

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Behavioral Health Task Force (BH-TF)

August 25, 2020

10:00 a.m. – 1:00 p.m.

MEETING SUMMARY

Behavioral Health Task Force Members Attending: Sonya Aadam, California Black Women's Health Project; Lenore Anderson, Californians for Safety and Justice; Seciah Aquino, Latino Coalition for a Healthy CA; Sarah Arnquist, Beacon Health Options; Charles Bacchi, CA Association of Health Plans; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI CA; Mary June Diaz, SEIU; Vitka Eisen, HealthRIGHT 360; Lishuan Francis, Children Now; Virginia Heidrick, CA Consortium for Urban Indian Health; Tanja Heitman, Santa Barbara County Probation Department; Emma Hoo, Pacific Business Group on Health; Andy Imperato, Disability Rights CA; Linnea Koopmans, Local Health Plans of CA; Kim Lewis, National Health Law Program; Elizabeth Oseguera, CA Primary Care Association; Hector Ramirez, Disability Rights California; Cathy Senderling McDonald, CA Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network; Carolina Valle, CA Pan-Ethnic Health Network; Marie Webber, UCSD Health; Stephanie Welch, Council on Criminal Justice and Behavioral Health; Jose Zavala, Fresno Unified School District; Ashley Zucker, Kaiser Permanente.

Behavioral Health Task Force Members Not Attending: Tom Insel, Steinberg Institute

State Representatives Attending: Mark Ghaly, CHHS; John Connolly, CHHS; Jim Suennen, CHHS; Will Lightbourne, DHCS; Jim Kooler, DHCS; Morgan Clair, DHCS; Sandra Shewry, CDPH; Mary Watanabe, DMHC; Toby Ewing, MHSA; Kim Johnson, DSS; Stephanie Clendenin; DSH.

State Representatives Not Attending: Nadine Burke Harris, CHHS; Tom Herman, CDE.

Public Attending (by phone): There were 124 members of the public attending by phone.

Welcome and Opening Comments

Dr. Mark Ghaly welcomed everyone and introduced Bobbie Wunsch from Pacific Health Consulting Group as the facilitator for the meeting. He welcomed two new members, Sonia Aadam from the Black Women's Health Project and Seciah Aquino from the Latino Coalition for a Healthy California.

The context today for the Task Force is vastly different than it was for our first meeting. COVID has impacted the state as a whole significantly, and sadly, there has been a disparate impact on racial and ethnic populations. We are increasing our response based on that data, as well as continuing to address the issues of age and disability. Additionally, we are focused on what this means to people's psychosocial and behavioral health.

There is deep impact on all of us and our communities from the events surrounding the killing of George Floyd that ignited a response across the country. It requires us to think about, and raise questions about, racism in health care, in public health, in government and in society that many people of color and Black Americans in particular face every day. Part of today's conversation is to consider the impact of these events, actions, and activities and what it means to have a more complete response to racism and the impact of COVID on behavioral health and race. We look to all of you to share your efforts over the recent months and offer input to imagine a better future.

Telehealth is helping to increase access to behavioral health services. COVID has forced us to push the envelope on innovations. I would ask us to do the same thing on racism in our state and in our communities to address the disparate impact on people of color. Also, the unaddressed needs in rural communities challenges us to step up, not just to provide access, but also deliver language concordance.

I look to the opportunity of this forums like this to advance an agenda that catapults California forward to a brighter place, so that when we look back, we will say we didn't squander this opportunity to improve and become better. And that COVID, as it unmasked disparities and problems, was an accelerator of change and improvement. I look forward to the results of today's conversation and thank you for all again for all you are doing in your day to day lives.

John Connolly welcomed members and thanked the California Health Care Foundation for their support of the Task Force. He reviewed the agenda that begins with input from members to gather perspectives on the events of recent months. Next, Jim Kooler, Assistant Deputy Director for Behavioral Health, DHCS will present on CalHOPE, a statewide crisis counseling program response to the COVID public health emergency. That will be followed with a discussion of the mission and objectives for the Task Force that were outlined at the first meeting and revised based on input from members. We will then turn to a discussion of the work plan for the next year and a half and are looking forward to your thoughts on the structure and timeline for developing a report to improve behavioral health as a state.

