# BEHAVIORAL HEALTH TASK FORCE MEETING

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY

September 13, 2022

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# 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

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# WELCOME & INTRODUCTIONS

MARK GHALY, SECRETARY, CalHHS

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

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# MEMBER INTRODUCTIONS

**Have you or a loved one ever reached out for support through a suicide prevention hotline?**

**Have you provided support services as a volunteer or staff on a crisis line?**

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# 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 |

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# LIVED EXPERIENCE PERSPECTIVES ON CRISIS PREVENTION AND RESPONSE

**Dino Alzadon**, Suicide Crisis Intervention Supervisor and Counselor, Suicide Prevention Center - Didi Hirsch Mental Health Services

**Miguel Serricchio**, Loss Survivor and Peer Facilitator, Didi Hirsch Mental Health Services

**Shauna Toh**, Crisis and Follow-Up Counselor, Suicide Prevention Center - Didi Hirsch Mental Health Services

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# BREAKOUT TOPIC SIGN UP

In preparation for our breakout discussions, please let us know in the chat which topic you would like to participate in:

- Prevention
- Response
- Stabilization

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# BEHAVIORAL HEALTH CRISIS CARE CONTINUUM PLANNING UPDATE

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

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# 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

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# 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

# 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

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# 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, stabilization[1]
- 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 warmlines[3]
- 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 lines[5]

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 warmline directories: NAMI National Warmline Directory, Warmline.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 lines[1]
- Opportunities to coordinate between **81+** county / local crisis & warm lines[1][2]

## Responding to Crisis

- Disconnects in policies for **crisis hotlines and the PSAP system** according to CA SWOT analysis[3]
  - 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 DHCS[4]
- CSUs serve people > 23 hours due to **capacity constraints in other services** according to DHCS[4]

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 warmline directories: NAMI National Warmline Directory, Warmline.org
3. SAMHSA's Gains Center California SWOT Analysis for California
4. DHCS Assessing the Continuum of Care for Behavioral Health Services in California

# 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

Sources: DHCS Assessing the Continuum of Care for Behavioral Health Services in California

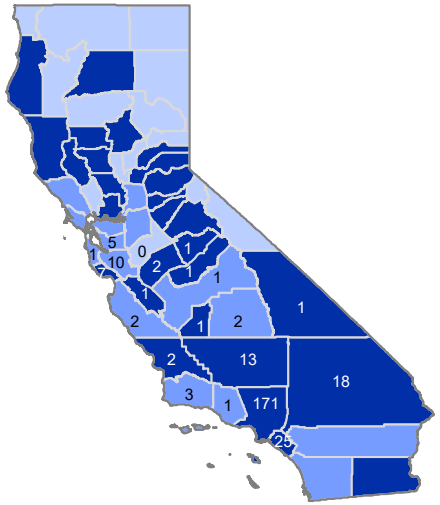
# 1: Availability & sufficiency of crisis services by county

## 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



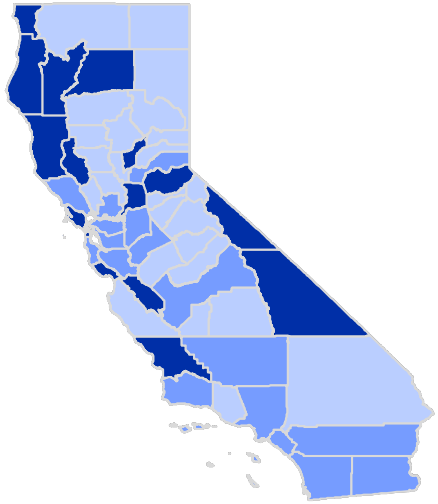

**37 of 44 counties** with mobile crisis teams have "sufficient"[1] intervention capacity

## 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

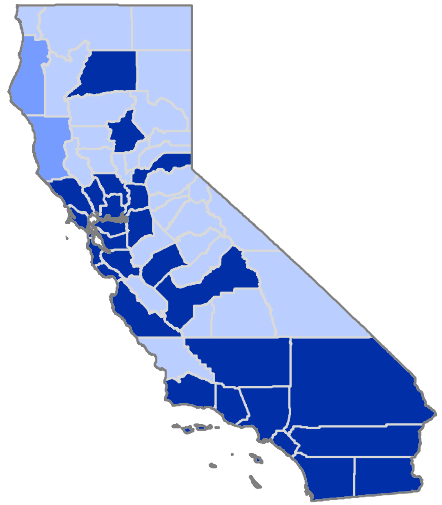


**16 of 33 counties** with Crisis stabilization units have "sufficient"[1] crisis stabilization capacity

## 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 sufficient[2] 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** | • **8+** major national warmlines, including the TeenLine<br>• Largely operated by non-profits with private funding<br>• Volume ranges from 10k – 75k+ conversations annually by line | • **5+** major national hotlines, including the **NSPL** which operates via **13 Lifeline Centers in CA**<br>• Operated and funded by mix of non-profit, for-profit, and federal gov. entities<br>• Volume ranges from 150k – 2.4M national crisis contacts / calls annually by line |
| **State-wide** | • **2+** state-wide warmlines, including<br>• Operated by gov / non-profit entities; funded by federal (e.g., CCP), state, and private sources<br>• Annual call volume ranges from 20k – 60k by line | • **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<br>• Operated by a non-profit organizations and funded by State of CA as well as private donors<br>• Annual call volume ranges from 15k – 300k by line |
| **County / local** | • **6+** county / local warmlines<br>• Operated by county governments and non-profits; funded through public (e.g., MHSA) and private sources<br>• Annual call volume can be up to 100k+ in certain counties | • **75+** county / local crisis lines<br>• Most lines run by counties and other operate as non-profits; some lines re-direct calls to lifeline centers<br>• Annual call volume can be up to 55k+ in certain counties |

