line beyond suicidal crises to support any behavioral health crisis. It presents an opportunity to be aspirational in thinking about how to prevent and respond to crisis and

support people in stabilization. Implementation will take time and the Substance Abuse and Mental Health Services Administration (SAMHSA) envisions a phased process to reach a fully-resourced crisis care system, beginning with building capacity in crisis contact centers so that people in crisis can reach someone to talk to, then expanding mobile crisis services so that individuals in crisis can access rapid crisis response, and finally providing access to a safe place and community-based crisis stabilization care. Deputy Secretary Welch emphasized the importance of investing in and partnering with local agencies and organizations to build up the CCC in California to reach the state's diverse communities.

In 2022, CalHHS will develop a plan to support the connections between crisis prevention, response, and stabilization efforts and services. The plan will build on existing planning efforts and investments and be informed by input from diverse stakeholder perspectives. Deputy Secretary Welch presented a roadmap for developing the CCC-P. She noted that the BHTF is one forum to share and get input on content being developed for the CCC-P and CalHHS will also engage BHTF members and others as subject matter experts through separate engagement opportunities outside of the BHTF meetings.

CALHOPE CRISIS COUNSELING PROGRAM

Jeremy Wilson, Program Director, and Kim Flores, Project Manager, presented on the CalHOPE Crisis Counseling Program (CCP). The CCP was developed by the state's County Behavioral Health Directors, building on a federal disaster aid program to meet the needs of Californians for crisis support during the COVID-19 pandemic. Through the SAMHSA CCP structure, the CalHOPE CCP provides non-clinical or pre-clinical emotional and crisis support in response to the COVID-19 pandemic.

The CalHOPE CCP is focused on mobilizing peer support and staying true to communities in its crisis care. The crisis support is provided by individuals with lived experience, family members, caregivers, and community health workers representing a broad diversity of identities, languages, and geographic locations so that anyone calling the line can access support that they identify with. The program uses remote technology platforms to serve individuals throughout the state. Target populations were identified as those that were being disproportionately impacted by COVID-19, including health, job, housing, and other impacts. To ensure the CCP was responsive to communities, CalHOPE partnered with CBOs that work with the target populations and have existing infrastructure to mobilize services in a short time.

The program builds on existing capacity and expertise, contracting with 29 agencies representing children, youth and transition-aged youth, culturally diverse CBOs (including five that work primarily with refugees), and statewide or general population. The CCP has over 500 counselors in total, providing resource navigation and emotional support in over 50 languages. In addition to providing counseling, working with CBOs throughout the state allows the program to provide culturally congruent outreach, which is critical to reaching many of the communities served.

In addition to the immediate support the CCP provides, the program has built up capacity in the state to respond to future needs, by building relationships between the State and many diverse CBOs across the state, as well as among the CBOs, training over 500 counselors who are now prepared to work in the public mental health system, and expanding mental health services into some communities for the first time.

The governor proposed continuing the program with funding from the State's general fund, which would allow the program to become even more responsive without the constraints of the federal emergency funding initially used.

ONGOING CCC EFFORTS IN CALIFORNIA: BHTF MEMBER LIGHTNING TALKS

BHTF members were invited to sign up in advance of the meeting to share brief descriptions of existing efforts related to a CCC in California. Multiple presenters emphasized the importance of building up prevention, response, and stabilization services simultaneously so that they can all effectively work in conjunction. For more details on the lightning talks, please view the recording here.

Crisis Prevention

- **Christine Olmstead**, Orange County Department of Education, shared about the multi-tiered system of support (MTSS) lens, a framework for universal support for all students.
- **Mandy Taylor**, California LGBTQ Health and Human Services Network, spoke to the role of LGBTQ community centers in providing formal and informal crisis care.
- **Sonya Young Aadam**, California Black Women's Health Project, shared about three community-defined evidence practices: Sisters Mentally Mobilized advocate training program, Sistahs Aging with Grace and Elegance (SAGE), and Anti-Violence Ventures.

Crisis Response

- **Lishaun Francis**, Children Now, shared the about the Family Urgent Response System.
- **Le Ondra Clark Harvey**, California Council of Community Behavioral Health Agencies, share about training for 988 call centers.
- **Ken Berrick**, Seneca Family of Agencies, shared about intensive wraparound supportive services to provide a wide array of support wherever the person needs it.

Crisis Stabilization

- **Michelle Cabrera**, California County Behavioral Health Directors Association (CBHDA), shared about crisis receiving and stabilization services in California, such as crisis stabilization units, urgent care facilities, sobering centers, peer respite and crisis residential services; she discussed reimbursement issues for these services as well.
- **Kim Lewis**, shared about mobile response and stabilization services for children and youth on Medicaid and Medi-Cal in California.
- **Kirsten Barlow**, California Hospital Association, discussed the importance of cross-sector collaboration, with each sector taking responsibility for its piece of supporting individuals.

PUBLIC COMMENT

Members of the public were invited to share thoughts on the Crisis Care Continuum presentations.

- Stacy Hiramoto, Racial and Ethnic Mental Health Disparities Coalition, emphasized the importance of collaboration with CBOs, particularly those that serve racial, ethnic, and LGBTQ communities, that is central to the success of the CalHOPE program and will be critical for other programs to succeed in the future.
- Karol Swartzlander, California Commission on Aging, expressed appreciation for Secretary Ghaly's leadership in garnering investments to advance behavioral health services for Californians, including the funding for additional positions in DHCS for working on behavioral health and funding for the Mental Health Services Oversight and Accountability Commission to advance the CYBHI. She emphasized, however, the need for funding to address behavioral health needs for older adults as well, noting that the Commission on Aging's request for funding for a geriatric behavioral health position within DHCS was not included in the legislature's proposed budget.

CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE

Melissa Stafford Jones, director of the CYBHI, shared updates on selected initiative-wide and workstream-specific topics, including stakeholder engagement updates and upcoming opportunities for engagement, an overview of recent accomplishments and upcoming milestones for some workstreams, and introduced the initiative-wide equity working group. She also shared an update on the process of defining initiative-wide outcomes, including updates based on feedback from BHTF members during the March meeting as well as from other stakeholder engagement efforts. Finally, Director Stafford Jones also gave an overview of the CYBHI landscape analysis and shared prospective plans for its use.

CREATIVE SOLUTIONS TO BUILDING OUT THE CRISIS CARE CONTINUUM – SMALL GROUP DISCUSSIONS

Attendees, including BHTF members and interested members of the public, participated in small group breakout discussions on building a robust CCC in California. Each group focused on either crisis prevention, response, or stabilization, and discussed the following prompts:

1. **Inventory**: In addition to the programs and services highlighted in the presentations during the morning portion of the meeting, please list additional programs and services as they address the group's focus area (crisis prevention, response, or stabilization).
2. **Gaps**: What is needed to ensure a robust CCC system in California? Who is not currently being served and what issues are not currently being addressed with regard to the group's focus area.
3. **Opportunities**: How can we expand and build programs and services to address these gaps in the short term? In the long term?

REPORT OUT ON BREAKOUT DISCUSSIONS

Following the breakout discussions, each group shared key takeaways from their discussions. Themes from the discussions and report-outs are summarized below. The detailed input provided during small group discussions is included in Appendix A.

BREAK DOWN SILOS

Many groups discussed the importance of breaking down silos to better keep people from falling through the gaps between systems, including building bridges between crisis prevention, response, and stabilization, as well as coordinating payers and data sharing.

- Create **bridge services** to build connection all along the continuum of care, which is currently fragmented

- o From crisis lines to crisis response services like mobile crisis units
  - o From crisis response services to further community-based services
  - o Improve hand-offs and provide follow-up support after crisis, including with parents and family members
- Align crisis services across funding streams and payers for a "**no wrong door**" approach
  - o Develop MOUs to better coordinate between systems and ensure communication between all providers and payers
- **Integrate** across programs and services, including **data sharing**
  - o Better integration between existing crisis lines and access phone numbers (911, 988, County-based 24/7 access numbers, suicide prevention call centers, FURS, friendship line, etc.)
  - o Link school system to other parts of CCC – enhance data sharing between schools and medical systems, following existing models
    - For example, there are many students that need services and struggle to pay for the care they need but are not Medi-Cal eligible
- Take a **public health approach** to prevention and upstream response
  - o Consider how to support isolated individuals that do not have existing care providers
- **Clarify roles** and responsibilities and increase **transparency**
  - o Have a clear delineation of available services, ensuring a universal array in every community
  - o Clearly communicate the support available
  - o MCP vs. County LPS role
  - o Strengthen monitoring and enforcement
- Role of **hospitals**
  - o Hospitals need to provide additional support, training, and resources to be part of a truly integrated system
  - o More needs to be done to support hospital emergency departments so that they can be a welcoming and helpful space for people in crisis

EQUITY AND CULTURALLY APPROPRIATE CARE

Many groups discussed equity issues in the CCC, highlighting the need for cultural humility and culturally appropriate care that is non-traumatizing for disproportionately impacted communities. One group noted that all services, at all levels of care across the continuum, should have equity as a key consideration, with transparency about how it is addressed from the process of designing services through implementation. Groups gave a variety of recommendations for addressing equity issues such as building trust and accessibility for community members, engaging with community-based organizations, and building up a workforce that is representative of the range of communities in the State. One group raised a guiding question of "how do we empower marginalized populations?"

- Be **transparent** about the equity lens
  - Be explicit in naming disproportionate impacts within the crisis response system (e.g., institutional racism impacting POC queer and trans communities; gender equity)
    - Many underlying barriers (economic, digital, etc.) particularly impact Black and Brown communities
  - There should be an equity focus within the process of designing and building services, which will help ensure that the services themselves are more responsive and effective
  - Incorporate feedback from users in development of services to prevent access barriers and improve utilization
  - Decrease emphasis on data, which can reproduce systemic issues
- **Non-traumatizing, anti-racist** crisis response options are needed for BIPOC, LGBTQ+, and other communities in crisis
  - Recognize trauma and cultural differences
  - Address Restrictive licensing requirements (e.g., at RCFE, SNF, etc.) that require calling 911 rather than appropriate behavioral health responses
  - There is a lack of culturally competent providers and services that acknowledge systemic racism. Targeted resources are needed.
- Community-based care
  - Establish multi-sectoral crisis collaboratives in each community
  - Existing community-based mutual aid entities already serve as trusted, community-embedded crisis prevention and responses
  - Work with trusted individuals within the community to share programs, skills, and information
  - Work with trusted community members for technical assistance related to when, where, and how to provide access points for services
  - The "Promotora" model has been successful in Latinx communities, where there is often cultural stigma surrounding MH treatment, which is deepened when government is the source of information and resources

- Culturally and linguistically appropriate care
  - The state needs to improve understanding of needs and services for different populations and where those can be accessed, understanding that there may be gaps in the service area
  - Translate resources
  - Consider providing therapy that is not "inclusive" but instead is focused on serving a specific community
  - Serving the deaf community
    - Lack of access and services for the deaf community – for example, there are no therapists in LA County who can communicate directly with deaf clients and many hotlines are not accessible (including texting, which requires people be able to communicate in written English)
    - Create a streamlined, developmental system to support the deaf community in all three areas of the continuum
    - Evaluate systems and interventions to ensure sufficient capacity to provide appropriate, well-matched services for each individual
- Training and integrating community practices
  - Provide community-focused trainings for behavioral health providers to help center cultural and lived experiences, making care more accessible and successful for community members
  - Incorporate ACEs and trauma-informed training
  - Need to integrate community practices into the medical model, not just more diverse hiring
  - Provide case managers with training on identifying providers and resources that will be a good fit

ACCESS, BARRIERS, AND COMMUNITY-BASED CARE

The issue of access and barriers arose in many groups. As one group said, to truly improve access, improvements need to be made in terms of capacity, access points, and cultural competency, with all these factors integrated in a community-based system of care.

