

BEHAVIORAL HEALTH TASK FORCE MEETING

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY

September 13, 2022

VIRTUAL MEETING PROTOCOLS

- Meeting is being recorded
- American Sign Language interpretation in pinned video
- Live captioning link provided in chat

BHTF MEMBERS

- Mute/Unmute Functionality for members and policy partners.
- Stay ON MUTE when not speaking and utilize the “raise hand feature” if you have a question or comment.
- Please turn on your camera as you are comfortable
- Use chat for additional conversation

MEMBERS OF THE PUBLIC will be invited to participate during public comments period at the end of the meeting

WELCOME & INTRODUCTIONS

MARK GHALY, SECRETARY, CalHHS

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

BHTF GUIDING PRINCIPLES AND COMMITMENT TO ENGAGEMENT

- ✓ **FOCUS ON EQUITY**
- ✓ **ACTIVELY LISTEN**
- ✓ **USE DATA TO DRIVE ACTION**
- ✓ **SEE THE WHOLE PERSON**
- ✓ **PUT THE PERSON BACK IN PERSON-CENTERED**
- ✓ **CULTIVATE A CULTURE OF INNOVATION**
- ✓ **DELIVER ON OUTCOMES**
- ✓ **WORK TO REDUCE STIGMA**

- 1. Stay focused on the agenda**
- 2. Anchor discussions in a person-centered approach**
- 3. Strive to examine and act in an equitable and inclusive manner**
- 4. Think innovatively and welcome new ideas**
- 5. Involve all BHTF members in discussions**
- 6. Uphold a respectful dialogue**

TASK FORCE MEETING AGENDA

- 10:00** Welcome and Introductions
- 10:15** Lived Experience Perspectives on Crisis Prevention and Response
- 10:35** Behavioral Health Crisis Care Continuum Planning Update
- 11:00** Short Break
- 11:05** Crisis Care Continuum Plan – Breakout Discussions and Report Out
- 12:15** Public Comment
- 12:30** Lunch Break
- 1:00** Update on the Children and Youth Behavioral Health Initiative (CYBHI)
- 1:20** CYBHI Ecosystem Working Paper – Presentation & Discussion
- 2:10** Short Break
- 2:15** The Dynamic and Changing Behavioral Health Environment - BHTF
Members Open Discussion
- 2:50** Closing Thoughts
- 3:00** Adjourn

LIVED EXPERIENCE PERSPECTIVES ON CRISIS PREVENTION AND RESPONSE

Shauna Toh

Miguel Serricchio

Dino Alzadon

BEHAVIORAL HEALTH CRISIS CARE CONTINUUM PLANNING UPDATE

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

Behavioral Health Task Force – Goals for 9/13 meeting

- Recap context, preliminary insights and themes from initial understanding of **the current state of crisis care services in California**
- Introduce preliminary **potential approach to statewide future state minimum service model** which will be the focus of the afternoon break-out discussions

Recap: CalHHS Role – Crisis Care Continuum Blueprint and Roadmap

Plan Components

- Identify the state-wide vision for full set of services for individuals experiencing crisis (interactions among 988, 911, Medi-Cal mobile crisis response, crisis receiving facilities, long term crisis residential services)
- Articulate state-wide minimum standards and metrics
- Define models / prototypes of how state-wide services could be implemented locally, recognizing different models will be needed in different counties/communities
- Provide a high-level view of resources required, or current investments that could be used, to support implementation of a robust crisis care response system
- Outline a governance model to support future implementation
- Identify approaches to reach major milestones (“the how to”), including what would be needed in terms of legislative authority, funding and approximate timing – a roadmap over several years of capacity building efforts

Source: CalHHS, Discussion materials from Commission on Emergency Medical Services Quarterly Meeting June 15, 2022

Preliminary takeaways of the current state of crisis care in California

- There have been many local and state-wide efforts related to crisis care; however, there is room for improved coordination between crisis prevention, response, stabilization¹
- Across CA counties, there are different approaches to crisis prevention, stabilization, and response with considerable geographic variation in the availability of services,² particularly county-run warmlines³
- Focusing on 988, California appears to meet readiness standards within the Lifeline Network-affiliated contact centers;⁴ however, there may be opportunities to ensure coordination and readiness across the broader network of call lines⁵

1. Based on the DHCS Assessing the Continuum of Care for Behavioral Health Services in California, 988 Implementation Plan for California – 988 Planning Grants, SAMHSA's Gains Center California SWOT Analysis, and participant reflections from the June 14 BHTF Meeting

2. Based on services offered by county as outlined in the DHCS Assessing the Continuum of Care for Behavioral Health Services in California and the 988 Implementation Plan for California – 988 Planning Grants

3. Only 6 county / local warmlines listed in the following National warmlines directories: [NAMI National Warmlines Directory](#), [Warmlines.org](#); however, all 58 counties have crisis lines

4. Readiness metrics outlined in NASMHPD 988 Convening Playbook: States, Territories, and Tribes; insights on California from DHCS Assessing the Continuum of Care for Behavioral Health Services in California, 988 Implementation Plan for California – 988 Planning Grants, & reflections from the June 14 BHTF Meeting

Opportunities for improved transitions across levels of crisis care

Preventing Crisis

- **No unified database** of statewide & local resources for use by call lines¹
- Opportunities to coordinate between **81+** county / local crisis & warm lines¹²