Sources: Trans Lifeline, Teen Line, NBC News, CopLine, LBGT National Hotline, NAMI HelpLine, National Geographic, YouthLine, NAMI HelpLine, Samaritans, 988 Implementation Plan for California, Veteran's Crisis Line , The Trevor Project, American Association of Suicidology, NSPL, Vibrant, Crisis Text Line, NSPL, Suicide Prevention Resource Center, MHOSF, CalHOPE, CHHS Open Data, Institute on Aging, CalHOPE, State of California, CHHS Open Data, Institute on Aging, California Coalition for Youth, San Joaquin County, NAMI, Project Return Peer Support Network, NAMI Orange County, Northern Valley Peer Run Talk Line, NAMI Sonoma, NAMI San Diego, San Francisco Suicide Prevention, Del Norte Triplicate, Community Health Improvement Partners, State of California, California Senate, CDSS.ca.gov

# Readiness for 988 within California's Lifeline network

## The 13 CA Lifeline Centers largely meet 988 readiness metrics outlined in the NASMHPD self-assessment[1]

- CA Lifeline Centers have an in-state call answer rate[2] of ~85-90%, with some variation across counties[3]
- 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 Lifeline[5]
  - Plan set for 80% chat/text in-state answer rate by 2023[5]
  - 7 Lifeline Centers offer text or chat locally[5]

## Efforts underway within the CA Lifeline network to prepare for projected increases in call volume[6]

- 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 Californians*[2]

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. NASMPHD defines meeting self-assessment criteria as 90% in-state calla answer rate
4. NASMPHD defines meeting self-assessment criteria as 24/7 primary coverage for Lifeline calls
5. NASMPHD 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

Source: 988 Implementation Plan for California, NASMHPD 988 operational readiness self-assessment for states, territories, and tribes

# Approach for review of national guidance documents

## Approach for synthesizing national guidance documents from SAMHSA and national leaders

- **SAMHSA National Guidelines[1] 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 sources[2] 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-level[3]

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

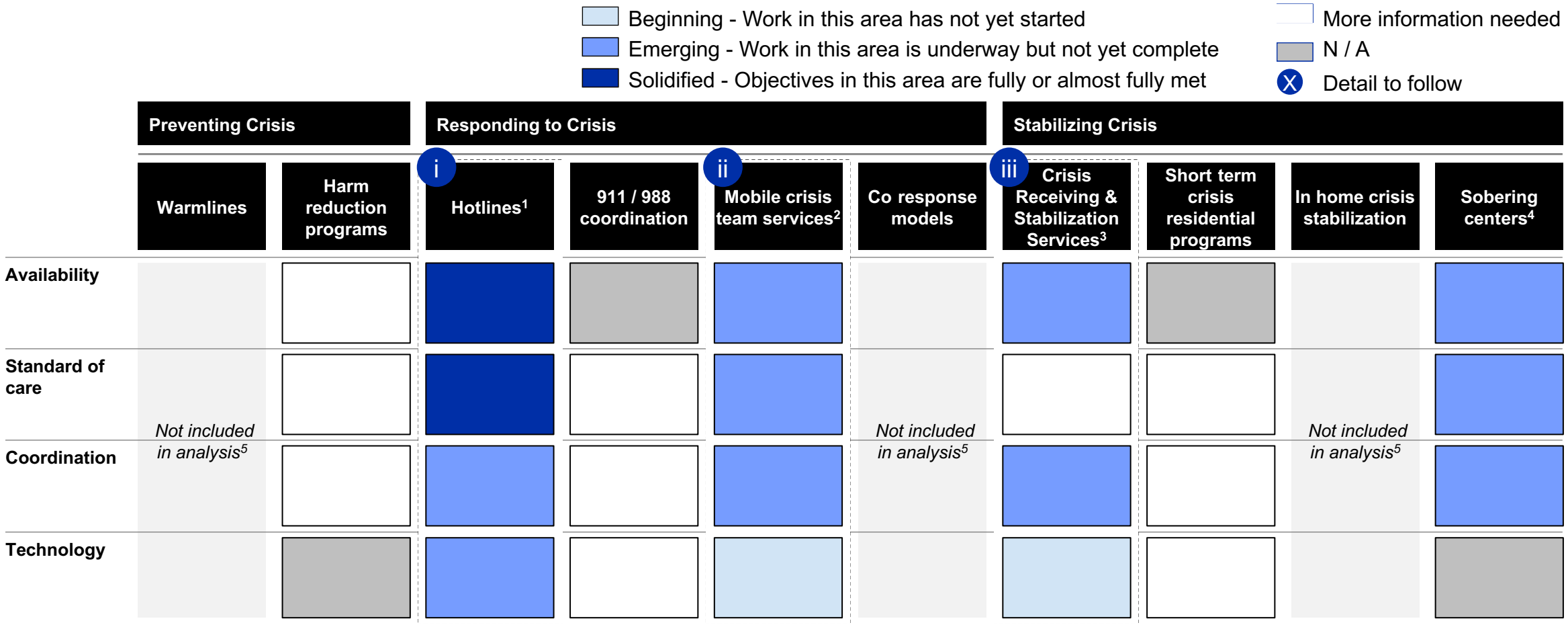
✓ Guidance documents included in analysis

| | 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 | *Not included in analysis[1]* | | ✓ | | ✓ | *Not included in analysis[1]* | ✓ | | *Not included in analysis[1]* | |
| **Example recommendations from national guidance documents** | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ |

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

Sources: SAMHSA Harm Reduction, National Harm Reduction Coalition, SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, NASMHSPD 988 Convening Playbook, SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes, Vibrant, Council of State Governments Justice Center, Crisis Residential Association,

# Overview of crisis care components in CA relative to national guidance




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

Sources: SAMHSA Harm Reduction, National Harm Reduction Coalition, SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, NASMHSPD 988 Convening Playbook, SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes, Vibrant, Council of State Governments Justice Center, Crisis Residential Association,

# 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 Crisis[1]

- 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 Crisis[1]

- 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

Sources: 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.*

Sources: Discussions with CalHHS and CSUS

# Thank you!

**For resources and more information regarding our behavioral health initiatives:**

**CalHHS Crisis Care Continuum – Plan webpage**

**Behavioral Health Task Force webpage**

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# CURRENT STATE OF CRISIS CARE SERVICES IN CALIFORNIA - MEMBERS DISCUSSION

- ✓ If there are systems or strategies that we missed as part of the assessment, what additional questions should we ask to ensure that the assessment is comprehensive?

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# SHORT BREAK

(5 minutes)

# CRISIS CARE CONTINUUM PLANNING

SMALL GROUP DISCUSSIONS

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# 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?**

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# 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

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# 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<br>• Currently available<br>• Currently in planning (~2-5 yr. timeframe)<br>• Aiming for | | | [30 min] Discuss:<br>• What is needed to make these standards available?<br>• 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<br><br>Improved outreach to bring in more volunteers with lived experience<br><br>Increased awareness of warm lines | Effectiveness should be evaluated<br><br>Some group members were not aware of existing warm line resources<br><br>Group identified this standard as a top priority |

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# 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

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# REPORT OUT

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

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# PUBLIC COMMENT

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# 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**

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

MELISSA STAFFORD JONES, DIRECTOR, CYBHI

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# 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 CYBHI[1].

- $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/ploads/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? | How do we get there? | Let's get to work! |
|---|---|---|
| Set Goals and Stand-Up Infrastructure | Develop Detailed Plans and Design Future State | Deliver and Accelerate Impact |
| Setting overall vision, initiative-level goals and standing up performance infrastructure. | Developing a robust plan, with clear accountability for design and delivery; sourcing ideas and designing the future state. | 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 37 focus groups with youth and caregivers[1], with support from 6 children, youth, and family engagement partners. An additional 7 focus groups and 20 interviews are planned.
- **Reimagine the ecosystem:** Completed phase one research, incluidng100 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) | | Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services (DHCS/DMHC) | ACEs and Toxic Stress Awareness Campaign (OSG) |
| Behavioral Health Virtual Services Platform (DHCS) | | | | | |
| 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

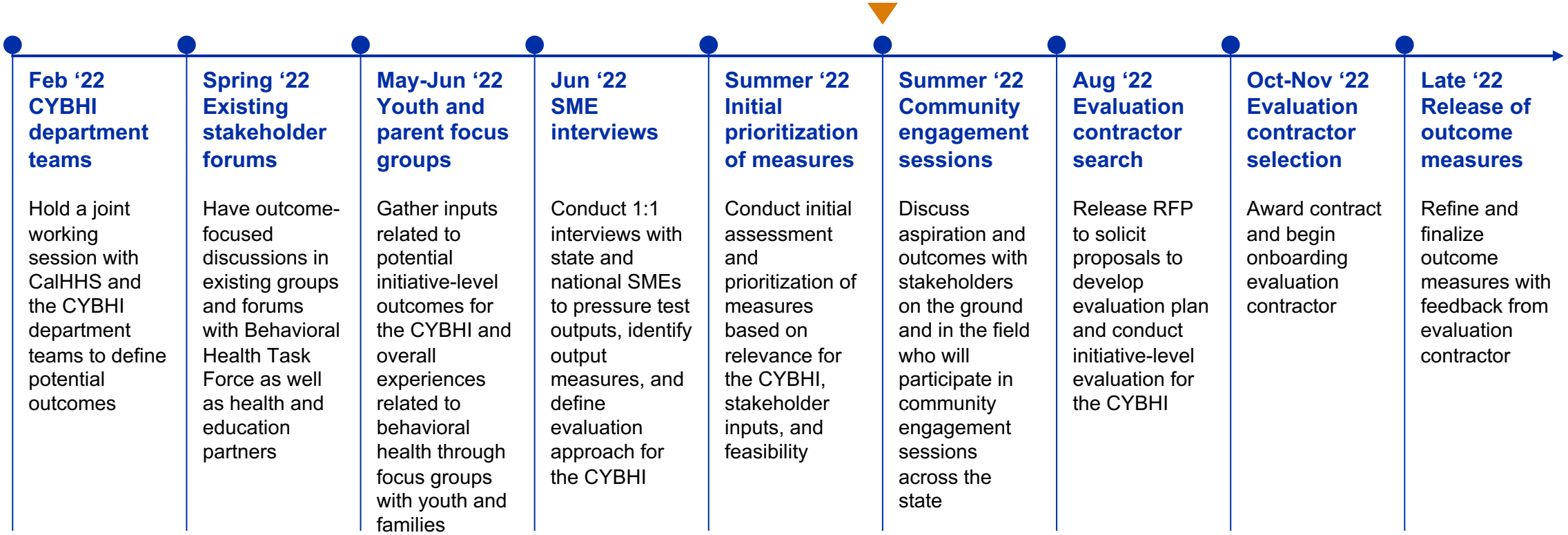
**Systems change evaluation**

**Policy evaluation**

**Program evaluation**

Source: California Health and Human Services Agency

# Approach and timeline for developing CYBHI outcomes



**Feb '22 CYBHI department teams**

Hold a joint working session with CalHHS and the CYBHI department teams to define potential outcomes

