SACRAMENTO STATE
COLLEGE OF CONTINUING EDUCATION

CALHHS BEHAVIORAL HEALTH AND TASK FORCE MEETING

Meeting Summary

TUESDAY, SEPTEMBER 13, 2022, 10AM – 3PM

MEETING SUMMARY PURPOSE

This document provides a summary of the Behavioral Health Task Force (BHTF) quarterly meeting held on September 13, 2022. This summary is an accompaniment to the presentation slide deck and meeting recordings, both available for review on the BHTF webpage along with other meeting materials.

Appendix A of this summary contains notes from each breakout group discussion.

WELCOME & INTRODUCTIONS

WELCOME

Secretary Mark Ghaly, California Health and Human Services (CalHHS), welcomed BHTF members and members of the public. He expressed his appreciation for the perspectives and input that participants bring to the BHTF meetings. Secretary Ghaly said that the meeting would focus on crisis care, helping the State thoughtfully ground in the experiences of those who have been in crisis as it works to put in place the range of services those experiencing behavioral health crises need. He noted that the State's work on crisis care is one piece of a comprehensive set of efforts to advance equitable care for Californians experiencing a range of behavioral health challenges and needs.

Deputy Secretary of Behavioral Health Stephanie Welch, CalHHS, introduced Matias Eusterbrock, Program Analyst with the CalHHS Office of Policy and Strategic Planning, who is a new staff person supporting the BHTF.

As an introductory activity, participants were invited to respond to a poll asking whether they or a loved one has ever reached out for support from a suicide prevention hotline and whether they have ever provided support services on a crisis hotline. A quarter of participants responded that they or a loved one have reached out for support from a hotline and 30% have provided support services as a volunteer or staff on a crisis hotline.

LIVED EXPERIENCE PERSPECTIVES ON CRISIS PREVENTION AND RESPONSE

Dino Alzadon, Suicide Crisis Intervention Supervisor and Counselor; Miguel Serricchio, loss survivor and Peer Facilitator; and Shauna Toh, Crisis and Follow-Up Counselor, Didi Hirsch Mental Health Services, shared their perspectives based on lived experience of their own or a loved one's struggle with suicide.

BEHAVIORAL HEALTH CRISIS CARE CONTINUUM PLANNING UPDATE

Deputy Secretary Welch gave an overview and update of the State's Crisis Care Continuum planning effort, as a follow-up to the presentation and discussion during the June 2022 BHTF meeting and the August BHTF Lunch and Learn in which she gave a longer update on the same subject. She recapped the anticipated components of the Crisis Care Continuum Plan and key themes from the feedback on crisis care gaps and opportunities that BHTF members provided during the June meeting. She outlined three preliminary takeaways from a review of the current state of crisis care in California and the opportunities for improvements related to each:

- 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
- 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
- Focusing on 988, California appears to meet readiness standards within the Lifeline Network-affiliated contact centers; however, there may be opportunities to ensure coordination and readiness across the broader network of call lines

Deputy Secretary Welch outlined a synthesis of how the State's crisis care systems align with national standards, with two key takeaways:

- Existing national guidance documents primarily focus on responding to and stabilizing crises; 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; however, there are inconsistencies for other crisis services operated at the county-level

She then outlined a possible approach for future state minimum standards to address objectives related to prevention, response, and stabilization.

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

CRISIS CARE CONTINUUM PLANNING – SMALL GROUP DISCUSSIONS

Attendees participated in breakout discussions to inform the State's Crisis Care Continuum (CCC) Plan. Participants shared input on the standards of basic behavioral health crisis care services that the State should strive to ensure all Californians have access to. Each group's discussion focused on either crisis prevention, response, or stabilization. Groups participated in a structured conversation as follows:

1. **Future State Standards:** Groups reviewed previously identified future state standards (which were informed by input gathered at the June BHTF meeting) and did a quick brainstorm of any missing standards that should be added.
2. **Current State of Standards:** Groups assessed the availability of those standards, indicating if each was currently available, currently in planning (with a ~2-5 year timeframe to become available), or something to aim for in the future but not currently available or in planning.
3. **Needs:** Groups discussed what is needed to be able to achieve each standard.

4. **Additional Input or Considerations:** Groups were able to share any additional input about the standards (e.g., listing examples of related programs or noting if group members have differing perspectives on the standard) and identify any key considerations regarding the standards.

KEY THEMES FROM BREAKOUT DISCUSSIONS

Key themes from the breakout discussions and report outs are summarized below. See Appendix A for each group's completed notes template, where groups tracked their discussions.

STATEWIDE CONSISTENCY AND ACCESS

There was broad agreement around the need for statewide standards of behavioral health crisis care services. While there are some locally-defined service standards, members emphasized the importance of State leadership to ensure that services are consistently available and accessible across jurisdictions like school districts or counties.

A key issue related to statewide consistency of care is the need to standardize the service response across payers, so that individuals in crisis receive the care they need regardless of who is funding it. Participants emphasized that this is an issue that will require systematic coordination across services and payer groups. Ensuring that care is not based on payer is an important equity issue, as many disparities are based on economic resources and the channels through which people access care.

Groups emphasized that availability of services is not sufficient if those services are not accessible to those who need them. One group recommended tracking the availability, affordability, and accessibility of services over time, from both a quantitative and a qualitative perspective. Additionally, groups highlighted the need for a "no wrong door" approach to ensure that people in crisis are able to get connected to the services they need regardless of their entry point to the system. Participants noted that this will require strong connections across the system, with intensive training so that the people working in the system are aware of the no-wrong-door approach and know how to connect people to the services they need.

In addition, one group emphasized that meeting statewide standards and improving access will require appropriately resourcing the system. The group highlighted in particular the importance of sufficient funding and adequate compensation for the workforce, as well as the need to address workforce burnout.

One group also said that improving coordination of medical and behavioral health care would support access to services. They discussed developing standards and reducing requirements for medical clearance and screenings to make the connections between medical and behavioral health care less traumatic and get clients where they need to be more seamlessly.

One group highlighted that the statewide standards should not remain static, but instead ongoing community engagement should be implemented to understand what is and is not working for community members and improve the system's responsiveness. One group noted that minimum standards and best practices are distinct, and both are needed.