Responding to Crisis

- Disconnects in policies for **crisis hotlines and the PSAP system** according to CA SWOT analysis³
 - No current policy on **interoperability between 911 and 988**³
 - Each PSAP has own **process for suicide risk assessment**³
- **Gaps in referrals to care** from hotlines according to 988 Planning Grants

Stabilizing Crisis

- **Lack of available stabilization services** following an initial crisis according to DHCS⁴
- CSUs serve people > 23 hours due to **capacity constraints in other services** according to DHCS⁴

1. 988 Implementation Plan for California – 988 Planning Grants

2. 81+ county / local crisis & warm lines based on crisis line directory from California (excluding call lines that are part of the NSPL network) and collating existing county / local warmlines based the following National warmlines directories: [NAMI National Warmlines Directory](#), [Warmlines.org](#)

3. SAMHSA's Gains Center California SWOT Analysis for California

4. DHCS Assessing the Continuum of Care for Behavioral Health Services in California

1: Availability & sufficiency of crisis services by county

Notes about approach to estimation (from the DHCS 2022 report **Assessing the Continuum of Care for Behavioral Health Services in California**)

- Estimates of county-level demand for crisis care services are based on population average demand for in-person crisis episodes, which do not adjust for
 - Differences across sub-populations and geographies
 - Variation over time (including trends driven by the COVID-19 pandemic)
- Estimations for county-level supply of crisis services are based on a survey of county behavioral health directors and DHCS licensure data, as included in 2022 DHCS report

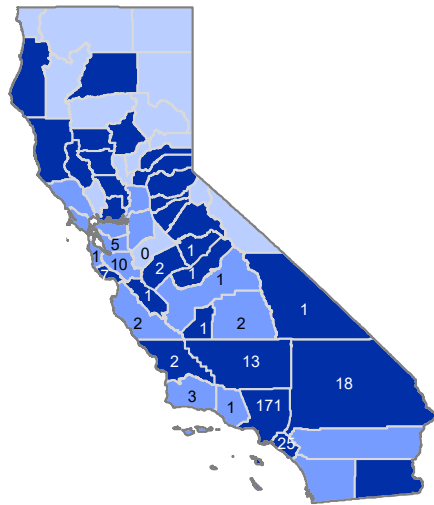
1: Availability & sufficiency of crisis services by county

Number of Mobile Crisis Teams by county

Relative to projections from the Crisis Now Model

Number of Mobile Crisis Teams According to Crisis Now Calculator

- "Sufficient"¹ mobile crisis teams available
- Not enough mobile crisis teams available
- No mobile crisis teams available



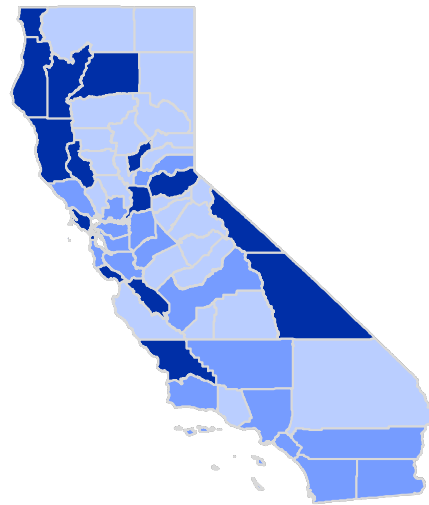
37 of 44 counties with mobile crisis teams have "sufficient"¹ intervention capacity

Number of Crisis Stabilization Units by county

Relative to projections from the Crisis Now Model

Number of CSU Slots According to Crisis Now Calculator

- "Sufficient"¹ CSU slots available
- Not enough CSU slots available
- No CSU slots available

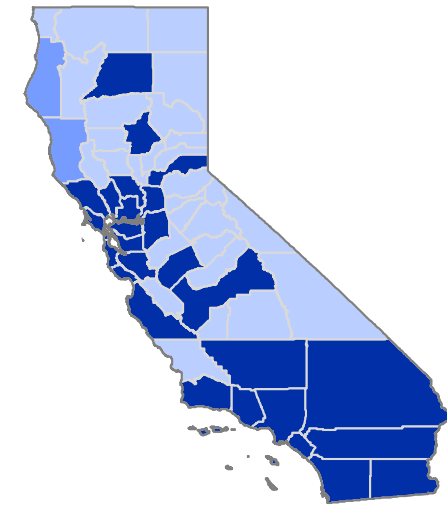


16 of 33 counties with Crisis stabilization units have "sufficient"¹ crisis stabilization capacity

Presence of Crisis Residential Treatment Programs by county

Counties with Operational Crisis Residential Treatment Programs

- Yes
- Not yet, in planning
- No



9 of 28 counties with CRTPs reported sufficient² crisis residential treatment capacity

1. County-reported resource levels meet or exceed NASMHPD Crisis Resource Need Calculator recommended county level resource allocations (as reported by DHCS)

2. Counties that reported operating Crisis Residential Treatment Programs and did not report requiring additional residential treatment capacity

Sources: [DHCS Assessing the Continuum of Care for Behavioral Health Services in California](#)