**Spring '22 Existing stakeholder forums**

Have outcome-focused discussions in existing groups and forums with Behavioral Health Task Force as well as health and education partners

**May-Jun '22 Youth and parent focus groups**

Gather inputs related to potential initiative-level outcomes for the CYBHI and overall experiences related to behavioral health through focus groups with youth and families

**Jun '22 SME interviews**

Conduct 1:1 interviews with state and national SMEs to pressure test outputs, identify output measures, and define evaluation approach for the CYBHI

**Summer '22 Initial prioritization of measures**

Conduct initial assessment and prioritization of measures based on relevance for the CYBHI, stakeholder inputs, and feasibility

**Summer '22 Community engagement sessions**

Discuss aspiration and outcomes with stakeholders on the ground and in the field who will participate in community engagement sessions across the state

**Aug '22 Evaluation contractor search**

Release RFP to solicit proposals to develop evaluation plan and conduct initiative-level evaluation for the CYBHI

**Oct-Nov '22 Evaluation contractor selection**

Award contract and begin onboarding evaluation contractor

**Late '22 Release of outcome measures**

Refine and finalize outcome measures with feedback from evaluation contractor

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

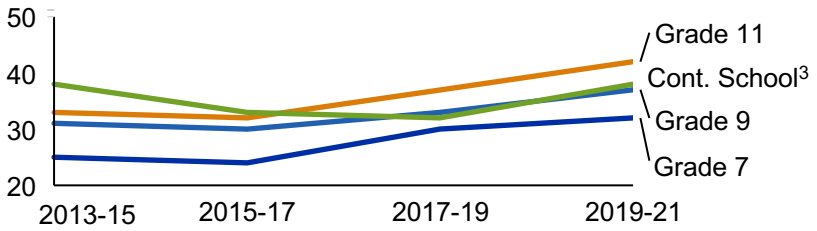
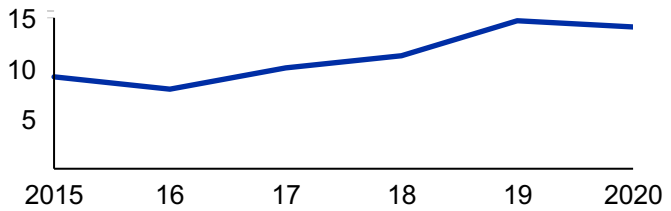
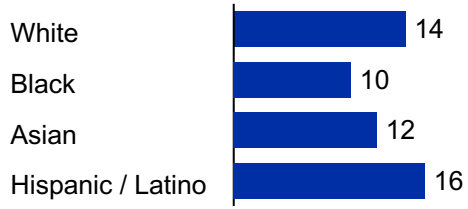
| | | Demographic information captured | | | | | Methodology | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Potential metrics[1]** | **Source** | **County** | **Age** | **Race / ethnicity** | **Gender identity** | **Sexual orientation** | **Frequency** | **Most recent data** | **Sample size[2]** | **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<br>9th grade: 20,000<br>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<br>Adolescents: 1,000 | Child: 10%<br>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**

| Potential metrics[1] | Source | Recent trend | Example comparison by demographic factors[2] |
|---|---|---|---|
| **% of teens who experienced chronic sadness / hopelessness during the past 12 months** | California Healthy Kids Survey |  |  |
| **% of teens who likely have had psychological distress during the past year** | California Health Interview Survey |  |  |









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, California Health Interview Survey, UCLA

# Questions?

# SHORT BREAK

(5 minutes)

# CYBHI ECOSYSTEM WORKING PAPER

CalHHS
California Health & Human Services Agency

# CA child & youth behavioral health ecosystem

Briefing for the Behavioral Health Task Force

# Context

# Context | Behavioral health ecosystem for CA children and youth

## We aim to understand the system's current state, opportunities and challenges

The Children and Youth Behavioral Health Initiative (CYBHI) aims to reimagine mental health and emotional well-being for ALL children, youth, and families in California by delivering equitable, appropriate, timely and accessible behavioral health services and supports

- CYBHI has a powerful vision for the future of mental health and emotional well-being in California; this effort intends to support what that vision means and how to reach it
- Thus, we are building tangible recommendations to sustainably realize this reimagined behavioral health ecosystem
- This effort will result in a working paper that ignites an action-oriented dialogue

## Recommendations informed by diverse sources

**Youth and family input sessions**

**Advisory Group meetings across youth, caregivers, public and state agencies**

**Expert interviews**

- **100+** interviews across relevant fields, functions and perspectives
- **20+** CA counties, and national experts beyond CA, represented

**Secondary research and literature**

**Writing team**

- **13** leaders with deep, diverse expertise across child-and-youth serving sectors