EQUITY

Participants highlighted that equity is a key issue that future state standards should address, with the aspiration of addressing the overrepresentation of certain groups among those experiencing behavioral health crises. Suggestions included:

- Analysis of outcomes should address outcomes for underserved and overrepresented groups, not just overall average outcomes
- Ensure care is culturally affirming and linguistically appropriate
    - Invest in community-defined practices
    - Target workforce development and recruitment to mirror the client population – Black communities; bilingual and bicultural communities
    - The definition of "stabilization" and what is considered a successful outcome should recognize cultural contexts and non-clinical outcomes like self-determination, community integration, and employment
- Expand investment in equity projects, such as the California Reducing Disparities Project and the Perinatal Equity Initiative
- Address the negative consequences that can be associated with seeking and receiving behavioral health care (for example, employment and professional consequences or impacts on things like family court and security clearances)
    - Provide support such as financial support, child care, and paid medical leave that allows people to receive the services they need – "time and space to heal"
    - Leverage people with lived experience and design thinking to anticipate and mitigate these potential harms and improve the experience of the person seeking care in a crisis

PREVENTION

Participants discussed the need to integrate upstream prevention, before reaching the point of crisis. Some groups discussed the importance of stigma reduction as a measure that can help prevent behavioral health crisis. They suggested bolstering school-based programs to address stigma among children. One group suggested integrating upstream prevention with those that are not yet involved in the behavioral health system in any way through avenues like Family Resource Centers. One group highlighted that screening is an important part of prevention. While there are many screening tools, the group said that a standard set of vetted screening tools was needed that was agreed upon for use across sectors. They recommended that the screening tools be free, open-source, and universal. A group also said that an aspirational goal would be to evaluate and measure the impact of stigma on behavioral health crises.

TRUSTED RESPONDERS AND APPROPRIATE CRISIS CARE SETTINGS

One group discussed the importance of ensuring that crisis responders are trusted community members, including peers. Law enforcement involvement in crisis response should be eliminated whenever possible. The group also discussed the importance of establishing alternatives to jail, juvenile hall, and even emergency room settings in order to provide appropriate crisis care.

NAVIGATION, EDUCATION, AND AWARENESS

Multiple groups discussed the need for navigation support and improved awareness to improve access. They discussed the need to educate and inform providers and the public in order to meet these minimum standards and improve care for people in experiencing behavioral health crises. Some examples include:

- Provide navigators to help clients understand the care available and access the care they need
- Educating providers, beneficiaries, and family members on available services
- Educating providers to better understand crises, for example distinguishing between mental health psychosis versus substance use-induced psychosis
- Competency training is needed related to intellectual and developmental disabilities to ensure appropriate access to care based on client need
- Increase community awareness of resources and reduce stigma through marketing campaigns

CONSIDERATIONS FOR SPECIAL POPULATIONS

Multiple groups addressed the need for special considerations regarding care for certain populations. The statewide standards should articulate standards of response for these different populations, including youth, older adults, and cultural and linguistic considerations.

DISCHARGE, FOLLOW UP, AND CONTINUED CARE

Multiple groups addressed the importance of thoughtful discharge, follow-up, and continued care. Suggestions and considerations include:

- Discharge planning should include a warm handoff, not just a list of resources
- Clearly identify who is responsible for follow-up and linking the client to services (e.g., provider that served the person while in crisis, insurer, primary care physician, other)
- Ensure that there are clear mechanisms to cover the work of follow up and linking to services under both Medi-Cal and private insurance
- One group highlighted that this is an equity issue: according to the AB 470 Performance Dashboard, 48 percent of African-Americans received no stepdown services in 2019-2020
- Training and workforce development will be critical to appropriate follow up care
- Clarify the linkages between discharge planning, follow up, and continued monitoring
- Follow up and discharge planning should consider not just the client, but also their family
    - Support the loved ones that will be accompanying and supporting the individual in crisis, for example with peer support and with support available in waiting areas
- As part of crisis follow up, establish psychiatric advanced directives for those that do not already have them
    - Name trusted people within psychiatric advanced directives
    - Connect psychiatric advanced directives to the crisis response system, so that the people answering calls and responding to crisis have access to that information

PUBLIC COMMENT

Members of the public were invited to share brief comments up to two minutes each.

- Carmen Perez said that Los Angeles County is experiencing significant impacts related to lack of workforce to meet the needs, particularly in Latinx and Asian Pacific Islander communities. She noted that the Department of Mental Health is reducing its services for this reason. She said that the State should have a greater focus on creating a strategic workforce development plan, with attention to preventative care and equity.
- Beth Burt said she was from the Autism Society Inland Empire. She said that there are many cases in which mental health providers will not work with people with autism, leaving families without the crisis care they need and in cycles of violence.
- Lilyane Glamben said she was from On Track Program Resources. She said that there is need for expanded community-based funding opportunities, including targeted funding to serve the African American community, for prevention-focused services. Community organizations working in the prevention and early intervention space become trusted sources of support through being a first line of response, but also often serve people whose needs exceed prevention. She said that the California Reducing Disparities Project has been doing important work in this space, but more funding is needed.

UPDATE ON THE CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE

Melissa Stafford Jones, director of the CalHHS Children and Youth Behavioral Health Initiative (CYBHI), gave an update on the CYBHI, an update on development of the outcomes goals for the CYBHI, and an overview of a CYBHI Ecosystem Working Paper. Ms. Stafford-Jones noted that the CYBHI is being undertaken as a core component of the state's Master Plan for Kids' Mental Health, in conjunction with a variety of related efforts and investments.

CYBHI UPDATE

Ms. Stafford Jones shared highlights of progress at the level of the CYBHI as a whole, as well as from individual workstreams. Key highlights of the overall CYBHI work since the last BHTF meeting in June 2022 include:

- 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 caregivers1, 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 subject matter expert interviews, to inform design of the future ecosystem
- 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

For more details, Ms. Stafford-Jones invited participants to view the CYBHI quarterly webinar update and other materials via the CBYHI webpage here.

CYBHI OUTCOMES AND OUTCOMES MEASURES

Ms. Stafford Jones shared an update on the process of developing outcomes goals for the CYBHI. She shared background on the CYBHI approach to evaluation and the timeline for development of the outcomes goals. The outcomes were developed with input from youth, caregivers, educators, cross-sector partners, and subject matter experts; BHTF members were also consulted through breakout discussions during the June 2022 BHTF quarterly meeting. From these diverse perspectives, input was synthesized into the following cross-cutting themes:

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

The outcomes goals, below, were developed based on these themes, which speak to both outcomes for the population and measures of system performance. Current work is focused on developing metrics and sources for each of the above outcomes.