- Access
  - Address fragmentation between delivery systems and payers
    - Align services across funding streams so there is "no wrong door" access to services and transitions are more seamless regardless of payer and coverage
    - Provide navigation support that spans the multiple delivery systems and payers, similar to CalAIM Enhanced Care Managers

- o Create pathways for real-time linkages to services, for example building on technological gains from the past few years through the peer-to-peer Cloud Nine system in Austin, TX, that connects individuals directly to telehealth providers
- Barriers
  - o There are gaps in knowledge about signs and symptoms of mental health needs as well as information about resources to connect to
  - o The 24-hour limitation for crisis stabilization services is a structural barrier
  - o Economic issues, food insecurity, and the digital divide are important barriers and often impact Black and Brown communities disproportionately
- Community-based care is one key way to improve access
  - o Improve local access to at least a minimal level of care
  - o Support crisis response services as part of community centers and mutual aid efforts
  - o Integrate wraparound services into the broader care model, with known team members providing crisis services
  - o Create pathways beyond emergency departments and jails: identify individuals who would not be best served through current (law enforcement and emergency department-based) crisis/emergency channels, providing alternative locations to receive support
  - o Existing models to build on
    - WellSpace crisis receiving program in Sacramento
    - Community Responder models with local responders
    - EMSA pilots
    - Peer respite model, e.g., Danielle's Place in Sacramento

CAPACITY AND WORKFORCE

Many groups identified workforce capacity as an important way the system needs to be further built up. Even those who are able to find access points may still find themselves waiting for long periods of time before receiving services, which can endanger their lives. Groups shared challenges and opportunities related to workforce capacity, including creatively leveraging existing personnel to help deescalate and address crisis, enhancing the workforce pipeline, and ensuring key competencies are met.

- Capacity limitations & challenges
  - o Difficulties securing appointments, particularly with specialists
  - o Staffing regulations make more robust service models (e.g., 24 hour support) more challenging
  - o CSUs and EDs unable to make appropriate placements
- Enhance the pipeline

- o Fully implement planned investments in the pipeline
- o Address both short-term solutions and long-term training and development
- o Address retention and pathways
    - Improve compensation to that it is more commensurate with the challenges of the work
    - Provide incentives to improve capacity (and thereby, access)
    - Create pathways for people with experience working in residential programs with children in foster care to become part of the CCC
- Competencies
    - o Ensure the workforce has adequate competencies to address community mental health crises
    - o Need providers that are able, willing, and adequately resourced to treat the most acute and complex individuals
    - o Culturally and linguistically appropriate training, services and programs are needed
    - o Better support CBOs that already work within communities to support cultural competence of services
- Expand the pool of providers supporting the CCC
    - o Increase the number of providers in the system that accept Medi-Cal
    - o Look into appropriate ways to leverage individuals in adjacent work and provide the needed training and support; for example, utilize the CDSS training initiative to provide career pathways for IHSS providers
    - o Consider drawing on non-licensed community-based providers, health workers, etc.
    - o Expand Supporter Role to help with transition processes; consider how those with commercial insurance can also receive this support
    - o Leverage telehealth
    - o Board Certified Behavior Analysts (BCBAs) can assist in stabilization as another source of support, that is already funded by health insurance. In many cases, an autism diagnosis is not required for health plans to fund BCBA support.
    - o Applied Behavioral Analysis interventions

TRANSPARENCY AND DATA

- Use data to prioritize and focus resources
    - o Prioritize resources first to the populations with the highest needs and the communities facing the greatest disparities and inequities
    - o Data is needed to help pinpoint the specific needs, and extent of need, for the range of populations, for example Medi-Cal/non-Medi-Cal, justice-involved, etc.
- Statewide resources and standardization of process

- o Develop a universal statewide intake/assessment process and questionnaire, assessment and progress report templates, and report quantitative data on progress toward goals
  - o Develop a statewide provider directory
- Data reporting and sharing
  - o Address data sharing needs to better support people as they move along the continuum of care
    - For example share data between State and local agencies, jails and prisons, and other entities that collect data
    - Develop a statewide database allowing sharing of information across agencies (e.g., so that first responders can know to bring a MH professional on calls to a given home)
  - o Need consistent reporting on 5150 and outcomes, with stratification by race/ethnicity
  - o Leverage DOJ reporting to increase consistent, statewide reporting
  - o Is there existing data on who uses ED services (perhaps from HCAI)?
- Defining stability
  - o Set goals and monitor progress
  - o Need to define criteria for stability to be able to reach and maintain it

FUNDING AND PAYERS

Throughout many of the group discussions, the issue of funding arose, with participants emphasizing the importance of ensuring that programs that are part of the CCC are fully and adequately funded. Many groups touched on the issue of the fragmentation of funding and payment for services, noting that funding is key to breaking down silos and helping people access services.

- Areas that need additional funding
  - o Better fund crisis response options that are non-traumatizing, focusing on alternatives to law enforcement and ED-based approaches and the services that communities have identified as safe for them
    - For alternatives to law enforcement and ED-based approaches, liability issues also need to be addressed
  - o Increase funding to support 24-7 crisis services
  - o Make the needed financial investments (amounts and rates) to expand acute crisis, inpatient, and post-discharge services
- Interconnected services are often funded separately, which increases divisions and silos

- o Address the lack of private insurance payment for services
    - ▪ A key issue is that private insurance often does not sufficiently cover services for people with disabilities that require specific interventions
  - o Look at the all-payer model in Arizona
- Funding opportunities
  - o FMAP reimbursement for crisis response
  - o MediCare as a means to extend Medi-Cal for other purposes, such as a 988 fee
  - o Create a shared savings mechanism to fund alternatives to law enforcement and ED-based crisis response, balancing the various needed systems and addressing liability issues