# Introduction | Who we are


Amanda Dickey


Carla Bryant


Chris Stoner-Mertz


Elizabeth Estes


Hayin Kimner


Jason Willis


Judy Li


Ken Berrick


Lisa Smusz


Lishaun Francis


Marni Sandoval


Mike Lombardo


Richard Knecht

*With project management and thought partnership support from BCG*

# Objectives for this session

Share what we've learned about the current opportunities, challenges and solutions in today's behavioral health ecosystem

Open a dialogue to inform and shape our work e.g.,

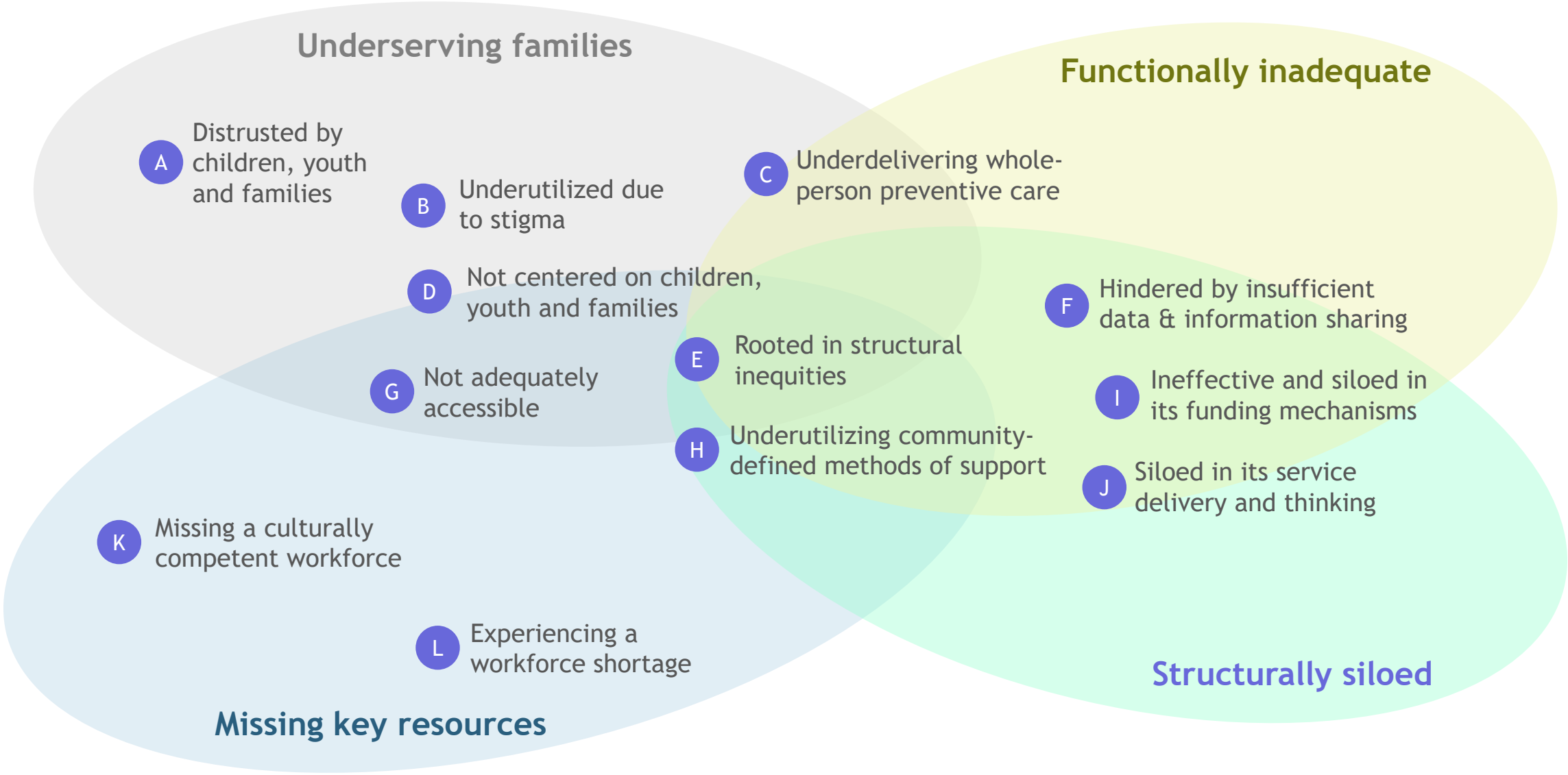
- Does the content resonate with your experience in the field?
- Where do you see your work intersecting with emerging recommendations?