- **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

DISCUSSION

BHTF members shared questions and comments related to development of the CYBHI outcomes goals and measures.

- I appreciate seeing that the CYBHI is including stigma reduction, including within systems, as it can have lasting repercussions for youth. This is an important aspect of prevention and building trust. I look forward to seeing how cultural elements are integrated into this aspect of the work, particularly for communities of color.
- When does the RFP for the independent evaluation close?
    - Ms. Stafford Jones said that the RFP closes on September 30, 2022. The evaluation will address systems change, policy evaluation, and programmatic evaluation. Rather than be conducted as a single evaluation at the end of five years, it will include some metrics to measure shorter-term progress along the way, as well as longer-term metrics.
- I recommend adding reduction in justice system involvement as a population outcome for CYBHI. Is the CYBHI working with justice system partners like the Office of Youth and Community Restoration and probation to ensure that metrics capture and stratify data on justice involved youth?
    - Ms. Stafford Jones said that as metrics and data sources are identified, she would add consideration of the availability of stratified data on justice-impacted youth. The CYBHI is collaborating with partners that work with youth in the foster system to identify opportunities for alignment in terms of shared metrics and tools that can be useful to partners and help improve services. Overall, the CYBHI aims to utilize existing metrics that are already used by the systems that serve youth.
- Do special education students participate in the Healthy Kids Survey?
    - BHTF members Christine Olmstead and Laila Fahimuddin said that students who receive special education services participate in the survey, unless their IEP directs otherwise or their parent/guardian requests that they not participate.
- The outcomes measures should address whole person centered outcomes – the impacts on individuals and their families – whereas those listed were are all utilization-related.
- Make sure that students with autism and developmental disabilities are not missed in the data collection.
- Suspension rates are an important metric, particularly for Black students who are often punished rather than being given care and support, leading to the school-to-prison

pipeline. The State already collects data on school climate indicators including suspensions and expulsions. These are important for equity accountability.

- The measures should look at the intersection of school discipline and substance use; some young people receive therapeutic approaches while others are punished.

CYBHI ECOSYSTEM WORKING PAPER

Mike Lombardo, Placer County Office of Education, Ken Berrick, Seneca Family of Agencies, Lishaun Francis, Children Now, and Marni Sandoval, Monterey County Behavioral Health, presented on development of the CYBHI Ecosystem Working Paper. The working paper is focused on how all the puzzle pieces of children and youth behavioral health fit together and how the CYBHI can contribute to a more integrated ecosystem.

The paper is based on feedback from diverse sources, including youth and family input sessions; advisory groups across youth, caregivers, public and state agencies; over 100 expert interviews from a range of perspectives; secondary research and literature; and a thirteen-person writing team with diverse expertise, including the presenters listed above. It aims to begin to answer the question of what will be functionally different in the systems that serve children and youth within this reimagined ecosystem. The paper will help inform how the CYBHI is implemented.

The presenters emphasized that the paper is still in development, with initial findings and ideas that will be further developed into recommendations, and that the objective of sharing the initial findings with the BHTF at this stage is to get feedback on both the needs and solutions.

The paper identifies twelve challenges within four overlayed categories: underserving families, functionally inadequate, structurally siloed, and missing key resources.

Participants used the chat to share questions and comments related to the twelve challenges.

- Insufficient data and information-sharing, ineffective and siloed funding mechanisms, and siloed service delivery and thinking resonate as root causes of many of the other challenges. For example, California doesn't allow for same-day billing for whole-person care (in FQHC's), and has a largely adult-focused, county-driven carve out. This limits accessible care, is parallel with other systems mistrusted, and provides insufficient pay to keep the workforce, let alone culturally competent folks who disproportionately may be single parents or come from communities with less resources.
- Incorporate upstream prevention.

- Different sectors have different understandings of mental health and how to handle issues related to mental health.
- Look into building out the Memoranda of Understanding under AB 2083 to cover all children and youth, not only those in foster care.
- The challenges have been known for years.
- Lack of specialty care is another challenge.
- Make sure that the paper addresses being inclusive of special populations.
- To address the trust issue, implement strategies to bring trusted community-based organizations/providers into our larger, well-funded systems. They would be instrumental in addressing equity gaps and in return could get access to a more stable funding source.
- Another challenge is the lack of affordable, comprehensive, quality coverage across all payers.
- Nuances related to substance use challenges are missing and will need to be addressed going forward, since it is often a separate system, separate providers, and carries huge stigma of its own.
- Add the early learning sector.
- Ground in the voices of Black children, youth, and practitioners, and include funding to Black-led and -serving organizations.
- Difficulty navigating the system to access care is a key challenge.
- Need more specificity, which will elucidate critical equity issues – for example naming which families are underserved, which communities are disproportionately missing key resources, who is most impacted by the functional inadequacies.
- Inequity should be another overlayed category in which many of the challenges would fit.

The presenters shared three integrated elements for a redefined ecosystem: function, process, and outcomes; structure, organization, and resources; and vision, mindset, and culture. Additionally, all solutions must be developed with and for youth and families. For each of the elements of emerging solutions, the paper includes multiple components with their respective objectives and functional needs. They noted that this effort is still in progress and high-level, and deeper specificity will be added as it is developed.

Participants used the chat to share questions and comments related to the elements of solutions and shared “bright spots” they have seen in behavioral health for children and youth.