Landscape of hotlines & warmlines available to Californians

Scope	Warmlines	Hotlines
National	<ul style="list-style-type: none"> • 8+ major national warmlines, including the TeenLine • Largely operated by non-profits with private funding • Volume ranges from 10k – 75k+ conversations annually by line 	<ul style="list-style-type: none"> • 5+ major national hotlines, including the NSPL which operates via 13 Lifeline Centers in CA • Operated and funded by mix of non-profit, for-profit, and federal gov. entities • Volume ranges from 150k – 2.4M national crisis contacts / calls annually by line
State-wide	<ul style="list-style-type: none"> • 2+ state-wide warmlines, including • Operated by gov / non-profit entities; funded by federal (e.g., CCP), state, and private sources • Annual call volume ranges from 20k – 60k by line 	<ul style="list-style-type: none"> • 3+ statewide hotlines, including the Friendship Line (which operates as both a crisis line and a warmline), the CA Youth Crisis Line, DSS Parent & Youth Helpline • Operated by a non-profit organizations and funded by State of CA as well as private donors • Annual call volume ranges from 15k – 300k by line
County / local	<ul style="list-style-type: none"> • 6+ county / local warmlines • Operated by county governments and non-profits; funded through public (e.g., MHSA) and private sources • Annual call volume can be up to 100k+ in certain counties 	<ul style="list-style-type: none"> • 75+ county / local crisis lines • Most lines run by counties and other operate as non-profits; some lines re-direct calls to lifeline centers • Annual call volume can be up to 55k+ in certain counties

Readiness for 988 within California's Lifeline network

The 13 CA Lifeline Centers largely meet 988 readiness metrics outlined in the NASMHPD self-assessment¹

- CA Lifeline Centers have an in-state call answer rate² of ~85-90%, with some variation across counties³
- 12 of 13 Lifeline Centers operate 24/7/365; Yolo County to become 24/7/365 by July 2022 (launch of 988)⁴
- 2 of 13 Lifeline Centers offer text/chat capabilities through Lifeline⁵
 - Plan set for 80% chat/text in-state answer rate by 2023⁵
 - 7 Lifeline Centers offer text or chat locally⁵

Efforts underway within the CA Lifeline network to prepare for projected increases in call volume⁶

- Assessment of network volume, coverage, and gaps planned for 6 months following launch of 988
- Applications submitted from 3 additional California contact centers to join the Lifeline network
- Process initiated to select a unified training platform
- \$20M from DHCS awarded for capacity & infrastructure, including \$8.5M in FY 22-23 for crisis line capacity
- \$~5M technology budget granted to CalOES
- \$14.4M SAMHSA grant application submitted

Beyond the Lifeline Centers, open questions remain for how 988 will integrate into the broader network of hotlines & warmlines available to Californians²

1. [NASMHPD 988 operational readiness self-assessment for states, territories, and tribes](#); performance against all criteria noted as "Criteria identified as priorities for July 2022" based on the State of California 988 Implementation Plan
2. The percentage of calls originating in California answered by a call center located in California
3. NASMHPD defines meeting self-assessment criteria as 90% in-state call answer rate
4. NASMHPD defines meeting self-assessment criteria as 24/7 primary coverage for Lifeline calls
5. NASMHPD defines meeting self-assessment criteria as 1+ Lifeline contact center currently has chat / text capabilities, capacity to handle at least 50 percent of chats / texts by July 2022 and 80 percent of chats / texts by July 2023, and state- / territory-wide 24/7 primary coverage for chats / texts
6. Efforts listed in the section "Expand and Sustain Center Capacity to Maintain Target In-State/Territory Answer Rates for Current and Projected Call, Text, and Chat Volume" section in the State of California 988 Implementation Plan, or funding-related efforts listed in the "Overall Background and Context" section of the State of California 988 Implementation Plan

Approach for review of national guidance documents

Approach for synthesizing national guidance documents from SAMHSA and national leaders

- **SAMHSA National Guidelines¹ outlined:**
 - **Minimum expectations:** baseline requirements as listed in the SAMHSA National Guidelines (for select continuum components); includes performing all **essential functions** outlined by SAMHSA for each service
 - **Best practices:** actions accepted as "gold standard" in addition to meeting minimum expectations, including **cross-cutting enablers** for excellent crisis care from SAMHSA
- All other practices from other sources² are classified in this document as **example recommendations from national guidance documents**

Approach for reviewing California's crisis system against synthesized national standards

Based on **public sources and preliminary stakeholder feedback**, relative to national standards, crisis care in California can be defined as:

- **Beginning:** Work in this area has not yet started
- **Emerging:** Work in this area is underway but not yet complete
- **Solidified:** Objectives in this area are fully or almost fully met

This review is based on publicly available sources and CalHHS has not yet vetted the analysis with stakeholders

1. [SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#)

2. [SAMHSA Harm Reduction, National Harm Reduction Coalition, NASMHSPD 988 Convening Playbook, SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes, Vibrant, Council of State Governments Justice Center, Crisis Residential Association](#)

Preliminary takeaways of California's performance against national standards for crisis systems















Based on synthesis of 7 public national guidance documents, 4 external sources on crisis services in CA, and preliminary stakeholder interviews

- Existing national guidance documents primarily focus on responding to and stabilizing crises;¹ CA may consider prioritizing preventing crises in the context of ongoing public health initiatives in the area
- When compared to national guidance documents for responding to and stabilizing crises, CA meets expectations for hotlines;² however, there are inconsistencies for other crisis services operated at the county-level³

1. Based on national guidance documents from [SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#), [SAMHSA Harm Reduction](#), [National Harm Reduction Coalition](#), [SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes](#), [Vibrant](#), [Council of State Governments Justice Center](#), [Crisis Residential Association](#)
2. National Standards from [SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#) & additional national guidance documents from Vibrant & NASMHPD; current state analysis based on the 13 Lifeline Centers affiliated with NSPL based on the DHCS BH assessment, 988 Implementation Plan for California – 988 Planning Grants, NSPL offerings, and June 14 BHTF meeting reflections
3. National Standards from [SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#) & additional national guidance documents from Vibrant & NASMHPD; current state analysis based on the [DHCS BH Assessment](#), as well as the 988 Implementation Plan for California – 988 Planning Grants and June 14 BHTF meeting reflections