*This is a high-level, work in progress draft;*
*your input is key to shaping the recommendations*

# First, we want to acknowledge the unique opportunity at hand

# Emerging insights on today's challenges

# Emerging insights | Today, California's child/youth behavioral health system is…




*Zoom chat: Which **three challenges** resonate the most with your experiences? What, if anything, is not represented?*

# Emerging insights details | Today's challenges (I/IV)

## Rooted in structural inequities

- Marginalized populations face **greater adversity due to systemic oppression**, resulting in more frequent and worsened behavioral health challenges
- Prior initiatives addressing the symptoms of structural racism have not taken root in a system **built upon inequity**

## Not centered on children, youth and families

- **Decision-making structures are not designed for partnering with children, youth and families** to center their needs, or to include their genuine participation in decision making
- **System lacks accountability** for system-level outcomes and those that matter to children and families

## Distrusted by children, youth and families

- There is an underlying **mistrust of the system**, including the medical and education systems, as a result of historical and ongoing practices and policies that have hurt youth and families
- Critical for ecosystem to **work to rebuild trust** with those being served

# Emerging insights details | Today's challenges (II/IV)

## Missing a culturally competent workforce

- **Lack of cultural competency, congruence, lived experience and meaningful representation** in the behavioral health workforce, which are results of **pay gaps, education requirements** that act as barriers
- **Child-serving workforce** (beyond behavioral health) needs **more information and training**

## Siloed in its service delivery and thinking

- Siloed **organizational structures and processes, legislative barriers and misaligned incentives** result in **disconnected stakeholders** shuffle responsibility, or let children 'fall through the cracks'
- The **complexity of navigating this system of supports** (both state and local) is a barrier for children, youth and families, as well as those providing care

## Ineffective & siloed in its funding mechanisms

- Existing funding sources are **excessively partitioned, overly complex, and under-utilized**
- Funds are **not in alignment with needs** and desires of children, youth and families
- **Perceived scarcity** and siloed systems leads to cost containment approaches rather than effective care provision

# Emerging insights details | Today's challenges (III/IV)

## Hindered by insufficient data & info sharing

- **Lack of information sharing (in data system capabilities and in practice)** to support individual cases as well as systemic evaluation, even where legally allowable and de-personalized
- **Privacy and confidentiality laws** (e.g., HIPAA) slow access to and delivery of care
- **Inconsistency and inequity in collection** leads to bad or incomplete data and analysis

## Underdelivering whole-person preventive care

- There is a focus on treating severe, acute diagnoses (via intensive methods and medication), rather than **whole-person preventive care,** non-clinical services & supports, and step-up/step-down care
- Children and youth often reach **crisis levels** before behavioral health is addressed, and support is often insufficient

## Experiencing a workforce shortage

- **Drastic shortage in supply and pipeline** of child/youth behavioral health practitioners
- **Lack of support and training** for the child-and-youth-facing workforce

# Emerging insights details | Today's challenges (IV/IV)

## Underutilizing community-defined methods of support

- Services are **not meeting the needs and desires of the communities**
- Children, youth and families are **not able to opt in or out of care** that they want or need
- Interventions can be **traumatizing** (e.g., involuntary admissions, police involvement, **family separation**) for children, youth and families experiencing crisis