CHILDREN, YOUTH, AND FAMILIES

- Consider differences between adult and children needs in a CCC
  - o Include child- and youth-specific stabilization services
  - o Include parent partners and peers within mobile response stabilization services (MRSS)
- Cultural and linguistic appropriateness are key to ensuring engagement resonates with children and their families and meets their needs
- Prevention must start in childhood
- Support parents and caregivers
  - o Support families throughout *and after* crisis
  - o More support is needed for family members and family respite, which can support both stabilization and prevention
- There is a gap in resources in educational environments (e.g., counselors in schools)
  - o WestEd is working with SBHIP to create an inventory of resources for students

LEGAL AND LICENSING

- Need for CSU licensing category within CDPH
- Rework facility licensing requirements to ensure they are workable – e.g., change 24/7 nursing staff requirement, address licensing process and timelines for inpatient psychiatric hospital facilities

CRISIS PREVENTION

- Need improved screening
- Expand diversion programs, including navigation support to utilize services and early identification to prevent high-level decompensation

CRISIS RESPONSE

- Existing models to build on
  - Ohio-based model for quickly getting up to 4 sessions of crisis stabilization with a licensed provider or psychiatrist for individuals at risk of going to (or in) ED

CRISIS STABILIZATION

- Mobile response stabilization services (MRSS) should be part of the CCC.

OTHER

- Consider that words may mean different things in different spaces (for example the word "peer"), so consider how this might play out with respect to resources and services.
- Opportunities to better serve individuals found incompetent to stand trial
  - IST population should receive fully supportive services, yet they continue to cycle between systems. There are opportunities to reduce emergencies related to this by expanding robust, comprehensive diversion, services, and supports.
  - This population, like others, should receive navigation support spanning all systems and payers

CLOSING – REFLECTIONS AND NEXT STEPS

Deputy Secretary Welch thanked participants for their engagement and encouraged them to share additional input on the CCC following the meeting. She noted that agency will continue engaging various stakeholders to provide input on development of the CCC-P, and many BHTF members will likely be tapped to continue to share their expertise and perspectives. Ms. Welch emphasized that the CCC Plan development process provides an opportunity to focus in on how to emphasize and promote key priorities around behavioral health into action.

NEXT STEPS

BHTF meeting follow up activities:

- Participants
  - Provide the facilitation team and Stephanie Welch additional input on the CCC-P
  - Provide feedback on meeting content and process through an [evaluation form](#) shared during the meeting
- Facilitation team
  - Share the BHTF meeting presentation slides, recording, and a meeting summary when complete

APPENDIX A. BREAKOUT DISCUSSION NOTES

As summarized above, BHTF members and public stakeholders participated in breakout discussions on the State's Crisis Care Continuum Plan. Groups took notes on their discussions, included below with minor edits for clarity.

GROUP 1: PREVENTING CRISIS

Inventory: Please list additional programs/services as they address crisis prevention.

> **Crisis Prevention:** Community-based preventive interventions for individuals at risk for suicide or mental health / substance use crises (e.g., Zero Suicide, harm reduction programs, warmlines, peer support, recovery support services)

Examples:

- Community Defined Evidence Practices (CDEPs) developed by CA Black Women's Health Project to provide safe, affirming, supporting spaces to talk, deal, heal, and cope with personal, family, and neighborhood crisis experiences. Sisters Mentally Mobilized Advocate Training Program, Anti-Violence Ventures: Black Men & Boys Take a Lead, and SAGE (Sistah's Aging with Grace & Elegance)
- Formal and informal crisis care in LGBTQ Community Centers
- Role of MTSS in preventing crisis

- Would like to see **schools and MTSS** better integrated
- In between crisis response and stabilization – ***work force related investments and proposals*** – not a new service or program per se, but ***there's a lot in the pipeline that hasn't come to fruition*** yet. Using non-licensed community-based providers. Like health workers can be leveraged etc.
- Acknowledging not the same as peers and peer support
- ***WF issues are both upstream as well as for service provisions***
- Importance of linking school system and LEA system. Sometimes that has happened on a county level, but that could be strengthened. There are some prevention activities through that incentive program. Future resource need could be to scale successful interventions.
- Aware of many issues that patients encounter as they seek care before it gets to point of crisis
- ***Importance of supporting parents and caregivers. If you support them, more effective at also supporting infant and toddler youth***

- *Essentials for Childhood initiative* – collaboratives across the state. Looking for opportunities to create supports, particularly for families
- How do we learn more about how we ramp up a broader response system. So that we can do broader upstream response & prevention form a PH perspective
- ACEs
- Dyadic benefit, Medi-Cal
- TI training for educators
- We struggle with screeners – MH screeners, SEL screeners

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
• Addressing students and families that don't qualify for Medi-Cal, but are struggling to pay co-Pays etc. Billing very difficult especially in cases where schools are operating in communities with high poverty but with many students and families not qualifying for Med-Cal. It's problematic for schools to disaggregate students who can access Medi-cal vs. private insurance. • Focus on HHS but not adequate focus on other Agencies like CDE, Corrections & Rehabilitation agencies.	• *MOUs between agencies in different sectors to provide a roadmap.* Need to better coordinate with 'outside folks' not sure what forces will be needed to get everyone to agree to a master plan so that we can agree foundationally on what works etc. **CCC isn't really part of CYBHI, so state could create something different as they implement 988. It's an opportunity to reiterate feedback to the state.** • **Strengthen Monitoring and Enforcement** • **Clarify roles and responsibilities -** there's a loose agreement/approach

The Silos continue to exist, event within this program.

- *Lack of continuity between our systems*. We often don't even know when there are MH crisis that occurs within our plans. We're unaware of when there are co-morbidities. Even basic information system isn't happening these days

- *Need for enhanced data sharing systems between schools and medical systems.* There are models out there. Can't start from scratch

- *Funding for CCC is more focused on adults, while most of our conversation is focused on children.* Flagging that the focus on kids is a new thing for the state.