Overview of national guidance documents in review

 Guidance documents included in analysis

	Preventing Crisis		Responding to Crisis				Stabilizing Crisis			
	Warmlines	Harm reduction programs	Hotlines	911 / 988 coordination	Mobile crisis team services	Co-response models	Crisis Receiving & Stabilization Services	Short-term crisis residential programs	In home crisis stabilization	Sobering centers ⁴
Minimum expectations from SAMHSA										
Minimum expectations: essential functions	<i>Not included in analysis¹</i>					<i>Not included in analysis¹</i>			<i>Not included in analysis¹</i>	
Example recommendations from national guidance documents										

1. Not included in analysis since there is not a clear, nationally recognized guidance document

Overview of crisis care components in CA relative to national guidance

- Beginning - Work in this area has not yet started
- Emerging - Work in this area is underway but not yet complete
- Solidified - Objectives in this area are fully or almost fully met
- N / A
- More information needed
- N / A
- X Detail to follow

	Preventing Crisis		Responding to Crisis			Stabilizing Crisis						
	Warmlines	Harm reduction programs	i Hotlines ¹	911 / 988 coordination	ii Mobile crisis team services ²	Co-response models	iii Crisis Receiving & Stabilization Services ³	Short-term crisis residential programs	In home crisis stabilization	Sobering centers ⁴		
Availability	Not included in analysis ⁵					Not included in analysis ⁵			Not included in analysis ⁵			
Standard of care												
Coordination												
Technology												

1. Current state analysis based on the 13 Lifeline Centers affiliated with NSPL based on the DHCS BH assessment, 988 Implementation Plan for California – 988 Planning Grants, NSPL offerings, and June 14 BHTF meeting reflections
2. Current state analysis based on county resources as reported in the [DHCS BH Assessment](#), as well as the 988 Implementation Plan for California – 988 Planning Grants and June 14 BHTF meeting reflections
3. Current state analysis based on county resources as reported in the [DHCS BH Assessment](#)
4. Current state analysis based on synthesis from the California Health Care Foundation, which states: “most California sobering centers share [these] key best practices that sustain and support their work”
5. Not included in analysis since there is not a clear, nationally recognized guidance document

Potential approach to future state minimum standards

The approach below is informed by national guidelines from SAMHSA and expert interviews

*Future state minimum standards may **address objectives of each component** (e.g., prevention, response, stabilization) regardless of specific service or setting being used to meet the standard*

Preventing Crisis

- Access to peer-based warmlines
- Access to community-based behavioral health services, such as:
 - Community-based social services
 - School-based and school-linked services
 - Primary care clinics and FQHCs
 - Outpatient BH care (e.g., CCBHCs, urgent care clinics, transition clinics, bridge clinics)
 - Peer support
 - Harm reduction
- Exposure to digital apothecary (e.g., CYBHI digital platform, CalHOPE digital tool)

Responding to Crisis¹

- Real-time coordination of crisis and outgoing services
- Linked, flexible services specific to crisis response
- Triage/screening & initial assessment, including explicit screening for suicidality
- Counseling throughout the encounter and intervene to de-escalate the crisis
- Family and individual psycho-education
- Exposure to peer support and family support
- Coordination with medical and behavioral health services
- Crisis planning and follow-up

Stabilizing Crisis¹

- Evaluation of needs and strengths
- Continued monitoring of care
- Crisis service discharge planning
- Linkage to ongoing care

Baseline standards for the crisis care continuum plan assume access to services in the broader behavioral health ecosystem addressing primary prevention of crisis and routine treatment of mental and substance use disorders

1. Based on the "Essential Functions" described for individual crisis care continuum components included in the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit

Recap: BHTF engagement to date and upcoming

● Today, September 13

May Lunch & Learn

- Introduce the Crisis Care Continuum effort to the BH Task Force

Tuesday, June 14th

- Introduce the Crisis Care Continuum effort to the BH Task Force
- Hear from members on related efforts through “Lightning talks”
- Gather inputs on gaps and opportunities in crisis care through breakout sessions

Wednesday, August 31

- Recap Crisis Care Continuum effort and context to the BH taskforce
- Share preliminary insights from initial understanding of the current state, national best practices, and initial future state minimum service levels

October and Beyond

- *Engagement opportunities to focus on population- and service-specific needs and gather feedback on major elements of the Blueprint.*

BHTF INPUT ON THE CRISIS CARE CONTINUUM

Participants at the June BHTF meeting discussed **gaps and opportunities** in building a robust Crisis Care Continuum in California. Key themes that emerged from the breakout discussions include:

Build capacity and expand the workforce across the continuum

Build in equity throughout all work; expand culturally appropriate and anti-racist care

Expand **community-based care** to improve access and trust

Align and integrate services across **funding streams/payers** for a “no wrong door” approach

Build **bridge services**, with real-time linkages and warm hand-offs

Address **data sharing and transparency** to focus resources and monitor progress

Thank you!