- The items in the section on addressing root issues of structural inequities are elemental.
- Empowering communities and families is key to make the system work for children, youth, and families.
- Address payment inequities and dysfunction, which are a root cause and structural inequity.
- Elevate Fetal Alcohol Spectrum Disorder, as it is relevant to many kids dealing with BH needs and involved in the criminal justice system.
- Commitment to addressing structural inequities is critical for upstream prevention.
- Clearly defined roles will enable better collaboration.
- Consider how utilization data can be aligned to elucidate the problems that are not being addressed within the current services and supports from counties and the State.
- Adopt target universalism to address support of specific sub-groups.
- There is already documentation of system failures; use these as "to do lists" with targeted efforts to tackle each one.
- Psychoeducation is needed.
- An integrated approach with alignment across the ecosystem is essential. There are so many potential sources of funding with misalignment of goals and priorities.
- Include primary care providers in the behavioral health workforce, since they see the majority of children and youth with behavioral health concerns.
- Develop and promote models where existing and new classes of providers for Medi-Cal (e.g., BH coach, peer support, CHW, PPS credentialed staff, therapists, etc.) work together. Define the roles and responsibilities and strengths of each contributor.
- In fostering innovation, focus on outcome-driven innovation.
- To develop a culturally diverse workforce, it is critical to think about starting very early in primary/secondary education and think about those supports needed.
- Ensure that BIPOC staff needs are heard and addressed.
- What are the steps to accomplish these goals? Will the Working Paper lay out a work plan?
- Provide pathways for peers for credentialed and non-credentialed roles, including pathways to move up the career ladder for those who want them.
- Innovation to scale requires alternative payment arrangements.
    - Mr. Berrick said that the group is looking at the issue of payment structures, including how payment structures across systems relate to one another.

- It would be helpful to see how the funding across different state sources come together (CDE, DHCS, HCAI, etc.) beyond the CYBHI.
- Include childcare and early care and educations settings within the integrated approach to child well-being and alignment across the ecosystem. Consider the overlap with Community Schools.
- Dedicated training is needed for culturally and linguistically competent services. Graduate schools are not providing specific training for providing services in languages other than English.
- In-language supervision is needed.
- Include and leverage home visiting, which is a core model of ACEs prevention and parent behavioral health support.
- Build from the MHSOAC's prevention and early intervention work. Their draft report is available at https://mhsoac.ca.gov/initiatives/prevention-early-intervention/.
- Community-defined shared outcomes, accountability, and continuous improvement is critical.
- Accountability should include across payers as well.
- Strong coordination is needed between CalHHS and California Department of Education on things like community schools and SBHIP.
- Data and information sharing should define HIE as needed for APMs.
- Consider specifying those most impacted as the communities that need to be empowered with authority to define outcomes.
- Leverage the DHCS Population Health Management service to ensure our most vulnerable children/youth are getting the services they need.
- Effective approaches to funding that maximize impact is critical.
- Coordinated care navigation is critical.
- Payer accountability is needed – transparent accountability of both MHP and MCO contributions to inequities.
- Focus on aligning the level of training needed to deal with which problems. Community health workers can help with many things, while others may need a licensed provider. It is critical that children have access to the whole continuum of care if needed.
- Ensure that providers have child-specific training. Children are not little adults.
- Define sustainable funding – if funding is tied to utilization rather than whole person-centered outcomes, it may ignore or even harm the individuals.

- Outcomes should be aligned to both physical and behavioral health HEDIS and WPC measures.
- Continue to invest in schools. They can be a key way to reach children and families, support health and wellbeing, and build trust.

DISCUSSION

The presenters posed the following discussion questions related to the Ecosystem Working Paper:

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?

Participant comments are summarized below.

- The person-centered approach is key.
- Centering individuals, families, and communities is elemental. Authentic stakeholder engagement should be a part of developing this work as well as oversight and accountability related to the implementation and outcomes. Those impacted should be involved in defining benchmarks, what is working, and what needs to be changed as it is implemented.
- Engagement needs to include families that may be juggling many demands, for example working multiple jobs and caring for their children. This is critical to make sure that the solutions are feasible.
- The California Reducing Disparities Project is an important bright spot. There is opportunity to expand and scale this program.
- The content presented is beautiful on paper but is too general. The depth of the need seems separated from what are shallow solutions, and lack of acknowledgement of how systems are creating harm. A deeper acknowledgement of the need is essential in order to ensure that the solutions developed truly address it.

- The high-level points are ambitious and hard to argue with. The key question is how to get there – how to remove the long-standing barriers and what the roadmap would look like to make these changes. Particularly things like the structure of funding are systemic issues that people have been trying to change for many years but have not yet. The conversation needs to go one step deeper to really address *why* these things have not been able to change yet. Things like political will are important considerations.
- In operationalizing the strategy, ensure that the work does not get built in siloes.
- The success of an ecosystem will depend on a well-organized system of oversight.
- Integration of behavioral health in primary care is working well, with around 80% uptake of behavioral health treatment. It is provided in a trusted place and coordinated within a system.
- Building a network of care means working with community-based organizations and developing an understanding of what each other do and how we can support each other.
- Outcomes need to focus on whole person-centered needs, addressing whether the services, supports, and programs are making a difference for individuals' needs, getting quality help when it is needed.
- It is time to acknowledge and take action on root causes and injustices. We have discussed much of this for too long.
- It would be helpful to see the different funding streams, programs, and systems players.
- Complex problems need complex solutions. Unfortunately, these complex solutions often move into an individualized model of care, which costs a lot of money.
- Create "proofs of concept" focusing on a single problem and contextualizing what cross-system collaboration would look like.
- Including primary care providers is critical to preventing further siloing. They are in the best position to work with families to define what solutions would be and address stigma and other barriers in behavioral health care.
- FQHCs and school-based health centers also have an important role, related to that of primary care providers.
- How will this working paper inform other departments' initiatives, programs, and priorities? It would be helpful to have each department under CalHHS lay out how they will respond to the problems, recommendations, and outcomes identified in the Working Paper.

- It is important that every actor/system in the ecosystem be able to operate at their highest level within their appropriate abilities. Each player has their own expertise, skillset, and area in which they flourish. While it is important that the system not be disjointed in siloes, it can also be even more difficult to navigate if there are not clear roles. This can also lead to less accountability.
- Triage is important – identify issues to focus on, where there are particular challenges and opportunities for more favorable outcomes.
- Paying for universal care coordination, including with the peer, doula, and Community Health Worker benefits, would help solve many of the challenges highlighted. For this to work, benefits both old and new cannot be as restricted to specific settings.
- Stakeholder engagement must include stakeholders with disabilities and their families, including people with autism and related disorders.
- Transition-Age Youth have specific challenges and needs and should always be considered a sub-population. Dedicated services are needed because of the particularities of this age, including brain development.
- Include "threat assessment" screening, in addition to other screening.

PATH FORWARD

The presenters shared their next steps in developing the Working Paper:

- Incorporate BHTF feedback and feedback from other stakeholder engagement 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

BHTF MEMBERS OPEN DISCUSSION: THE DYNAMIC AND CHANGING BEHAVIORAL HEALTH ENVIRONMENT

BHTF members were given an opportunity to share about work they are doing as it relates to the BHTF and to elevate topics that have not yet been addressed at the BHTF.