- *Need for our infrastructure to be supported by cultural changes as well.* Need to positively norm help seeking behavior.

- *Need to better support parents and caregivers as part of the continuum*

that counties have taken – that's not serving children well.

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

Opportunities to build out the CCC:

1. **MOUs**
2. **Stronger Requirements and Monitoring of those requirements**
3. **Ensuring capability to comply (resources)**
   a. It's one thing to, for example, mandate data sharing between entities, but if there' snot capacity to data share, it won't happen. Has to be paired with resources
   b. Acknowledging that data collection hasn't historically been our forte.

GROUP 2: RESPONDING TO CRISIS

Inventory: Please list additional programs/services as they address crisis prevention.

> **Crisis Response:** Acute crisis response services, including hotlines, 911 diversion, mobile crisis teams, social service response, and co-response models

Examples:

- Seneca Family of Agencies created continuums that included mobile response to serve child welfare and broader mental health populations. We also worked with schools on response to crisis within schools.
- Child Welfare Council worked on Continuums of Care that included crisis services, prevention of crisis, and response post-crisis.
- Molina Cares grant to bring together 988 call centers to utilize a training platform for training call center staff. CBHA represents 4 call centers who provide crisis services to hundreds of thousands of Californians and will be the designee for the 988 number.
- Family Urgent Response System
- expansion of Trauma Recovery Centers (TRCs), community-based centers that provide a wide range of crisis and mental health support to victims of violent crime. CA used to only have one TRC, but there are now 16 TRCs across the state. These serve as a very important entry point for victims to get mental health support. The state Victim Compensation Fund funds this work.
- Community-based violence intervention programming, which is a combination of conflict mediation and mentorship, as well as crisis assistance and behavior health support for people at risk of being hurt by neighborhood gun violence. CalVIP funds this work.
- Comprehensive reentry services, as many people leaving the justice system fall into crisis unless they have some sort of immediate support. The Returning Home Well

initiative as well the state Adult Reentry Grant Program are examples of how this work is funded

- Friendship line – warmline for older adults

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
Pipeline/incentivize workforce to ensure adequate access	FMAP reimbursement for crisis response, MediCare as means to extend MediCal for other purposes, potential for 988 fee
Lack of connectedness of all the numbers (911,988, 24/7 county access numbers, suicide prevention call centers)	Integrating the various 24/7 lines available where possible (FURS, Friendship line, County access lines, Suicide Prevention call centers
Inability of existing numbers to dispatch	
Lack of non-traumatizing response options for BIPOC, LGBTQ+ and other communities in crisis - Restrictive licensing requirements at - RCFE, SNF etc that require call to 911 rather than appropriate BH response Educational systems default to 911 or CWS rather than other more appropriate response	Community based mutual aid entities available, trusted, embedded in community. Serve as prevention and crisis response

CALHHS BEHAVIORAL HEALTH AND TASK FORCE MEETING
Meeting Summary
TUESDAY, JUNE 14, 2022, 10AM – 3PM

No statewide consistent reporting on 5150 and outcome-transparency and stratification by race/ethnicity	DOJ reporting as leverage to increase statewide consistent reporting CalHHS dashboard Lifting up what works-practices
Ensuring adequate workforce competencies to address crisis in community mental health	Establish crisis collaborative per community – multi sectoral – transparency, protocols
Culturally/linguistically appropriate training, services, and programs in acute settings (LGBTQ+, BIPOC)	
Consumer knowledge/education around how to access care- what's available and safe	Clear delineation of available services prevention, community based, FSP, deep end in every community and ensuring universal array
Anti-racist crisis response (BIPOC, LGBTQ+, peers in response)	
Seamless transition from crisis response to services when necessary	

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

Connection of crisis lines and integration into continuum of care including dispatch and services.

Intentional focus on equity across the continuum that is data informed

GROUP 3: CRISIS STABILIZATION SERVICES

Inventory: Please list additional programs/services as they address crisis prevention.

> **Crisis Stabilization:** Community-based crisis stabilization services, including in-home crisis stabilization, crisis receiving facilities, peer respite, and crisis residential services

Examples:

- Advocating for and enforcing crisis intervention services in Medi-Cal

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- Crisis stabilization units – many which were built out with SB 82 administered through CHFFA
- Emergency departments (with appropriate support, training, resources)

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
- Emergency departments (with appropriate support, training, resources) - Need to address MCP role vs. county LPS role - Efficient and effective means to medically clear individuals for admission - Crisis stabilization beyond 23 hours - Crisis stabilization units – many which were built out with SB 82 administered through CHFFA - CDPH has no licensing category for CSUs*	- Many residential programs with experience working with children and youth in foster care who are well positioned to provide behavioral health services (facilities, expertise). We need to figure out a pathway to retain them and bolster their ability to address non-foster care involved children and families with behavioral health needs. - Address workforce compensation that acknowledges the difficulty of the work - Address the financial investments (amounts and rates) that are needed

- o Current licensing requirements for health care facilities are not workable (e.g., nursing staff 24/7)
- CDPH licensing process and timelines for inpatient psychiatric hospital facilities must be addressed
- Urgent care
- Sobering centers
- Peer respite
- Family respite support
- Support, involvement, training of family members throughout a crisis and after a child or adolescent experiences a crisis.
- Crisis residential
- In-home services models
- Adequate local access to a minimal level of care for individuals in crisis
- Providers able, willing, adequately resourced to treat the most acute or complex individuals dealing with multiple conditions, challenging behaviors, etc.
- Better hand-offs and follow-up after crisis averted, including parents and family members in particular.
- Clear and ongoing communication to community members, parents, families about the support they can access during and after a crisis.
- Look more broadly at utilizing (and equipping with support, training) the other individuals working in other venues (e.g., IHSS).
  - o CDSS training initiative to provide career pathways for IHSS providers could be utilized.

to expand acute crisis, inpatient, and post-discharge services
- Improve on the cultural competence of the services we provide, perhaps by using additional peer respite. Identify ways to better support community-based organizations who are already mission driven and located within these communities.