Discussion of Behavioral Health Impacts of COVID-19, Recession, and Recent Community Action regarding Anti-Racism

John Connolly opened the session by inviting members to offer their thoughts on behavioral health across the state and how California should respond to the needs in the context of COVID and the public health emergency, the recession that it caused, and recent community action in the wake of George Floyd's murder. What does this mean for us as a state, what is the impact on behavioral health and specifically the work of this group? What are the important considerations, the priorities for us as a state in advancing and improving behavioral health and what should we do in the Task Force to generate recommendations for Secretary and the governor to advance behavioral health services, prevention, and early intervention?

Bobbie Wunsch facilitated input from each member on the following questions:

1. What behavioral health impacts has your organization seen as a result of COVID-19?
2. How has your organization's work changed as a result of COVID-19?
3. How have racial justice and equity been discussed or addressed in your work?
4. How have racial disparities been highlighted in your organizations?
5. How can we address racial equity, justice, and disparities in our work in this task force?

Member Comments

Sonya Adam, California Black Women's Health Project: The work of the California Black

Women's Health Project addressing the issues of health disparities, and anti-Black racism in particular, is longstanding and continues - elevated by recent events. I am curious to hear from others to discuss how we might pivot our work to navigate, understand and implement change, especially in mental health and behavioral health.

Virginia Heidrick, CA Consortium for Urban Indian Health: I'm a member of the Yurok tribe of Northern California. COVID-19, for many of us, hasn't brought anything new, because these are the challenges we experience as American Indians and Alaskan Natives as overlooked and unrecognized populations. California has more than a hundred federally recognized tribes, yet tribes are rarely mentioned. In the state and federal government response to COVID, no one's really paying attention to what is happening in Indian country. Currently, one of the largest reservations in California is having an outbreak of COVID-19 and we have yet to see an adequate state or county response to provide that community with the support that they need to adequately respond to more than 60 cases in a 12 by 12 square mile area with 1,200 people living in it. The other pieces of COVID align with poverty, access, education, and socioeconomic indicators. The Indian health program network in California, both tribal and urban programs, were among the last health centers to get testing and only have capacity to test up to 30 individuals per day regardless of how many individuals need a test. So, the needs are not being met in communities where there is only one grocery store, one gas station and one major employer. There is a real opportunity to stop the outbreak, but also the real opportunity for it to grow rapidly. I encourage us to think about the first people of this state and country and how we are included or not included in these conversations?

Jose Zavala, Fresno Unified School District: COVID has forced our school district outside of its comfort zone. On the instructional piece, we are doing our very best to accommodate the needs of 75,000 students and their parents. Parent mental health has worsened due to uncertainties, being out of work, having to stay at home and having to teach their students. The situation has forced us to collaborate more with community partners to absorb overflow of mental health needs with our own practitioners. We have passed out 65,000 technology devices to students and we have trained our practitioners to provide telehealth services for social emotional and mental health support. It is still a work in progress, but we have created online referral systems to give teachers and support staff the ability to identify students who need support and then provide support to those students. On racial injustice and cultural deficiencies, we started a professional learning series for our 10,000 staff last year that began with cultural proficiency. It is a process that will take the rest of this year. The goal is that every staff member within our district will have gone through this training and will continue to go through updated versions as we go forward.

Mary June Diaz, SEIU: SEIU and its leaders take anti-racist work seriously and want to ensure racial justice and equity. SEIU California is a founding organization for the Commit to Equity Coalition of 80+ organizations actively working on racial justice and equity.

Lenore Anderson, Californians for Safety and Justice: We are a criminal justice reform advocacy organization and all aspects of our work have been affected by both COVID-19 and the racial justice uprisings across the country. We work with survivors of crime and people living with past convictions, as well as incarcerated people and their loved ones. All of those populations have been deeply impacted in the aftermath of COVID. Many are experiencing job losses and income reductions and that has increased behavioral health stresses. Many frontline community service providers were not immediately able to transform to online services or have appropriate PPE. There are faith-based service providers trusted by survivors of crime that have been severely impacted and are not able to provide support and service. Therefore, we have seen increased stress and behavioral health needs among survivors. There is also the issue of access to emergency needs, like domestic violence shelters being unable to quickly ensure that everyone

can have a separate room. Those problems were quite concentrated from March to May. Leaders in California have mobilized to support community service providers in the state and much has improved over the last several months. However, behavioral health needs, trauma, recovery access to emergency housing and to emergency mental health are all under stress for people who have experienced crime and that is exacerbated by race and racism. Incarcerated people of color have less access and there is significant spread of COVID in facilities that are, by design, keeping people in close quarters. That has caused great behavioral health stress for people who are incarcerated as well as their loved ones.