- In Governor Newsom's veto message of SB 57, he noted that there would be some kind of follow-up work done regarding issues around supervised consumption and harm reduction. Is there a plan in the works to carry the conversation forward around addressing the overdose epidemic, including supervised consumption?

  - Ms. Welch said that the veto message indicated that there would be follow up with local government partners, and that CalHHS is beginning the follow up on this.
- Two themes that emerged in the earlier discussions were making cross-sector connections and the role of community schools. In the spirit of both of these, some important considerations are how do community schools connect with to SBHIP, CYBHI, and CalHHS. It is important to create links between the many funding sources and the spaces where communities connect to the work that is being done, like community schools.
- SAMHSA hosted a National Recovery Summit in August that brought together participants from the substance use and mental health worlds. It would be interesting to hear a report out from the Summit, perhaps at the next BHTF meeting.
- The development of CARE Court created a significant rift in the behavioral health world in California, and even within the BHTF there were some members that worked hard for CARE Court and others that worked hard against it. It is important to create space to process and heal the rift as a community, to the extent possible. We need to make space to talk about how the peer voice was or was not included in development of CARE Court and the implications for other major initiatives from Governor Newsom and Secretary Ghaly. To be functional and effective as a Task Force, we need to talk about this elephant in the room.
- With all the investments in behavioral health, it is important to move beyond expanding existing approaches and making small changes to them. Instead, we need to think through the ways fundamental transformations are needed to serve the people that the programs are meant to serve. This may even mean stopping some current approaches and developing entirely new ones. Assessing whether the State's current programs meet the needs in the field is a critical first step.
- There is an opportunity at this moment around the intersection of education and behavioral health. There is increasing interest and recognition of the need for coordination between the two systems, for example at the county level, supervisors and behavioral health directors working together. For kids that have multiple challenges, coordination between behavioral health and schools is an important opportunity to meet needs.
- As more systematic change is undertaken, it is important to focus on changes that will be meaningful in the long-term.

- The U.S. Access Board developed a Diversity, Equity, Inclusion, and Accessibility (DEIA) Strategic Plan; we should build on this work.
- Does the State have guidelines on ketamine treatment and clinics, which are becoming more common around California?
- Governor Newsom recently signed an executive order directing State agencies and departments to take additional actions to embed equity into their missions. A new Racial Equity Commission is also being formed. We should consider how the can BHTF work with the new Commission on issues of mutual importance related to disparities, for example in children's behavioral health.

NEXT STEPS & CLOSING

Ms. Welch thanked BHTF members and stakeholders for joining the meetings and for sharing their valuable input. She said that, in addition to sharing an update on the Crisis Care Continuum planning effort, the December BHTF meeting would focus on issues related to substance use disorder (SUD), which is a cross-cutting issue among many of the departments under CalHHS with lots of work happening at this time.

APPENDIX A. BREAKOUT DISCUSSION NOTES

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

BHTF MEMBER BREAKOUT GROUPS

GROUP 1 – CRISIS PREVENTION

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS** - Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS** - Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS** - AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Access to peer-based warmlines	*x*		*Statewide standards*	*Need to be more culturally & linguistically competent & accessible* *Improved outreach to bring in more volunteers with lived experience*	*Effectiveness should be evaluated* *Some group members were not aware of existing warm line resources* *Group identified this standard as a top priority*

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				Increased awareness of warm lines Training Sufficient funding and pay for the workforce Address burnout by reducing paperwork processes Marketing campaigns so community knows this resource exists Stigma Reduction	Awareness and training are needed across sectors How do we apply “no wrong doors?” For example, if I call a warmline, but should be going to a clinic, how am I directed, or if I show up at a clinic, but my insurance status is an issue, how can I be directed to the resources without barriers?

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Access to community-based behavioral health services, such as:					
• Community-based social services			We know these exist, but are they available in every community and are they able to scale?	Training Sufficient funding and pay for the workforce Community based services Address burnout by reducing paperwork processes Need navigators	Awareness and training is needed across sectors Better collaboration across sectors.

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• School-based and school-linked services			We know these exist, but are they available in every community and are they able to scale? Common Standards across the system	Training Sufficient funding and pay for the workforce Address burnout by reducing paperwork processes Need navigators	Awareness and training are needed across sectors Existing CA State Standards and Frameworks for educators need to be revisited where mental health exists in the standards and frameworks and how do we incorporate this into daily teaching. Physical health is paramount in prevention. (Can Superintendents Mental Health workgroup do this?)
• Primary care clinics and FQHCs	x		We know these exist, but are they	Training	Awareness and training are needed across sectors

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
			available in every community and are they able to scale? Common Standards across the system	Sufficient funding and pay for the workforce Address burnout by reducing paperwork processes Authentic stakeholder engagement	
• Outpatient BH care (e.g., CCBHCs, urgent care clinics, transition clinics, bridge clinics)			We know these exist, but are they available in every community and are they able to scale?	Training Sufficient funding and pay for the workforce Address burnout by reducing paperwork processes	Awareness and training are needed across sectors

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				Authentic stakeholder engagement	
• Peer support			We know these exist, but are they available in every community and are they able to scale?	Training Sufficient funding and pay for the workforce Address burnout by reducing paperwork processes Diversity, Equity, Inclusion, and Accessibility (DEIA)	Awareness and training are needed across sectors

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS** - Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS** - Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS** - AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Harm reduction			We know these exist, but are they available in every community and are they able to scale?	Training Sufficient funding and pay for the workforce Address burnout by reducing paperwork processes Supplies	Awareness and training are needed across sectors
Exposure to **digital apothecary** (e.g., CYBHI digital platform, CalHOPE digital tool) *What is “digital apothecary”?				Training	Awareness and training are needed across sectors

1. FUTURE STATE STANDARDS Standards (baseline resources available for all)	**2A. CURRENT STATE OF MEETING STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF MEETING STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF MEETING STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Screening tools			We know these exist, but need a standard set to choose from that are used across sectors.	Universal, open source, free, and not 1,000s to choose from, have a vetted set that is agreed upon across sectors. Training	