○ Consider individuals who are very isolated and ways to support them in the community who may or may not have an existing care provider. • Workforce (licensed/non, adequate numbers, adequate supports for them to be effective, long-term needs to develop trained staff as well as short-term solutions) • Commercial coverage and broader health care industry coverage of and investment in services currently only covered by Medi-Cal for SMI and SUD. • Leverage telehealth/e-consults	

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

* Although CDPH doesn't license CSUs, they are regulated under DHCS, which established a regulatory framework *(§ 1840.348. Crisis Stabilization Staffing Requirements*) including requirements around personnel, staff to beneficiary ratios, etc. These regs likely should be modified to support our new mobile crisis benefit since trying to staff those with unique staffing will be an even greater challenge.

GROUP 4: PREVENTING CRISIS

Inventory: Please list additional programs/services as they address crisis prevention.

Crisis Prevention: Community-based preventive interventions for individuals at risk for suicide or mental health / substance use crises (e.g., Zero Suicide, harm reduction programs, warmlines, peer support, recovery support services)

Examples:

- Community Defined Evidence Practices (CDEPs) developed by CA Black Women's Health Project to provide safe, affirming, supporting spaces to talk, deal, heal, and cope with personal, family, and neighborhood crisis experiences. Sisters Mentally Mobilized Advocate Training Program, Anti-Violence Ventures: Black Men & Boys Take a Lead, and SAGE (Sistah's Aging with Grace & Elegance)
- Formal and informal crisis care in LGBTQ Community Centers
- Role of MTSS in preventing crisis

- CalHOPE outreach has been effective
- WestEd is currently working with SBHIP in creating an inventory of resources for students. There are clearly not enough resources in an educational environment, especially counselors.

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
• Number 1 issue is access to services, and even when there is access, it is difficult to secure an appointment, especially for specialists (e.g. eating disorders). Secondarily, Crisis Stabilization Units and Emergency Departments have issues with placement. There is a major need for wraparound services • Issues with access to information, including in schools. Many students don't know how to identify the signs	

and symptoms of mental health needs, nor a safe way to connect them or their friends to these services. There is also a gap in resources for youth and families in educational environments. There are also underlying barriers to treatment such as economic issues, food insecurity, and the "digital divide", which particularly affect Black and Brown communities.

- There is a cultural stigma surrounding mental health treatment in the LatinX community, particularly when the source of information and/or resources is the government.
- There are gaps in knowledge of available services, as well as a lack of services that are provided by culturally competent providers that understand the different needs of those in the Black community while acknowledging systemic racism. There is a lack of targeted resources for such folks. There should be integration between the medical model and that of community practices in order to address the issue of prevention. Behavioral health systems should be required to work with community practices, not just having more diverse hiring practices. These providers need to be sensitive to the needs of the community and

- There that has been success with the use of "Promotora" (sources of information from within the LatinX community).

- Opportunity to require community-approved trainings for providers.

recognize cultural and family dynamics as determinants of health.
- Prevention must not solely focus on adults. In fact, these issues begin from childhood.

- Recommend a triage approach – there is too much emphasis on data, which is aggregated, and when the data is disaggregated, more systemic problems become evident.

- There is an opportunity to present programs such as parenting skills to trusted individuals within communities for the most effective outreach.

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

4 themes where there are issues and opportunities for improvement:

- Access/ Information
- Resource Limitations
- Cultural Competency
- System/Community Integration

GROUP 5: RESPONDING TO CRISIS

Inventory: Please list additional programs/services as they address crisis prevention.

> **Crisis Response:** Acute crisis response services, including hotlines, 911 diversion, mobile crisis teams, social service response, and co-response models

Examples:

- Seneca Family of Agencies created continuums that included mobile response to serve child welfare and broader mental health populations. We also worked with schools on response to crisis within schools.

- Child Welfare Council worked on Continuums of Care that included crisis services, prevention of crisis, and response post-crisis.
- Molina Cares grant to bring together 988 call centers to utilize a training platform for training call center staff. CBHA represents 4 call centers who provide crisis services to hundreds of thousands of Californians and will be the designee for the 988 number.
- Family Urgent Response System
- expansion of Trauma Recovery Centers (TRCs), community-based centers that provide a wide range of crisis and mental health support to victims of violent crime. CA used to only have one TRC, but there are now 16 TRCs across the state. These serve as a very important entry point for victims to get mental health support. The state Victim Compensation Fund funds this work.
- Community-based violence intervention programming, which is a combination of conflict mediation and mentorship, as well as crisis assistance and behavior health support for people at risk of being hurt by neighborhood gun violence. CalVIP funds this work.
- Comprehensive reentry services, as many people leaving the justice system fall into crisis unless they have some sort of immediate support. The Returning Home Well initiative as well the state Adult Reentry Grant Program are examples of how this work is funded

Deflection (5 pathways)

Community Responder Models – local responders

Model in Ohio – get an appointment quickly; up to 4 sessions of crisis stabilization with licensed provider or psychiatrist who might be at risk of going to ED or in ED rather than waiting months. 40% increase in youth ED visits since pandemic. Returners went from 6% to 15% during pandemic.

Are there current data on who uses ED services? Maybe HCAI?