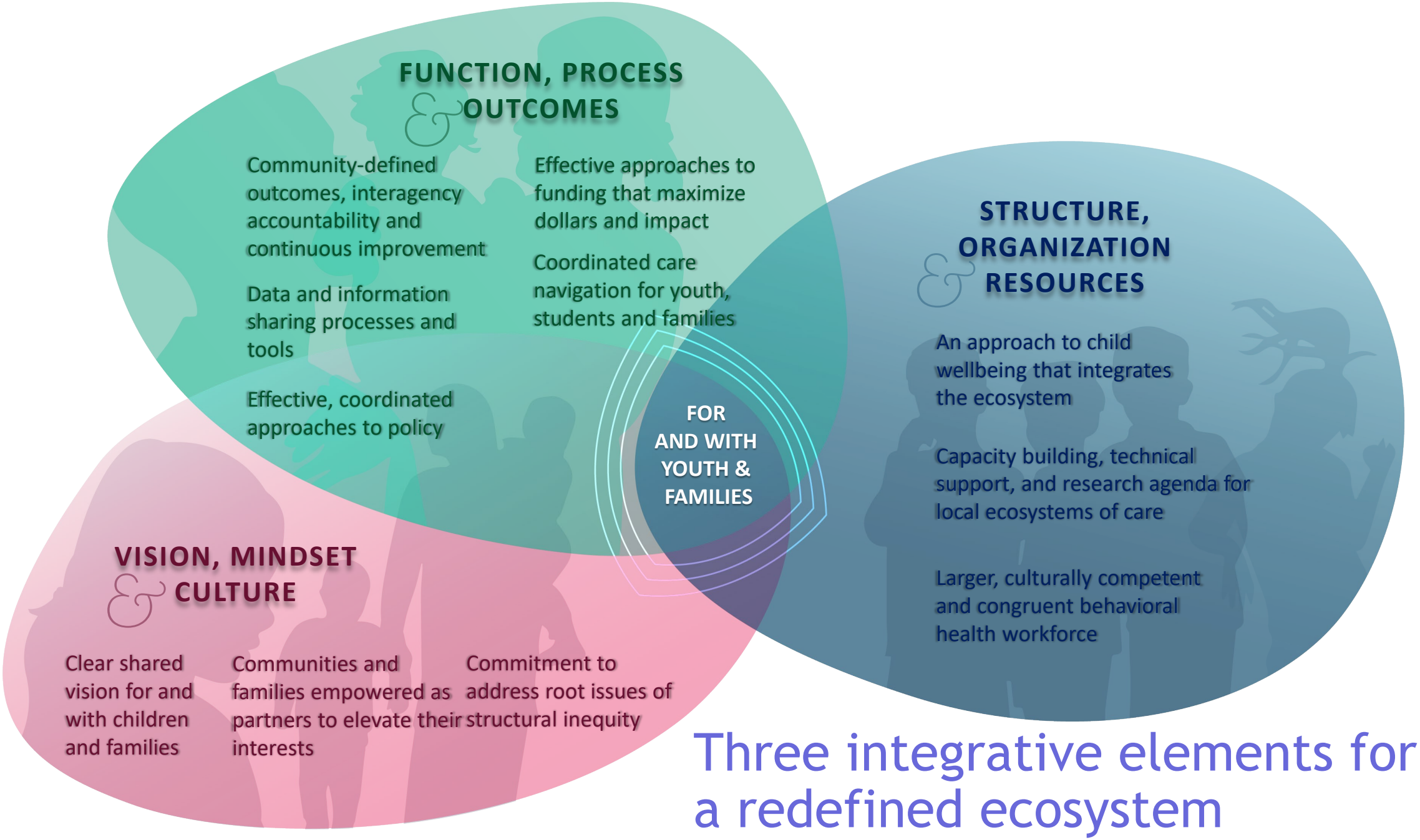
## Not adequately accessible

- Children, youth and families experience **barriers to accessing care across the continuum**
- **Wait times are often months long** due to lack of infrastructure, workforce & system capacity
- Efforts to raise awareness of available supports are often not **high-impact or well-targeted**

## Underutilized due to stigma

- Children, youth, and families are often **deterred from addressing issues due to societal and institutional stigma** which create barriers to accessing support, delaying interventions, shifted focus on academics in school and allowing problems to become more severe

# Emerging insights on solutions




# Three integrative elements for a redefined ecosystem

# Emerging solutions | Vision, mindset and culture

| | 1 | 2 | 3 |
|---|---|---|---|
| | Clear shared vision for and with children and families | Communities and families empowered as partners to elevate their interests | Commitment to address root issues of structural inequity |
| Objectives | • Define a clear vision and mission in partnership with communities and families<br>• Transform organizational culture to prioritize shared vision | • Elevate children, youth, families, and communities to real positions of power for decision-making, program design and funding<br>• Honor and value lived expertise of children, youth and families<br>• Elevate community-defined supports, including preventative care and methods to overcome stigma<br>• Center ecosystem on the needs and priorities of children, youth and families | • Identify failures to achieve equitable outcomes identified across ecosystem and proactively heal distrust<br>• Play an active role in uplifting all children, youth and families and promoting equity |
| Functional needs | Alignment and **buy-in from stakeholders**, **interagency governance structures**, conscious **cultural transformation** efforts | Elevation of **community-defined care models**, care **based on needs vs. diagnoses**, **feedback loops** that drive improvement & accountability | Clear **leadership mandate**, outcomes evaluated through **equity lens**, **culturally congruent services** |

*Zoom chat: Do these solutions resonate with you? What 'bright spots' have you seen work well?*

# Emerging solutions | Structure, organization and resources

| | 4 | 5 | 6 |
|---|---|---|---|
| | **Integrated approach to child wellbeing and alignment across ecosystem** | **Capacity building and technical support for local ecosystem of care** | **Larger, culturally competent & congruent behavioral health workforce** |
| Objectives | • Establish clear responsibilities and authority (e.g., through structural entities) to direct policy, funding and implementation across the ecosystem<br>• Support functional coordination across agencies at state and local level, with collaboration across the ecosystem<br>• Promote transparency, agility and accountability through oversight and explicit ownership of shared goals and outcomes | • Deliver cross-sector technical assistance, training, and capacity building to improve integration of services and supports attuned to local contexts<br>• Foster innovation to support and scale community- defined and culturally proficient best practices | • Grow the size and diversity of every part of the behavioral health workforce<br>• Provide robust, trauma-informed supports to entire child-serving workforce, including training and support for personal wellbeing |
| Functional needs | Cross-sector **collective impact table** where youth, families and community **drive decision-making** | **Cross-sectoral,** aligned and coordinated **technical assistance**, **menu of technical assistance** for local entities | **Streamlined, financially-accessible paths** to licensure, **trauma-informed care training** for workforce |

*Zoom chat: Do these solutions resonate with you? What 'bright spots' have you seen work well?*

# Emerging solutions | Function, process and outcomes (I/II)

| | 7 | 8 | 9 |
|---|---|---|---|
| | Community-defined shared outcomes, accountability & continuous improvement | Data and information sharing processes and tools | Effective, coordinated approaches to policy |
| Objectives | • Empower communities with authority to define outcomes that align with shared vision, needs and desires<br>• Build joint accountability across agencies and organizations, transparently measuring success against community-defined outcomes<br>• Create child, youth and family-centric feedback loops that drive continuous quality improvement in service delivery | • Establish a culture of data collection, information sharing and evaluation of child-serving interventions<br>• Streamline and share data between entities to support efficient, effective care coordination at local level | • Collaborate on policy implementation processes<br>• Align actions between state and local agencies to increase impact and efficiency |
| Functional needs | **Community-defined goals** supported by local decision-making entities; **cross-entity monitoring** of joint outcomes; robust **quality improvement** | **Guidance on acceptable information sharing**, unified, transparent **progress tracking**, **harmonization of local assessment tools** across age groups and levels of need | **Interagency policy implementation teams**, alignment of policy **with vision and target outcomes** |

*Zoom chat: Do these solutions resonate with you? What 'bright spots' have you seen work well?*