GROUP 2 – CRISIS PREVENTION

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Upstream Stigma elimination among youth & adults		x	x	Bolstering school-based program via CYBHI; Culturally centered/ trusted messenger engagement;	Evaluation/measures of impact Affordable, Accessible, Available - not just the quantifiable measure, but a quantifiable - quality measure as well (if/then from the intervention to a longer-term outcome); Address disparities & not just averages
Upstream work with those who are not yet BH system involved			X	Investment in family resource centers (ex. Lincoln in Bay Area has a center),	

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				community-defined practices/spaces	
Standards addressing Black communities incl workforce development, investments in CDEP			x	More targeted OPPS/investments like CRDP; PEI;	

GROUP 3 – CRISIS RESPONSE

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Receipt of crisis call	X	X	X	988 should be able to link to a county crisis line for a mental health crisis) or 911 (depending on the nature of emergency). 911 should be able to… County crisis lines should be able to… 211 should be able to FURS? Friendship Line should be able to 988 operators (and/or other responders) to have electronic	SUD-specific needs (e.g., overdose) should not get routed to a county crisis line. *Note: it may be difficult to decipher between mental health crisis and psychoses associated with SUD.* Need decision trees with appropriate infrastructure. Requiring all payers (private/commercial, Medicare, Veterans) to pay for field-based mobile crisis responses on the back end.

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				access to Psychiatric Advance Directives	Patchwork systems - need to be streamlined.
Response/dispatch	X	X	X	Need sufficient workforce that is trained on behavioral health crises (including psychoses…both mental health and SUD-induced (e.g., Colorado dispatch model). Don't take people to jail or the youth to juvenile hall (educate providers on alternative options)! Similar for emergency rooms…try to establish use alternative, more appropriate	988 - optimal outcome would be to keep person where they're at. Requiring all payers (private/commercial, Medicare, Veterans) to pay for field-based mobile crisis responses on the back end.

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				locations. Ex. Wellspace CRHB program. Need children-specific vs. adult and older adult models (see SAMHSA). Best practices: Those who are known and trusted by the person (existing crisis plan?)	
Linked, flexible services specific to crisis response				Standard: Ensure EMTALA is being followed.	

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Triage/screening & initial assessment, including explicit screening for suicidality			X	Some consistency/standardization of processes Standardized screening and assessment tools that are culturally / linguistically appropriate Age considerations, too	
• Counseling throughout the encounter and intervene to de-escalate the crisis	X	X		Best practices: Those who are known and trusted by the person (existing crisis plan?). Could involve a provider, if known.	

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Family and individual psycho-education	X			Teach people "bluntly" about what to use and what is the right response. Advance Directives, System Design, Available Services, even the BH condition(s).	Respite is an important resource (needs to be in all medical insurance plans). Consent to include collaterals
• Access to peer support and family support	X	X	X	Build out peer respite Build out a statewide peer benefit under Medi-Cal Family psychoeducation	

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Coordination with medical and behavioral health services				Medical clearance that's easy and flexible (don't have to take everyone to the ER to get cleared). Need payers across counties.	LPS
• Crisis planning and follow-up			X	Psychiatric Advance Directives created	
• Medications					
Models for trauma response (e.g., shooting, fire) - on-site, hospital, post-incident			X		

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Financial model to make this work across payers			X		ARPA prohibitions on Medicaid covered MCS
LPS Considerations across all of the above.					

GROUP 4 – CRISIS RESPONSE

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Real-time coordination of crisis and outgoing services		X		Understanding the flow btw response services	How do we take it to the next level?
Linked, flexible services specific to crisis response		X			
Triage/screening & initial assessment, including explicit screening for suicidality	X			Make sure what exists is coordinated	Youth vs adult assessments
Counseling throughout the encounter and intervene to de-escalate the crisis			X	• Assessment of available models & best practices/training curriculum.	Consideration for implementation of each stage (e.g. Public Safety,

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				Understand & recognize gaps.	Mobile Crisis Response, Rural vs non-rural communities, etc.).
Family and individual psycho-education			X	• Transform the system to authentically engage families and peers. • What language do we use to engage in treatment? • Do we actually have translation available for behavioral health terms? Translate access literally and figuratively to ensure statewide access.	-Linkage between 0-3 or organic things that are happening. -How do we educate and how does that apply in implementation -Common understanding of nurses, teachers & practitioners. -Low-income students have a different environment and information flow.

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
					-Clearing house of resources as a library.
Exposure to peer support and family support			X	Ex: Technology and applications for providers with resources including peer to peer programs for community Peer support requirement in contracts (e.g. 50% - 70% of responses should include a peer). Community based peer to peer resources.	

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Coordination with medical and behavioral health services			X	Dependent on services and coordination. (e.g., emergency room connected to LPS facility), Stigma in a medical setting with a psychiatric concern remains. Ongoing education is needed for psychiatric emergencies due to medical causes. Transfers from crisis stabilization for medical clearance are complex. Training for 911 and 988 operators to connect individuals	Identify where the gaps between services are and coordination of care is needed. COVID testing has created an additional barrier to transitioning to next steps. Consider co-locating services (e.g. young people or kids, screening onsite would prevent an ambulance ride). Integrated systems can benefit from in-home stabilization.

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				to behavioral health folks that people need. Get to a place where medical clearance at an ED is the exception and not the rule and leverage telehealth for the clearance. –State guidance on minimizing harm as a standard of practice	
Crisis planning and follow-up			X	What does a system of follow-up look like after response? Case study examples of being seen by a provider and	Especially follow up with the whole family, not just the individual. Would be helpful to have tech that can help with data sharing so that

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				discharged, but how do ensure they don't fall through the cracks. Quality metrics that health plans are measured on (e.g., follow-up after psychiatric visit) For example, KP has an integrated care system, and get a patient an appointment before they leave their ED. When we talk about follow-up we need to think about wraparound support for the whole family – not just the kiddo.	follow-up care can be more quickly flagged and coordinated by providers.