We have received thousands of phone calls from people all over the state very worried about their loved ones who are incarcerated and unsure what will happen. Are they going to be released? Are they not? This is an area that we continue to have great concerns, the difficult work of making decisions about who gets released and when, and how to make sure people are released safely. California has not been a state that has historically released people quickly who are no longer a danger. The opportunity to transform public policy and release people who do not need to be incarcerated in greater numbers would be an improvement for the behavioral health of the state. The behavioral health needs for people who are being released and those living with past convictions are substantial. People are released with limited support and re-entry has not been invested in at scale. California is not unique in that regard, but California is unique in having a concern about this issue. People are facing extreme barriers to finding employment and housing, and those will exacerbate behavioral health needs. COVID-19 has underscored what we know about how implicit bias and structural racism are the root causes of an inequitable mental health system. We also know that the pandemic has disproportionately impacted communities of color and their mental health, low wage workers, immigrants, LGBTQ communities, and persons with disabilities.

Carolina Valle, CA Pan-Ethnic Health Network: We are a network of community based organizations across the state working to ensure a strong transition to telehealth platforms and modalities. Our partners face a wide range of barriers making that transition, from the digital divide to stepping up outreach efforts to ensure that communities of color are actually being connected to economic support and the mental health services. Social distancing requirements have created new challenges for communities and the organizations that serve them because many programs are based on social cohesion and connection to culture and communities. We were founded in the wake of racial demonstrations nearly 25 years ago, in response to the beating of Rodney King, and think that now is the moment to talk about how intergenerational patterns of systemic racism and implicit bias are driving the persistence of mental health disparities and the dwindling of resources in communities of color. Racial equity has to be central to the conversation about mental health reform. As we move forward to ensure access for priority populations, we invite everyone to ensure we also are talking about racial equity.

Marie Webber, UCSD Health: There has been an uptake in telehealth that is not decreasing now that we are bringing people back to the clinics. It showed everyone what is possible in terms of connecting with providers in different ways. We see increased stress and behavioral health needs across everyone - organizations, patients, family members, and providers. We are monitoring the health and wellness of providers, from their child-care struggles to their COVID health and safety, to make sure they are healthy and able to deliver care. We are also focused on getting people in for care when they need services and not just connecting via telehealth because we have escalations to acute stages that need to be addressed. In terms of the racial justice and inequity that's been discussed in our system, we are conducting listening sessions for staff, residents, students and physicians and it has exponentially increased our dialogue about racial equity. We are reviewing of policies about how we do business and it has shed light on a number of changes, including curriculum development for students and medical students, for how we can be more inclusive and deliver equitable care. For this Task Force, it is important we ensure inclusivity in the mission and focus the objectives on culturally competent care and

equitable delivery of care across the state - not leaving any group out. If we collect outcome data, we can improve disparities for the vulnerable groups identified in an equitable way.

Mandy Taylor, California LGBTQ Health and Human Services Network: The LGBTQ community historically has received most of their behavioral health supports through their cultural communities, and COVID has greatly impacted their ability to get that support. LGBTQ people are born into LGBTQ families as well as rejecting families where they are now sheltering in place and this is increasing their anxiety. We have lost community members to suicide during COVID. There were already high rates of trauma, anxiety, and toxic stress and COVID has added to that while also reducing access to supports. The behavioral health system historically has not always been a safe and affirming place for support, so the loss of community is concerning. I think we need to focus on culture and affirmation when we talk about the system, so people feel safe and affirmed and the system is supporting cultural communities

We did a virtual town hall and heard it is especially challenging for those who are experiencing intersectional identities, in particular trans Black women. This year, the number of trans Black women who have been murdered has been exponentially higher than previously. Living with and losing community members in that way, and fearing that could happen to you, impacts daily life and the ability to be well. We also heard from the Latinx community that the lack of resources in Spanish has been a big barrier, particularly for first-generation LGBTQ folks not able to access LGBTQ and culturally affirming support. It is important that we focus on the most marginalized population within each community and make sure those voices are centered, ensure they are doing the work and that we support them. California values consumer led movements, nothing about us without us. Professionals should not be making the decisions but should go to communities most impacted and ask what they need, how we can support them and how the system should be changed to address disparities.