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
Data to pinpoint the specific populations in need and the extent of the problem for each population (e.g., Medi-Cal/non-Medi-Cal, justice-involved, other demographics).	Seek opportunities to identify data to understand the different populations driving crisis needs, which should include data sharing (e.g., jails, prisons, behavioral health). This will help to prioritize and focus resources on strategies/solutions that will actually solve the problem.
Identifying individuals who would be better served to go someplace else (other than ED or jail/prison), how to intervene and where they should go.	Instead of taking patients to ED, take to alternative destination (examine EMSA pilots). For law enforcement, implement prevention deflection (one example is the WellSpace Crisis Receiving for Behavioral Health (CRBH) program). Need to make sure there is sufficient funding to support alternative locations (could examine mechanisms for shared savings to balance systems). Also need to ensure liability issues are addressed.
Missed opportunities with MISTs and FISTs – they are identified and should be fully supported, but continue to cycle in and out of systems. Need to minimize/reduce these types of emergencies.	Expansion of diversion programs, which requires robust, comprehensive services and supports to ensure basic needs are met, that available resources across multiple delivery systems are maximized, and that individuals receive the support necessary to navigate and utilize systems/services. Would be optimal to identify a strategy for early identification to prevent the high-level decompensation we see today.

Individuals have difficulty navigating multiple delivery systems.	Expansion of the Supporter Role (like in CARE Court) to walk individuals through transition processes. Would the ECM Lead Care Manager do this? What is done for people with commercial insurance?

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

GROUP 6: CRISIS STABILIZATION SERVICES

Inventory: Please list additional programs/services as they address crisis prevention.

> **Crisis Stabilization:** Community-based crisis stabilization services, including in-home crisis stabilization, crisis receiving facilities, peer respite, and crisis residential services

Examples:

- Advocating for and enforcing crisis intervention services in Medi-Cal

- **Our team noted: Stabilization IS Prevention of the next crisis episode.**

- A Statewide/Universal/Standardized intake/assessment process should be developed (questionnaire)
- We should develop a "Provider Directory" that is available Statewide and individuals (case managers) should be trained on providers and strategies that would be a good fit for individuals (as different interventions are shown to be effective for different populations)
- A case manager should be assigned to support the individuals/ family and
- Goals should be developed and a standardized report template (assessment and progress report templates)
- Progress should be monitored
- Quantitative data on goal progress should be reported on
- A State Database should be created so professionals in different areas and different state agencies can share information (this can assist first responders if they are called

to a home in the past know to bring a mental health professional with them to the call) etc….

- Board Certified Behavior Analysts (BCBAs) are "Providers" of BHT services through Medi-Cal and Private insurances. Although BCBAs provide services using a behavior analytic service delivery model, this is not specific to those with an autism diagnosis and many other individuals can benefit from our support.   These professionals can assist in the crisis prevention/stabilization of individuals that need to be managed. This can be another source of support that is already funded by health insurances. A diagnosis if autism is not required in many cases for funding from the health plans.

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
All Items above are gaps that do not exist along with a solution to create them	Provider directory that services and supports can be made available to diverse populations

o Behavioral side: evidence based ABA (Applied Behavioral Analysis)/intervention services
    ▪ Assessment and template of need for treatment and process for timeline to continue support; goals that individual needs to stabilize and confirm stability beyond. Also helps with accountability and assessment.
    ▪ Need criteria to say when and how you define stability
    ▪ Recognize cultural challenges and trauma
	Culturally relevant services and assessing path forward is important. Peer respite model - Sac Danielle's Place, established a community to avoid gaps of services.

• How do we empower marginalized populations?	

• lack of deaf community services and issues that arise. Generalized services within ABA.
   ○ I.e. Gay community and conversion methods
   ○ Can we provide therapy that is not inclusive, or provide therapy that is a good match for specific community seeking services?
   ○ What is the goal and response to the crisis?
   ○ Deaf people aren't included in a mental health procedure. When we discuss how to establish care, access would mean including those communities. LA County has 0 access, no therapist can community directly. Who is going to provide that therapy/service? The current system is not set up for access.
   ○ Emergency situations and next steps for ensuring stability is non-existent in the current structure. These are important supports that are needed, and the profession needs it for inclusivity and access.
	Assessment tool is helpful, as schools have a different process

in general we as a state need to have a framework of understanding the various theoretical frameworks for various populations and understand where those are offered highlighting there may be various gaps in service area	
Texting hotline: • texting is difficult, trying to develop a video option as its difficult to have a conversation via text, as English isn't most people's first language. A national hotline TTY is an antiquated technology, need ASL interpreters to support this system. • the data on utilization of texting is low. The perception that it wasn't a publicized service. Inclusion is even more important as a service may be poorly designed, and feedback from users is critical in the development of services.	
Assigning a case manager to monitor the person, to ensure they are accessing services to avoid relapse (prevention)	
Bridge services on the continuum (unfortunately, these services are not available everywhere). Fragmented continuum, its complicated. Funding is lacking.	
Standardization of services throughout the state - people don't know that the state doesn't have a strong continuum.	

If folks aren't getting the funding, there are continued silos. Priorities need to be based on services. People don't know how to access services, it should be included in the funding. Or guide towards a different agency.	
CS is funded differently, with a different model. Round 4 FAQ - the state requires 2 different RFPs to fund multiple services, complicated the interconnected. Fund by the state the interconnected pilots, reduces silos/divisions of efforts	

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

GROUP 7: PREVENTING CRISIS

Group 7 did not submit breakout discussion notes.

GROUP 8: RESPONDING TO CRISIS

Inventory: Please list additional programs/services as they address crisis prevention.

> **Crisis Response:** Acute crisis response services, including hotlines, 911 diversion, mobile crisis teams, social service response, and co-response models

Examples:

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- Community-based violence intervention programming, which is a combination of conflict mediation and mentorship, as well as crisis assistance and behavior health support for people at risk of being hurt by neighborhood gun violence. CalVIP funds this work.
- Comprehensive reentry services, as many people leaving the justice system fall into crisis unless they have some sort of immediate support. The Returning Home Well initiative as well the state Adult Reentry Grant Program are examples of how this work is funded

- MRSS
- Wraparound programs that use a child and family team based care and planning model that includes the expectation that crisis services are part of the model of care and crisis response by a known group of team members, including peers and parent partners, is built in and adequately funded, and provided with cultural and linguistic appropriateness and through effective engagement.

Gaps and Opportunities

1. **Gaps:** What is needed to ensure a robust CCC system in California? Who is not being served and what issues are not being addressed with regard to **crisis prevention**?