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Relationships between behavioral and medical health services			X		
Timeliness of services (aka warm body handoffs)			X		

GROUP 5 – CRISIS STABILIZATION

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Evaluation of individuals' needs and strengths, including community and family support that can be utilized		X		Training and workforce development Client centered practices	
Continued monitoring of care			X	The responsibility to perform linkage/follow-up needs to be clearly identified. Is it the provider who just served the person, or their insurer, or their primary care physician, etc.? Ensure there are clear mechanisms to have this activity	County Mental Health Plan data indicates gaps in step-down to outpatient care, following discharge from inpatient hospitalization. This may be an indicator of our challenges in providing follow-up even after providing crisis stabilization. ● According to AB 470 Performance Dashboard, 48 percent of African-Americans

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				covered by private insurance and Medi-Cal	receive no stepdown services in 2019/20. • https://data.chhs.ca.gov/dataset/adult-ab470-datasets/resource/c1908f78-3716-4b91-8afa-0dc9c3c2058a
Ability to access and stay in care based on client need (rather than limited availability of resource, disability diagnosis)			X	Increased number of resourced providers Competency training in IDD	Lack of access for people with disabilities (especially autism)
Crisis service discharge planning			X	Discharge planning needs to include a warm hand off to	California's Rehab SPA identifies the following components of "crisis stabilization," which do not infer the robust discharge planning and

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				services, not just a list of resources in the community. Training and workforce development	follow-up we would recommend start to occur: • Assessment • Collateral • Therapy • Crisis Intervention • Medication Support Services • Referral
Availability and quality of linkage to high-quality, ongoing care		X		Training and workforce development	Recommend combining or clarifying differences between “linkage,”

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				Identify best practices (e.g., Caring Contacts)	"discharge planning," and "continued monitoring"
Remove immediate and long-term negative consequences and harms from seeking and receiving ongoing care (e.g., professional consequences, family court, employment, security clearances). Immediate harm reduction can include attending to child care, paid medical leave from work, pet care, help with rent, etc..			X	Training and workforce development Longer-term follow up	Self-determination and community integration as bedrock values Peer-respite Assistance with childcare Leverage people with lived experience and design thinking to anticipate and remove or mitigate potential harms and improve the experience of the person seeking help in a crisis

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Care should be provided in a culturally appropriate and culture affirming manner		X		Training and workforce development, with intentional efforts to recruit and retain a workforce that mirrors the client population	Definition of "stabilization" and what would be considered a successful outcome should recognize cultural contexts and non-clinical outcomes (e.g., employment, living in the community with self-determination, community integration)
Consideration must be given to the family, friends, or other supporters who may be accompanying individuals in crisis			X	Examples: offer a peer supporter, thoughtful design of and support available in "waiting area"	

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Equitable access to care and adjunct support for all socioeconomic statuses			X		"Time and space to heal"

PUBLIC PARTICIPANTS BREAKOUT GROUPS

GROUP 6 – PREVENTION

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Planned virtual platform			*X*	*Still missing community engagement, disenfranchised members won't be the ones calling.* *Reducing stigma of mental health, education at larger level, campaign, social emotional learning for students & teachers, trauma informed*	*CalAIM* *Local level infrastructure concerns* *Mobile clinic support with Wi-Fi capabilities*
Access to community-based behavioral health services, such as:					

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Community-based social services		X		A lot of resources, but in pockets, or broad but not well known. (Community Information Exchange) Need connections, electronic referrals, follow-up on referrals. Systems not coordinated enough to be consistent.	Services rely on Grants, when funding ends, the service ends Provide sustainable funding streams ongoing, build infrastructure and evolve into electronic systems.
• School-based and school-linked services		X		Students and families trust people at school and the connections made by the known staff. Schools do strive to meet the needs of students/families but resources are not always on campus, nor available.	Schools do not share consistent mental/behavioral health systems so when students move they may lose continuity of care. Therapeutic support resources are not readily available.

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
				Local professionals shift from school based and county-based careers.	Mobile clinic could rotate on a known schedule.
• Primary care clinics and FQHCs			X	There are some available but not fully available due to transportation, capacity, language, Medi-Cal utilization is low	Gaps in service
• Outpatient BH care (e.g., CCBHCs, urgent care clinics, transition clinics, bridge clinics)			X	Same barriers as each of the previously mentioned areas of support.	Mobile clinics=Privacy pods where people can connect with specialists, bus is the resource on schedule, substance use, mental health, quality care access, internet connectivity without transportation hurdles

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Peer support			X	Need more. Qualifications and requirements could be barriers to be certified. Need to find ways to certify, employ and create work environments so that peer counselors can earn a living wage	
• Harm reduction					
Exposure to digital apothecary (e.g., CYBHI digital platform, CalHOPE digital tool)					

GROUP 7 – CRISIS RESPONSE

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Real-time coordination of crisis and outgoing services		X	988 dispatch for mobile response		
Linked, flexible services specific to crisis response					
• Triage/screening & initial assessment, including explicit screening for suicidality		X	Establishment of standard tool in counties providing mobile crisis; standardization to compare counties or within counties		

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• Counseling throughout the encounter and intervene to de-escalate the crisis					
• Family and individual psycho-education					Allowing family members to have contact with 18+ year olds; protocol to include family members contact info when placed on a psych hold
• Exposure to peer support and family support		X			
• Coordination with medical and behavioral health services					

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Crisis planning and follow-up					
Response time standards for urban (60 min) and rural (120 min)			Aiming for 90 min for rural		
Collect data to analyze recidivism rates and compare within and across counties					
Standards in working with police - reducing needs to involve police					Aspire to decrease police involvement and standard across counties. Screening during phone call to determine if a person cannot tolerate law enforcement.

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Protocol for cross county communication					
Standardized training for writing 5585/5150 holds					

GROUP 8 – CRISIS RESPONSE

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Real-time coordination of crisis and outgoing services				Establish min time for arrival on scene and pick up time to answer call Incentives to utilize more peer and family supports	
Linked, flexible services specific to crisis response					
• Triage/screening & initial assessment, including explicit screening for suicidality					

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Counseling throughout the encounter and intervene to de-escalate the crisis					Counseling - word choice
• Family and individual psycho-education					Define what this is. Engage family is other natural supports. Needs to be intentional
• Exposure to peer support and family support					Exposure not strong enough
• Coordination with medical and behavioral health services					

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
• Crisis planning and follow-up					
• Real time data from all to drive and correct disposition (stabilized, resources, high need individuals)					State dashboard with a min data set
• Historical data					
• Dispatch standards					
• Maximize technology to facilitate real-time care					

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
coordination and dispatch (example: LA County)					
• Have 24/7 access to consultation					
• Advocacy and funding for ALL payors				Remove barriers and red tape to access funding Standardization of mobile response teams, on-call, etc. using CMS guidance for requirements and funding	
• Training standardization				Alignment of training requirements, curricula, etc. (Think Tank model)	