For resources and more information regarding our behavioral health initiatives:

[CalHHS Crisis Care Continuum – Plan webpage](#)

[Behavioral Health Task Force webpage](#)

CURRENT STATE OF CRISIS CARE SERVICES IN CALIFORNIA - MEMBERS DISCUSSION

- ✓ Accuracy of assessment
- ✓ Gaps
- ✓ Additional questions that should be part of the assessment



SHORT BREAK

(5 minutes)

CRISIS CARE CONTINUUM PLANNING SMALL GROUP DISCUSSIONS

BREAKOUT DISCUSSION PROCESS

PURPOSE

- ✓ Connect with other members of the BHTF
- ✓ Inform the CalHHS Crisis Care Continuum Plan development

TIMING 45 minutes in breakout discussion – discuss questions & fill out template; prepare for report out

GROUP ASSIGNMENTS Participants are randomly assigned to participate in breakouts – grouped by BHTF membership and the public.

OVERARCHING QUESTION

What **STANDARDS** should we strive for to ensure that all Californians have access to basic behavioral health crisis care services?

BREAKOUT DISCUSSION AGENDA

[3 min] Logistics Before starting the discussion, please **identify**:

- **Timekeeper**,
- **Facilitator** to ensure that everyone has an opportunity to contribute to the conversation, and
- **Notetaker and reporter** on behalf of the group when we reconvene

[5 min] Quick Brainstorm

- Are we missing any standards to ensure that all Californians have access to basic crisis care services?

[7 min] Assess availability of standards For each standard, identify whether it is

- Currently **available**
- Currently **in planning**
- **Aiming for**

[25 min] Discuss

- What is **needed** to make each standard available?
- Share **additional input or considerations**

[5 min] Prepare to report out Identify 2 key takeaways from the group's discussion

DISCUSSION TEMPLATE WALK THROUGH

CRISIS PREVENTION					
1. FUTURE STATE STANDARDS	2. CURRENT STATE OF STANDARDS			3.A NEEDS	3.B NOTES
[5 min] Quick brainstorm: Are we missing any standards? Add to the list below.	[7 min] Assess availability of standards: check the appropriate column for each standard <ul style="list-style-type: none"> • Currently available • Currently in planning (~2-5 yr. timeframe) • Aiming for 			[30 min] Discuss: <ul style="list-style-type: none"> • What is needed to make these standards available? • Use the notes column to share additional input (e.g., examples of programs; note if there are differing perspectives on the standard within the group; etc.) 	
Standards	Currently AVAILABLE	Currently PLANNING	AIMING FOR	What is needed to be able to achieve the standard?	Additional input or considerations
Access to peer-based warmlines	x			Need to be more culturally & linguistically competent & accessible Improved outreach to bring in more volunteers with lived experience Increased awareness of warm lines	Effectiveness should be evaluated Some group members were not aware of existing warm line resources Group identified this standard as a top priority

REPORT OUT

Please share, in 2-3 minutes, **two key takeaways** that another group has not already shared



PUBLIC COMMENT

Lunch Break

Please return to this same Zoom meeting following the lunch break.

(If you choose to leave the meeting during the break, please re-join using the same link as the morning session.)

The afternoon session will begin at 1:00pm

UPDATE ON THE CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI)

MELISSA STAFFORD JONES, DIRECTOR, CYBHI



Children and Youth Behavioral Health Initiative: Behavioral Health Task Force Meeting

CYBHI Update

September 13, 2022



California's Master Plan for Kids' Mental Health

California's Master Plan for Kids' Mental Health

In August 2022, Governor Newsom announced California's Master Plan for Kids' Mental Health, an integrated multi-year effort uniting historic investments across disciplines to more holistically serve the state's diverse children, youth, and families.

- **CYBHI at the Core** of the Master Plan
- **\$4.7B so every Californian aged 0-25 has increased access** to mental health and substance use supports
- **Whole Child**, "All of the Above" Approach

Additional investments and initiatives that are being implemented in coordination and collaboration with the CYBHI¹.

- \$4.1B on a community schools
- \$5B on a Medi-Cal CalAIM initiative
- \$1.4B to build the healthcare workforce
- Additional State budget investments in school-based behavioral health workforce

¹ Based on Governor Newsom's Master Plan for Kids' Mental Health, August 2022, https://www.gov.ca.gov/wp-content/uploads/2022/08/KidsMentalHealthMasterPlan_8.18.22.pdf?emrc=6d3847

Source: [Governor Newsom's Master Plan for Kids' Mental Health](#), August 2022

The Children and Youth Behavioral Health Initiative

The **Children and Youth Behavioral Health Initiative (CYBHI)** is a historic, five-year, \$4.7 billion initiative to **reimagine and transform the way California supports children, youth and families.**

The initiative focuses on:

- Promoting mental, emotional and behavioral health and well-being.
- Prevention and providing services to support children and youth well-being.
- Providing services, support and screening to ALL children and youth for emerging and existing needs connected to mental, emotional and behavioral health and substance use.
- Addressing inequities for groups disproportionately impacted by mental health challenges and that face the greatest systemic barriers to well-being.

Built on a foundation of **equity** and **accessibility**, the CYBHI is designed to **meet young people and families where they are** to create an ecosystem that can help them **when, where** and **in the way they need it most.**

The initiative is managed by the California Health and Human Services Agency (CalHHS) working in partnership with CalHHS Departments, other state agencies, and a wide range of partners and stakeholders.

Source: California Health and Human Services Agency

CYBHI updates

Reminder: Phases of the Children and Youth Behavioral Health Initiative

What is our vision?

Set Goals and Stand-Up Infrastructure

Setting overall vision, initiative-level goals and standing up performance infrastructure.

How do we get there?