Lishuan Francis, Children Now: For kids, we see the same concerns of anxiety and depression due to the uncertainty around COVID. That uncertainty is not just job security, but also young people becoming caregivers for family members who are sick. Support from the informal environment, whether community centers or school, was really important for children and youth and those environments are now virtual or non-existent. It is nothing new for many communities when we talk about over-policing and police violence. What is not being stated explicitly is the role of over-policing and the post-traumatic stress disorders, in particular that Black males face, when they live in communities that have been overpoliced. We still are not drawing those links between what is happening in the communities and behavioral health impacts and outcomes. It has been hard in the past to get the state to verbalize the impact of what is happening in communities on the behavioral health of kids and the behavioral health of adults. I am speaking to root causes. I would like to challenge the Task Force and myself to be explicit about what it means to be poor and its impact on mental health, what it means to operate in a community that is being overpoliced and its impact on mental health. Whether or not we are solving those problems, when we are not explicit about these issues it makes it seem as if the problems are purely clinical - if we get a bit more medication, a few more therapists, then everything would work out. That simply is not true, and it does a disservice particularly to Black and Brown kids.

Kim Lewis, National Health Law Program: As others have highlighted, health disparities, food insecurity, and housing are the issues that really impact quality of life and are disproportionately impacting people of color, LGBTQ, and people with disabilities. Those are all communities more negatively harmed by the health policies we have today at the federal and state level. Things are perhaps a bit more equitable, but there is a lot of work to do. COVID has increased the impact and made the crisis greater, with resources depleting and people feeling the impact of the recession. Our work and written materials have highlighted the impact through a health equity

and racial justice lens, as well as how structural racism disproportionately impacts and harms communities. Specific to behavioral health, access has always been difficult for these populations and remains so, despite the availability of telehealth. This is going to have a lasting impact in terms of access to health, and telehealth is never going to completely fill the need. Access is declining, even with the use of telehealth, because some communities and populations lack access to technology and internet access to utilize services. It is incumbent on the state to take more aggressive action to ensure access is available through telehealth and also in person. These are critical community based services for children, adults and particularly people with disabilities. They are not going to meet all their needs through phone access, zoom meetings or telehealth. They need in person contact and support for education to access services. There are many ways that what we are doing now needs to pivot to address disparities more effectively. Access to affordable healthcare through Medicaid is a critical link because people are losing their jobs and losing their health insurance. It is incumbent on us to expand Medicaid in every way possible and maximize coverage.

Ashley Zucker, Kaiser Permanente At Kaiser, we made a huge transition to virtual care. We were 20- 30% virtual before COVID and then as high as 99% virtual care during the pandemic. Now we are trying to find that new-normal balance. Face to face is still critical and we can supplement it with virtual options through telephone and video. Some challenges we have seen with COVID are patients who require a psychiatric hospitalization, but then test positive for COVID. They may be medically stable; maybe even asymptomatic for COVID, but they are psychiatrically unstable. There are not any inpatient psychiatric facilities that will take COVID patients. We also had issues with patients who were previously COVID positive and facilities requiring a significant amount of time to have passed before they will accept those members. There are difficult placement issues with patients and having to provide care in less than optimal situations, such as on the medical floor in the emergency department. We have also seen an increase in severity level overall for mental health patients. Especially for the severely mentally ill, the transition to virtual has been challenging and some are not able to access virtual care or rely on the physical support of coming in and meeting with case managers or their groups. It is important we address the mental health of our mental health professionals and other frontline workers, whether in health care or other essential functions. They are under an extraordinary amount of stress. In terms of racial justice and equity, we have held internal listening sessions and a series on coping with modern day racism in America, which was led by our equity inclusion and diversity national group. We held an equity inclusion and diversity series for our leadership as well as a series specific to the LGBTQ community. We launched “Belong at KP”, a multiyear journey to advance the equity and inclusion vision for staff and establish an equitable care health outcomes advisory board, to build on our work to mitigate healthcare disparities and inequities with our patients. Nationally, we committed \$70 million to investments in grants and programs to support businesses owned by members of underrepresented groups. In terms of the Task Force, We have to continue to be intentional to make sure this is part of our work and clear in our mission.