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• Inclusivity and cultural humility					
• Shared expectation of what should happen and not happen					

GROUP 9 – CRISIS STABILIZATION

1. FUTURE STATE STANDARDS Standards	**2A. CURRENT STATE OF STANDARDS -** Currently AVAILABLE	**2B. CURRENT STATE OF STANDARDS -** Currently PLANNING	**2C. CURRENT STATE OF STANDARDS -** AIMING FOR	**3.A NEEDS** What is needed to be able to achieve the standard?	**3.B NOTES** Additional input or considerations
Evaluation of needs and strengths			x	CLARIFY IF THIS IS NEEDS/STRENGTHS OF CLIENT OR THE SYSTEMS' NETWORK SUFFICIENCY (BOTH should be standards) We need publicly published data about county services available/network adequacy to address a major gap in county accountability The state needs standards about how many beds are needed for every tier of crisis stabilization - counties cannot self-certify this information –	Need to avoid duplication of assessment across crisis prevention, response and stabilization Need to address how documentation burden is impacting programs, including added/redundant documentation across program types, county plans, and managed care plans Services for children and adults should be separated and not commingled.

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				like the 'Yes'/'No' survey data shared re crisis res beds where 9 counties say they have enough beds but providers and the public have no knowledge of what that's based on nor how accurate...it isn't aligned with the experience of those suffering. Data sharing/HIE across all systems, including physical and BH, and CBO's (SDOH data) When counties are evaluating programs, we need a standard for evaluation (that even lay people understand?) so we aren't	

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				comparing apples and oranges and can ensure optimal resource use.	
Continued monitoring of care			X	Does this refer to monitoring when a client is in a facility/in-home stabilization encounter or after they leave and are in community? (both important) Health information exchange/remote monitoring to follow clients after discharge to evaluate outcomes and success of interventions is sorely needed across all BH services	Staffing standards are critical but cannot be sustained with current workforce crisis (esp. for contract providers competing with counties/managed care and the private sector) Staff sharing across programs should be allowed in regulation (provided set ratios are met) to allow for staffing and cost efficiencies as census fluctuates. Primary care docs do urgent care shifts same day, and some even home visits, based on

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				Also need to include families and peers in remote monitoring and care teams. They spend the most time and often know first about decompensation. Wraparound is essential, even for adults, and less available on the commercial side, which is inequitable (and costly to PPO's paying more for bed-days)	fluid demand – why should BH differ, adding unnecessary strain to a service-constrained workforce?
Crisis service discharge planning			x	Need standardization across counties/MCO's/providers, including interoperability in data systems adhering to ONC regs (crisis care data should be portable via smart	Co-location of multiple tiers of crisis care to facilitate step-up/step-down within a single facility and enable VBP within a single organization.

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				phone just the same as physical health data!) How are we including families and peers in discharge planning and plan adherence?	
Linkage to ongoing care			X	Linkage within 24 hours is important, but needs to also include linkage to an ongoing provider that can continue to see them. Who is responsible for the linkage? The facility provider? The health plan? Need an outside case manager	This hand off is especially important for unhoused individuals - where MH needs take a back seat to basic needs (food/shelter, etc.) Linkage isn't a strong enough term. Linkage often means a list of referrals. The goal is that the client experiences a seamless continuity in their discharge, step-

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				to facilitate a warm hand off at discharge	down/residential, and outpatient care. BH is way far behind the rest of health care in the way we think about linkage, (likely due to antiquated, at-cost payment structures physical health care has never been subjected to). We need funding streams that fund the bridge or even bundle services, so the state's many BH investments can be leveraged/braided. And we need accountability. In managed care there is growing accountability. But in county BH

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					plans there is little to none, and the public has no idea of the counties' roles in limiting care–service inadequacies need to be published on web-based dashboards so people can advocate for equitable access.
Prevention: CCBHCs			X	Additional state funding and buy-in	Strong connection between 988 and CCBHCs
Integration with other crisis and BH services			X	Remove counties' siloed payments for specific programs and transition to FFS or capitation/PMPM across programs/services. CSU's, residentials, and in-home stabilization/wrap-around services	Linkage is too weak a standard for such a fragmented system, and usually leads to referral databases with limited closed-loop tracking and no HIE. We need to catch up to the rest of healthcare and **pay for and**

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				should be bundled for better outcomes – NOT separate pay mechanisms or separate line items forcing staff to account for their every minute.	***measure integration*** – it's a best-practice/standard everywhere else in healthcare. Why not here?

PUBLIC – ADDITIONAL POST-MEETING INPUT – CRISIS RESPONSE

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Real-time coordination of crisis and outgoing services		X	X	Technology – Didi Hirsch 988/911 Pilot	Real-time linkages with analytics, need-to-know only, Cloud 9 TeleHealth Austin Tx
Linked, flexible services specific to crisis response					
• Triage/screening & initial assessment, including explicit screening for suicidality		Make sure in place	Not state mandated tool but standardized within county	Standardization to evaluate	Reduce recidivism and recycling through the systems
• Counseling throughout the encounter and intervene to de-escalate the crisis					

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Crisis planning and follow-up					
• Family and individual psycho-education		Advanced directives planning		5150 – when child turns 18, adults have to reach back to family, ability for family members to connect to patient	
• Exposure to peer support and family support		Advanced directives planning		Same as above box	
• Coordination with medical and behavioral health services					

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Crisis planning and follow up		?	ECMs linked	MCT start; protocols? MCT can get a jump on reentry, transitional, more permanent planning	Cloud 9 telehealth type platform. Intervention in the field. Who could you talk with to make you feel better?
				Food, housing, income, clothing, structure for recovery. Go to one place for basic needs.	
Discussion response times standards	60 min urban 90 min rural	X	X 90 minutes rural	Standard protocols for screening needed across counties because people move. System spans the state.	

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Working with Law Enforcement. Avoid LE? LE is not responding to suicide calls in LA at present				Part of screening essential. Yolo County working with police. Limit use of LE. What does it mean? How does it actually work?	
				All teams need standard crisis training. Standards training for psych holds, writing psych holds	
			Some peer training and certification taking place	Not standard 5150s across state. Personal experience that SUD professionals better utilized. Hospital intakes for 5150s, no standard. What is criteria? What	During intake protocol – who's OK for us to contact

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				appear using peers support for intake?	