Develop Detailed Plans and Design Future State

Developing a robust plan, with clear accountability for design and delivery; sourcing ideas and designing the future state.

Let's get to work!

Deliver and Accelerate Impact

Launching a full-scale effort to drive, accelerate and sustain impact.

- CYBHI workstreams may be in different phases based on their implementation plans
- Most workstreams are currently at the design phase, with few components of the CYBHI moving toward implementation
- Phases will be iterative, ensuring feedback and learnings are continuously incorporated

CYBHI highlights of progress since June 2022

- **Advance equity:** Established Equity Working Group with 39 members; conducted first full group meeting August 17 (presentation materials)
- **Center on children, youth, and families:** Completed **XX** focus groups and **XX** interviews with youth and caregivers¹, with support from **XX** children, youth, and family engagement partners
- **Reimagine the ecosystem:** Completed phase one research, including 100 SME interviews, to inform design of the future ecosystem – *detailed discussion to follow*
- **Increase awareness:** Published Back-to-School Mental Health Resources for youth, parents, families, and educators
- **Embed accountability:** Released Request for Proposal for CYBHI Evaluation Consulting Services, with the submission deadline on September 30, 2022 and contract award announcement planned in late October 2022

¹ Focused on initiative-wide topics; additional workstream-specific children, youth, and family engagement includes multiple focus groups, interviews, design sessions, and other engagement activities

Source: California Health and Human Services Agency

CYBHI Workstream Key Updates

Workforce Training and Capacity		Behavioral Health Ecosystem Infrastructure		Coverage Architecture	Public Awareness
Behavioral Health Counselor and Coach Workforce (HCAI)	CalHOPE Student Services (DHCS)	School-Linked Partnership and Capacity Grants (DHCS)	Behavioral Health Continuum Infrastructure Program (DHCS)	Enhanced Medi-Cal Benefits – Dyadic Services (DHCS)	Public Education and Change Campaign (CDPH)
Broad Behavioral Health Workforce Capacity (HCAI)	Trauma-informed Training for Educators (OSG)	Student Behavioral Health Incentive Program (DHCS)			
Behavioral Health Virtual Services Platform (DHCS)				Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services (DHCS/DMHC)	ACEs and Toxic Stress Awareness Campaign (OSG)
Healthcare Provider Training and e-Consult (DHCS)					
Scaling Evidence-Based and Community-Defined Practices (DHCS)					

Source: California Health and Human Services Agency

1. Adverse childhood experiences

Additional resources and updates

Quarterly Public Quarterly Webinar on July 15, 2022:

- [presentation materials](#)
- [video recording](#)

[August 2022 Stakeholder update](#)

1 Focused on initiative-wide topics; additional workstream-specific children, youth, and family engagement includes multiple focus groups, interviews, design sessions, and other engagement activities

Source: California Health and Human Services Agency

CYBHI contacts

- To provide input on initiative-wide topics or sign up to receive regular updates about the CYBHI, please email CYBHI@chhs.ca.gov
- To engage on workstream-specific topics, please use the following contact information and resources:
 - Department of Health Care Services:
 - Contact information for questions/feedback: CYBHI@dhcs.ca.gov
 - Children & Youth Behavioral Health Initiative [Webpage](#)
 - Student Behavioral Health Incentive Program (SBHIP) [Webpage](#)
 - Behavioral Health Continuum Infrastructure Program (BHCIP) [Webpage](#)
 - CalHOPE Student Support [Webpage](#)
 - Department of Health Care Access and Information (HCAI): HWDD.ADMIN@hcai.ca.gov
 - Department of Managed Health Care: CYBHI@dmhc.ca.gov
 - California Department of Public Health: CYBHI@cdph.ca.gov
 - Office of the California Surgeon General: info@osg.ca.gov

Source: California Health and Human Services Agency

CYBHI outcomes and outcome measures

CYBHI approach to evaluation

The CYBHI plans to adopt a multi-dimensional approach that combines three evaluation types. All three types of evaluation are equity-centered, including through the engagement of children, youth, and families as well as evaluation methodologies, analyses, and data disaggregation that are intentionally oriented toward equity