Elizabeth Oseguera, CA Primary Care Association: In addition to what others have said, I want to highlight the importance of education outreach efforts. Given the COVID-19 pandemic and moving to virtual services, we are noticing patients are confused as to where they can access services and whether or not they are available, including mental health services. They are also confused about the COVID-19 coverage available to them. For example, there have been stories of community members going to a private provider and being charged for getting a COVID-19 test. I am wondering what we can do to better inform them about free testing sites? In addition, as we think through education outreach efforts, we need to be sensitive to languages used in communities and make sure that materials are available in multiple languages. As we have moved to a more virtual world and health centers are using more telehealth, the no show rates have dropped from double digits to single digits, which is great. However, there is a digital divide

and digital inequities. Many patients lack high speed internet access and smart phones. If they do have the smart phones, they may not have enough funding for the data needed for telehealth visits, or maybe there is no funding to put onto that cell phone for that day or month. Because of that, we would love to see the state help address this in a more intentional manner to put more resources to address this digital divide and inequity that has existed for decades. Regarding racial justice and equity, CPCA has created a work group on supporting Black communities that focuses on addressing their health needs. We created four goals at the organizational level to address internal biases and racism, remove barriers to health care access, improve education and outreach efforts to Black communities and support health equity for Black communities within five specific health areas, including Black maternal and infant health, cardiac and respiratory issues like asthma, lead testing and exposure, lowering cancer rates and mental health. We developed talking points for groups to use with members of the legislature and on social media. We created a webinar series to help organizations talk about and internal changes that need to be made to address unintended bias and racism within the organization.

Charles Bacchi, CA Association of Health Plans: We represent all of California's Knox Keene health plans that provide coverage to 26-27 million Californians. I want to offer my appreciation for the ability to hear from the other Behavioral Task Force members here at the beginning of the call. It confirms many of the things we are seeing, and I won't repeat those, but it's important to hear from each other about what is important to the diverse communities of California about COVID-19 impacts. We saw a huge reduction in medical services in March that has started to bounce back in the months that followed. That included big reductions in behavioral health treatment services being provided by our networks. Those have been increasing steadily, not only the transformation that we had planned to do administratively to handle the gigantic influx of telehealth services and resulting tele-health claims. And, we are also seeing very specific impacts, as reported here by many of the advocates. We have had increases in therapy sessions through telehealth and increases in crisis calls. And an increasing need for medication management since people are not getting out to receive their medication and an uptick in medication assisted therapy for those with substance abuse disorders. It has been challenging for us and our provider partners to make it all work. On racial inequity and injustice, I don't think any of us has the entire answer to solving that problem, but I know that our plans individually are supporting organizations that are working to address the issues. They are also conducting listening campaigns in the local communities to understand how, as health plans, they can better address it. It loops back to social determinants of health and the work many of us were doing in both Medicare and Medi-Cal. While it was wise to put the CalAIM work on hold due to COVID-19, we do need to get it started again because a lot of the things we are talking about there, whether related to behavioral health or health inequities, is important work. We look forward to starting that again.

Chris Stoner-Mertz, California Alliance of Child and Family Services: Others have highlighted the critical issues, including transitioning to telehealth for behavioral health services, that has been a huge lift for our providers. There is a real concern about the invisible youth who are completely disengaged, both from education and behavioral health. Many of our organizations are thinking about what is next in this pandemic and the lack of resources for marginalized and communities of color. What are we not seeing and what do we need to be prepared to manage after we are through the health crisis? Our organizations are also looking both inside and out as to how they can shift and change their work to be more responsive to those they serve. What do we need to do structurally, where do we need to look at our behavioral health systems or child welfare systems, at the implicit and explicit racism that is within our structures? And, we really have to look at how we are expanding access to Medi-Cal. There is a lot of effort on the national level to look at how we can get more FMAP financing to support efforts, particularly for children and youth. We need to look at where we pull resources and how the way that they are defined as a

medical model approach is leaving out populations that we need to be serving better.

Vitka Eisen, HealthRIGHT 360: Many of the clients we serve in the publicly funded substance use disorder treatment world live on the other side of the digital divide. They experience homelessness and are disproportionately people of color. Continuing treatment through COVID-19 has been challenging because it is a high touch field and creating relationships and connections with people is harder to do via telehealth. We are glad to have the opportunity to expand services to include telehealth, yet we are reaching a third fewer clients for outpatient services than normal. The residential side is incredibly challenging because the programs are dense congregant living environments. To manage the safety of staff and clients and keep the flow of clients coming in, while managing outbreaks, has been incredibly challenging. We need to make sure we are still seeing clients and not have to shut programs down. It is important to note that the number of people dying of overdoses in California has gone up. In San Francisco, more people have died of overdoses since March than have died from COVID-19. That is not to say that COVID-19, isn't critical, but it's also to put it in context that it doesn't stop the other things that we have to respond to.