2. **Opportunities - the road ahead:** How can we expand and build **crisis prevention** programs and services to address these identified gaps? In the short-term? Long-term?

GAPS	OPPORTUNITIES
Need to align crisis services across siloed funding streams and health insurance payers,	Link people in real time through the platform that provides connection and options (live

including silos by population (Probation funding for those in juvenile justice; FURS for youth in child welfare, School funding for youth in Special ed.)	help, crisis services, referrals) in real time, including a peer to peer network and opportunity to build on the technology devices and broadband gains made from dealing and responding to the COVID pandemic, and shifts that happened as a result, such as telehealth access. One example shared was from Austin, TX: Cloud 9; another example: CYBHI Platform being developed.
With the huge need and so many gaps in the crisis services continuum and system, the need to focus on those pops with the greatest need/at the most risk first is important. This should be based on serving those with the greatest disparities and facing the greatest inequities (racial and gender).	

REPORT OUT: Please share two key takeaways from the discussion to inform the development of the CalHHS CCC-P/988 Blueprint.

APPENDIX B: INPUT FROM CHAT

CRISIS CARE CONTINUUM & 988 PRESENTATION

- Please make sure you include Board Certified Behavior Analysis (BCBAs) in the continuum of professionals that can support this initiative

CALHOPE CCP PRESENTATION

- Kudos for making a REAL effort and actually awarding contracts to CBOs that reach underserved racial and ethnic communities!!!!
- CalHOPE CCP was designed with equity as a first consideration, and I think it shows!
- Brilliant integration of peers and diverse CBO's! Here's hoping SB 803 will get them equitably paid.
- Agreed - it is an amazing collaborative of agencies . And kudos to the CalMHSA team for their leadership on their work to support this program.
- Yes! So often, there is some phrase in the principles of a project that includes the word "equity", but then the project just goes on and does business as usual. If people shy away from or don't use the words "race" or "ethnicity", then you can bet the project will not really reduce the existing disparities.
- What search engine/platform do the CalHOPE counselors use?
    - We created our own resource search site, that's on CalMHSA.org. In the appendix slides, we included a link to our repository site that includes a link to the search engine. We have provided the slides to HHS Agency to provide to everyone.
- This program has created a lot of career pathways for many folks - especially for peers entering the workforce.

LIGHTNING TALKS

Crisis Prevention

- MTSS
    - Are these still referred to as Tier 1, 2, 3?
        - Yes, also Tier 1, 2, and 3, but the key is services and supports are tiered, not students.

- o By the way, apropos of Christine's primary care analogy, no one says a pcp failed when they refer to a specialist… a successful teacher should have help!
- LGBTQ community centers
  - o Thank you, Mandy, for giving such a great explanation of LBGTQ centers in the community! Many similarities to ECBOs (ethnic community based organizations).
- Sisters Mentally Mobilized advocate training program, Sistahs Aging with Grace and Elegance (SAGE), and Anti-Violence Ventures
  - o Go Sonya! For all, here is the website for the California Reducing Disparities Coalition (CRDP), https://cultureishealth.org/ , Culture is Health.
  - o Thank you so much Sonya! Very informative and enlightening!!
  - o Yes!!! Safe Black Space!!

Crisis Response

- Training for 988 call centers
  - o Please visit the call center consortium that we've created that highlights the call centers. Call centers are run by CBOs and counties: https://www.988california.org/
- Intensive wraparound supportive services
  - o Agree- continuum is so important

Crisis Stabilization

- Crisis receiving and stabilization services in California
  - o Here's the RAND analysis I mentioned on acute inpatient needs: https://www.rand.org/pubs/research_reports/RRA1824-1-v2.html
- Mobile response and stabilization services for children and youth on Medicaid and Medi-Cal in California
  - o https://healthlaw.org/resource/childrens-behavioral-health-mobile-response-and-stabilization-services/
- Cross-sector collaboration

PUBLIC COMMENT

- Really appreciate the state's engagement on this topic and all the great presentations. How is CHHS state thinking about the role if systemic racism in the continuum of crisis care? The development of this continuum, as many of the presenters spoke to, must be

done with an explicit focus on racial and health equity given what we know about how often people of color with crisis behavioral needs are met with law enforcement.

- Here is a resource on advancing equity in the 988 conversation - https://kennedysatcher.org/wp-content/uploads/2022/06/988-Policy-Brief_Final.pdf?mc_cid=c325a4f560&mc_eid=bf8cb50c4e

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BREAKOUT GROUP DISCUSSION REPORT OUT

- I echo the comment about the importance of differentiating between adults' and children's system needs. 🙂
- Agree with sub-specialty and children's unique needs here
- Thanks for such a powerful space for discussion.

APPENDIX C: HCAI BEHAVIORAL HEALTH WORKFORCE LINKS

- Building a behavioral health workforce pipeline: Health Professions Pathways Program, https://hcai.ca.gov/loans-scholarships-grants/grants/hpcop/
- Recruiting and retaining the behavioral health workforce through loan repayment and scholarship programs:
  - Advanced Practice Healthcare Scholarship Program, https://hcai.ca.gov/loans-scholarships-grants/scholarships/aphsp/
  - Allied Health Scholarship Program, https://hcai.ca.gov/loans-scholarships-grants/scholarships/ahsp/Licensed
  - Mental Health Services Provider Education Program, https://hcai.ca.gov/loans-scholarships-grants/loan-repayment/lmhspep/
  - Steven M. Thompson Physician Corps Loan Repayment Program, https://hcai.ca.gov/loans-scholarships-grants/loan-repayment/stlrp/
- Building and expanding the psychiatric workforce, Psychiatric Education Capacity Expansion Program, https://hcai.ca.gov/loans-scholarships-grants/grants/bhp/
  - o Psychiatric Residency Grant Program
  - o Psychiatric Mental Health Nurse Practitioner Grant Program