Systems change evaluation



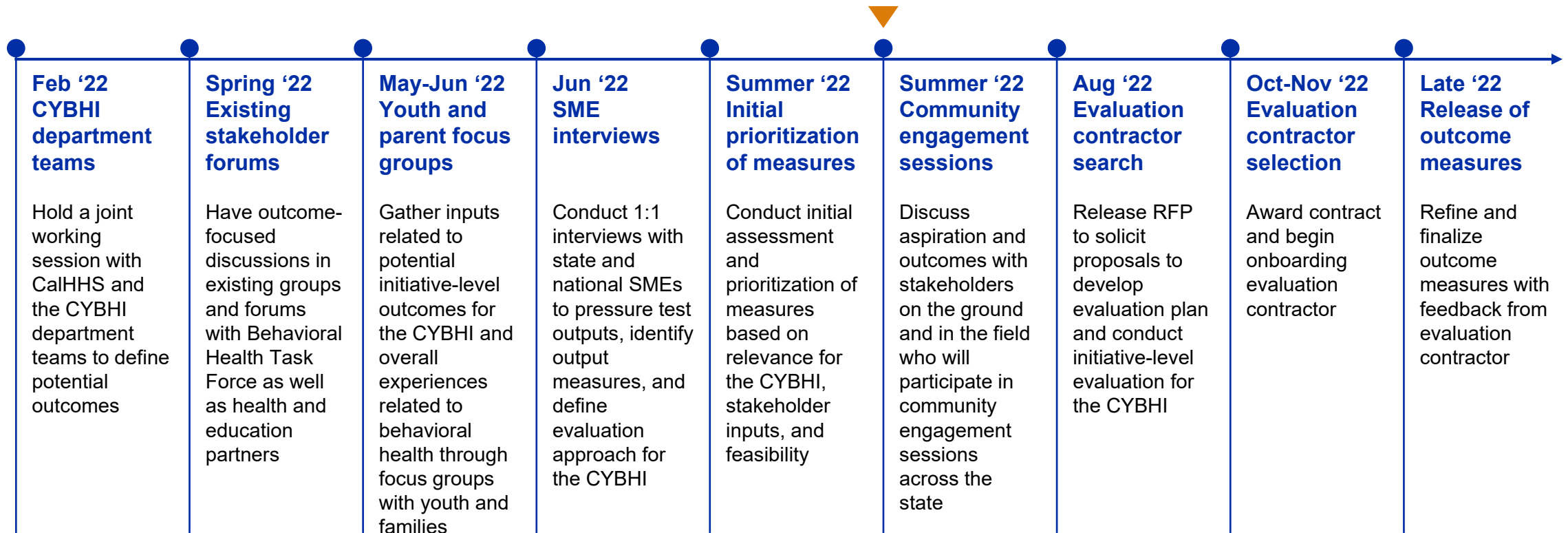
Policy evaluation



Program evaluation

Source: California Health and Human Services Agency

Approach and timeline for developing CYBHI outcomes



Source: California Health and Human Services Agency

Synthesis of stakeholder feedback: cross-cutting themes

Themes emerged from conversations with youth, caregivers, educators, cross-sector partners, and SMEs and are discussed further in the CYBHI Initiative-level Outcomes and Outcome Measures Summary Document

Youth and family experiences with BH system	The need for the system to be more “welcoming,” “responsive,” “empathetic,” “accepting,” and “less, or not at all, “scary,” with timely follow-up care and 24/7 access to online support services
Non-clinical strategies and services	The importance of social support, community building activities (e.g., fun days and community events on campus), green spaces / nature, art therapy, fitness facilities, nutrition, and safe spaces and forums to discuss mental wellness
Workforce diversity and capacity	Sufficient, responsive, culturally, and linguistically capable staff and the desire to build connections with BH professionals who are representative and reflective of the identities they serve
Agency and self-determination	Equipping youth and families to make informed decisions by providing education and access to navigation tools, including trusted places that can provide connections to resources and information about accessing services
Affordability	Access to free or low-cost services and supports in the context of youth financial vulnerability due to frequent changes in their insurance status
Role of families and caregivers	The need to focus on family supports, strengthen intergenerational relationships, and help caregivers with access and system navigation, recognizing that families themselves may be barriers to discussing and seeking mental health resources
Confidence in systems and institutions	Low level of trust as a barrier to accessing services and supports; broader ramifications of systemic racism, poverty, food and housing insecurity

Source: California Health and Human Services Agency; focus groups and discussions with youth, families, cross-sector partners, and SMEs in March – early July 2022 (see specific sources and stakeholders listed on page 5 of this document)

Synthesis of stakeholder feedback: direct quotes from interviews and focus groups



Youth and family experiences with BH system

“The important thing is that they return the phone call. That shows that they’re interested in your problem. [...] Because it’s happened to me sometimes, you go to the agencies and there’s a waiting list, then you never hear back from them.” [Parent focus group participant]



Non-clinical strategies and services

“They [(surrounding libraries)] have a bunch of different resources for people to relax, because you can read books, there’s board games, you can connect with other people. And I think they have an art station, where you can do crafts and stuff. And they have a recording studio. And I feel like something like that in our schools would be really helpful to students” [Youth focus group participant]



Workforce diversity and capacity

“[with] my current therapist...I talked about my culture, living in a multi-generational household and how they stress me out... there’s respect. And these cultural differences, my current therapist understood it. I don’t need to say anything; she just gets it versus seeing someone who didn’t look like me and didn’t come from my similar background.” [Youth focus group participant]



Agency and self-determination

“Empowering beneficiaries, families, and communities to drive the decision of the care, even when it need to be changed.” [BHTF member]



Affordability

“It’s extremely expensive to get any type of support. My first therapist was like a hundred dollars a session. And that was every single week. And that was after insurance. It’s just not affordable when it’s that expensive.” [Youth focus group participant]



Role of families and caregivers

“Educational resources for BIPOC family members, [so] that the people closest to us can be more open to supporting us in that endeavor.” [Youth focus group participant]



Confidence in systems and institutions

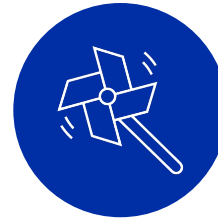
“BIPOC people in general don’t have necessarily positive experiences when it comes to doctors and mental health in general.” [Youth focus group participant]

Source: California Health and Human Services Agency; focus groups and discussions with youth, families, cross-sector partners, and SMEs in March – early July 2022 (see specific sources and stakeholders listed on page 5 of this document)

Synthesis of stakeholder feedback: approach and process



Level of specificity, especially on equity and including clearly articulated goals for specific populations as well as commitments to address specific barriers and inequities



Youth, family, and community engagement, including shifting toward more meaningful opportunities for engagement (e.g., community leadership, youth-led programming) and establishing a two-way communication, with follow-ups to share how feedback is incorporated