In terms of our work around structural racism and anti- Black racism, it is really about the substance use disorder treatment world becoming overly entangled with the criminal justice system. As substance use was criminalized, that had a disproportionate effect on Black and Brown communities. We can draw a straight line from the drug laws of the 1970s to the deaths of George Floyd and Briana Taylor in terms of aggressive policing tactics and the degree to which the substance use treatment world had become reliant on drug courts or coercion to keep clients in treatment. We have to ask ourselves the question, how are we implicated in this in this work and what does it mean to become reliant on coercion? It is complicated, but if you become overly reliant on coercion, you never develop the creative muscle and innovation and the interventions that truly meet people where they are. The recent popular uprising in response to the murders of Black people by police has put us in the position of rethinking what it means to be coercive and what it means to truly meet clients where they are.

Jessica Cruz, NAMI CA: NAMI agrees with those who have spoken before. We have always fought for people living with serious mental illness and families with COVID. We have been advocating for increased PPE, increased service at the county level and the digital divide. Issues around board and care and within the criminal justice system have been top of mind with COVID. There has been more awareness around wellness and triggers. The heightened stress and anxiety, if not addressed, will result in more individuals needing higher levels of care. Our costs have increased 60%, primarily due to family members looking for resources and services. We continue to provide support groups and education to families impacted by mental illness.

Andy Imparato, Disability Rights CA: I will mention things not yet highlighted. We are concerned about the health and safety of people with mental health disabilities and other disabilities who are living in congregant settings during the pandemic. We are doing everything we can to get people out of unsafe settings. We appreciate there is a Task Force that reached out to us around criminal justice reform with the acknowledgment that people with disabilities are disproportionately showing up as victims of police violence. We are advocating that people with disabilities be at the table and we are concerned about co-morbidity of mental illness with other types other types of disabilities. For example, in the intellectual and developmental disability community, COVID has disrupted people's routines and is creating problems with isolation and depression. The capacity to respond in the context of the pandemic is not what it needs to be. We are also worried about the impact evictions will have on the mental health and general health and safety of people with disabilities if the moratorium expires. We just celebrated the 30th anniversary of the Americans with Disabilities Act. There is a conversation in the disability

movement about centering the voice of people with disabilities who are Black and also members of other disadvantaged communities and look at the intersection between disability and the other identities. This is long overdue conversation in the disability movement.

Tanja Heitman, Santa Barbara County Probation Department: I want to echo and affirm the importance of this discussion and the recognition that the disparities and racial inequities within the criminal justice system exist. As a result, we have an even greater responsibility right now to ensure our organization and others that serve the criminal justice population, focus on wellness and advocate for our clients who have already been victims of too many failed systems and policies. There is an urgency for us to focus on their access to housing, behavioral health, food, other basic necessities, employment, transportation, and healthcare. We are working to elevate their voices within the court process, as well as with partner agencies during this time. The virtual world is not always accessible and responsive to our clients. We are shifting resources towards re-entry to meet the challenges of those returning to our communities from prison and jail.

Sarah Arnquist, Beacon Health Options: With regard to racial equity, one major goal that is heightened now is to develop reporting capabilities that have the stratification to reveal where disparities exist so we can develop specific strategies to address the drivers and barriers. Telehealth has transformed the industry and how we think about access; how we think about connecting people to services. We have seen a 50 fold increase in telehealth services since the beginning of the year. We didn't see a decrease in the number of visits per individual because of the drop in the no show rates as access to services improved. We also saw that the preference for telephone-only is quite strong, partly because of barriers related to broadband access, but also due to the intimacy and confidentiality that phone-only brings to the conversation. We are working to collect provider information and display to the membership in our provider directory - who is offering telehealth of the 1,000 providers in California. A survey last month indicated 80% intend to continue to use telehealth as a modality after the pandemic. How do we display that accurately and how do we think about our network in new ways? We can now leverage language capabilities and specialty access across geographic boundaries in new ways and do that efficiently to meet member needs who don't speak English as their primary language and make sure telehealth is accessible for them, in the emails and texts to connect. We can put an ASL or language interpreter into the three way conversation via telehealth. There is still a need for in-person services, but it is exciting with this new competency to try to distribute services in new and better ways for members.