# Emerging solutions | Function, process and outcomes (II/II)

| | 10 | 11 |
|---|---|---|
| | Effective approaches to funding that maximize dollars and impact | Coordinated care navigation for youth, students & families |
| Objectives | • Optimize funding across sources<br>• Incentivize and embed cross-agency collaboration<br>• Maintain funding that is sustainable and effective | • Provide children, youth, students and families with known, easy access points to supports<br>• Create seamless transitions between various supports as needs evolve<br>• Clarify and cooperate amongst agencies on care responsibilities |
| Functional needs | Support for **interagency partnerships**, guidance on approaches to **maximize funding**, **agile and timely funding streams** | **Single access point** for behavioral health and related services, established and **robust referral pathways**, defined **universal array of services** |

*Zoom chat: Do these solutions resonate with you? What 'bright spots' have you seen work well?*

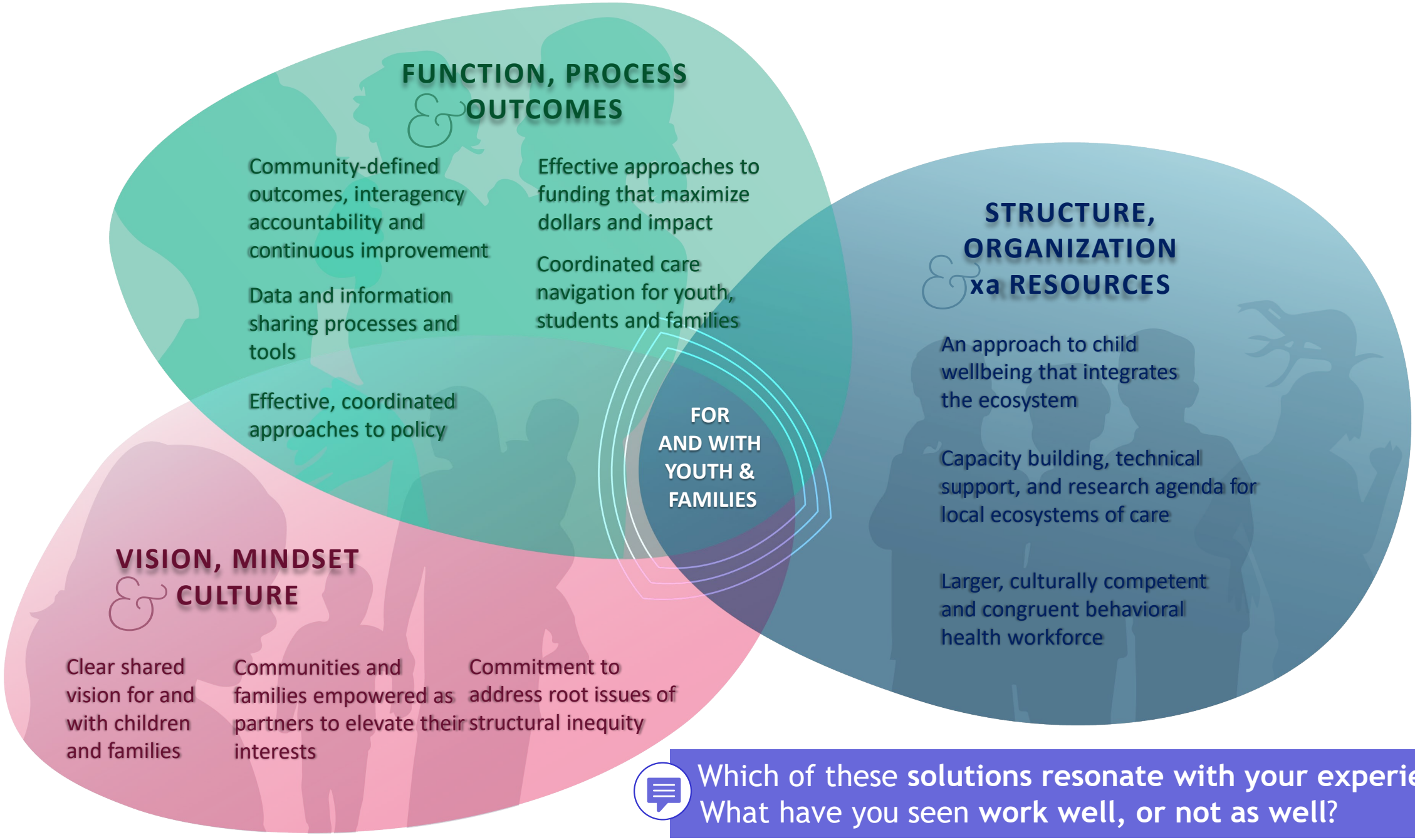
# Initial questions for discussion

*Shared in pre-read*

1. We've discussed the ways we've collaborated with children, youth and families in crafting these recommendations. As we work on systems change, what are the most **effective ways you've seen of continuing to center the needs and wants of children, youth and families**?

2. Which of these **solutions resonate with your experiences**? What have you seen **work well, or not as well**?

3. Where do you **see your work intersecting with the emerging recommendations**? What should this work build on?




Which of these **solutions resonate with your experiences?**
What have you seen **work well, or not as well?**

# Path forward

Incorporate feedback from you and other stakeholders to shape recommendations

Build working paper draft that includes connections to ongoing work across the state

Release working paper alongside series of conversations to support dialogue and ignite change

# Thank you

# THE DYNAMIC AND CHANGING BEHAVIORAL HEALTH ENVIRONMENT

BHTF MEMBERS OPEN DISCUSSION

CalHHS
California Health & Human Services Agency

# CLOSING THOUGHTS

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

CalHHS
California Health & Human Services Agency

# 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

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