Clear language and consistent communication, including the need to clarify terms (e.g., “ecosystem”), not use jargon, and avoid terminology that may not be clear for individuals without prior knowledge of the BH system (e.g., “upstream” / “downstream” services)

Source: California Health and Human Services Agency

CYBHI outcome measures identified by CalHHS



Population outcomes

1. Increase in overall **mental well-being** for children and youth
2. Decrease in **mental health challenges**
3. Decrease in rates of **suicidal ideation** for vulnerable populations
4. Decrease in **emergency room visits and hospitalizations** for children and youth with mental health related conditions
5. Decrease in rates of **school absenteeism**
6. Decrease in **stigmatizing attitudes** toward behavioral health
7. Improvement of **experience with BH services and supports** for children, youth, and families



System performance measures

8. Increase in **knowledge of available BH supports and services**
9. Increase in children and youth who **received mental health and substance use services and supports**
10. Increase in **diversity of BH professionals**, especially in underserved communities
11. Increase in **preventive services and family supports** for children ages 0-5
12. Increase in **substance use prevention strategies** specifically for younger children and adolescents
13. Decrease in **barriers to care** for children and youth from underserved communities
14. Increase in **cross-sector collaboration** and adoption of continuous improvement approaches
15. Increase in utilization of the **school-linked statewide fee schedule**

Source: California Health and Human Services Agency

Example deep-dive: Decrease in mental health challenges – data sources

Data availability  Limited number of categories  Multiple detailed categories

Demographic information captured

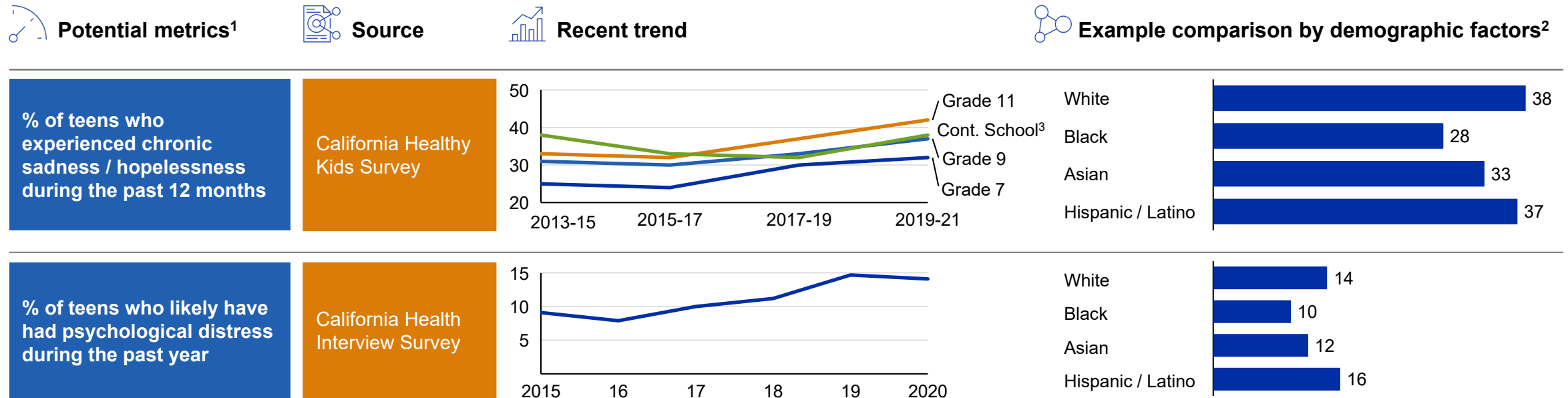
Methodology

 Potential metrics ¹	 Source	County	Age	Race / ethnicity	Gender identity	Sexual orientation	Frequency	Most recent data	Sample size ²	Response rate ²
% of teens who experienced chronic sadness / hopelessness during the past 12 months	California Healthy Kids Survey						Biennial	2017-2019	7th grade: 10,000 9th grade: 20,000 11th grade: 20,000	80%
% of teens who likely have had psychological distress during the past year	California Health Interview Survey						Continuous survey model with annual release of data	2020	Children: 4,000 Adolescents: 1,000	Child: 10% Adolescent: 5%

1. Based on CalHHS selection
 2. Rounded, of most recent publicly available data
 Source: [California Healthy Kids Survey](#), CalSCHLS; [California Health Interview Survey](#), UCLA

Example deep-dive: Decrease in mental health challenges – high-level historical data

PRELIMINARY, DRAFT AS OF AUGUST 23, 2022



1. Based on CalHHS selection
 2. YRBSS data taken from 2017 due to limited availability across all race groupings in 2019. Otherwise, data taken from most recent available year (2019-21 for CHKS and 2020 for CHIS)
 3. Continuation high schools

Source: [California Healthy Kids Survey](#), [CalSCHLS](#); [California Health Interview Survey](#), [UCLA](#)

Questions?



SHORT BREAK

(5 minutes)

CYBHI ECOSYSTEM WORKING PAPER

Presentation slides for this presentation are forthcoming

THE DYNAMIC AND CHANGING BEHAVIORAL HEALTH ENVIRONMENT

BHTF MEMBERS OPEN DISCUSSION

CLOSING THOUGHTS

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

NEXT STEPS

UPCOMING BHTF MEETINGS

- December 13th | 10am – 3pm
- 2023 quarterly BHTF meeting dates forthcoming

FOLLOW UP ON BHTF MEETING

- Meeting evaluation
- Meeting summary, recording, and materials