Emma Hoo, Pacific Business Group on Health: COVID impacts are varied among our members with some having to furlough 90% of their employees while others have been able to adapt to a work from home environment relatively quickly. Among companies that furloughed employees, we found an overwhelming majority continued the health benefits. There has been an investment in telehealth and digital mental health solutions to expand access, but also a focus on a policy perspective around payment parity that supports primary care and behavioral health providers in both the telehealth and telephonic environment. Some employers focus on employee resource groups to support families with young children as well as looking at upstream drivers of mental health and stress, like loneliness and social isolation that comes from the extended period of working from home. On the health equity side, there is a broad exploration of strategy to promote health equity in both medical and behavioral health services. One area is improving the collection of data by health plans and transmission of data that is captured by providers and enables better analysis of quality gaps and differences in treatment patterns. There are differences in preventive care and screening rates based on race and ethnicity, as well as gender differences. There are also approaches to cover the cost of contributions differentially for low income individuals to improve access to care for those individuals.

Carmela Coyle, California Hospital Association: First, the impact of COVID-19 on psychiatric hospitals is a real challenge for all of us. Psychiatric hospitals have had to implement social distancing, moving patients into single rooms and continue to provide care. We have fewer psychiatric hospital beds available at the same time our hospital emergency departments are overwhelmed addressing behavioral health challenges because of the issues we have been discussing this morning. We have a crisis brewing in terms of our ability to care for the impact of COVID-19. In a different direction, so many important things have been said but most certainly the current challenges that are in the spotlight - COVID-19, police brutality, racial injustice - widen the lens we should have as we consider how to improve behavioral health in California. And it widens that lens because there are even more people in need, and we have to address those needs even more carefully to ensure equity for all. I feel strongly that this does not change, but underscores, the purpose of this Task Force to improve behavioral health in California and to ensure high quality accessibility to behavioral health care. The behavioral health challenges are longstanding and they have been driven by many factors, serious mental illness, diseases of the brain, unemployment, homelessness, substance abuse, poverty, violence, and now we're piling on with the pandemic, police brutality and racial and other kinds of injustice.

Cathy Senderling McDonald, CA Welfare Directors Association: I think it's been extremely powerful to see the urgency that our members feel about addressing the disparities underlying the work. We are looking internally and thinking about how we make sure the work we are doing with our members and constituents, as well as internally with our own operations, are committed to addressing systemic racism. With this systemic opportunity to make a difference, we can all work together to think about behavioral health and what the opportunities are through this group. There is such an interconnection across child welfare, poverty, and other safety net programs. The individuals in those programs have existing underlying issues related to disparities and then layering on the COVID impacts, the recession that is deeper and different from other recessions. I hope we think about how to harness the power in this virtual room to make sure we bring all of the services, whether that is Medi-Cal, child welfare, or CalFresh. How do we use the opportunities when our members are connecting with those individuals to also talk about behavioral health, to talk about the issues that are being addressed now through the diversity equity and inclusion work and not miss the opportunity to make that connection. There is so much more work to be done and I am honored and optimistic that we can get things done together in this moment that could build a foundation for the future.

Seciah Aquino, Latino Coalition for a Healthy CA: I want to root our conversation today in a definition of racism offered by Professor David Williams at Harvard School of Public Health. *Racism is an organized system premises on the categorization and ranking of social groups into races and devalues, disempowers and differentially allocates, desirable, societal opportunities and resources to racial groups regarded as inferior. This leads to is prejudice, which comes from the development of negative attitudes and beliefs towards those racial groups, and differential treatment of members in these groups, which we call discrimination by both individuals and social institutions.*

As we take on this work, we need to think about systemic solutions and individual solutions. When we think about everything happening now, COVID-19, police brutality, the fires and exposure for farm workers, the burden that the Latino community is facing makes sense in the social determinants of health perspective. The Latino community has been systematically disenfranchised over the years. When we think about building a culture of health, where we live, our work, race, class, zip code and age, immigration status plays into how those burdens affect us. The Latino community is seeing the pandemic as a double burden. Not only are we overly represented in the number of cases and deaths, but also hardest hit by unemployment. I want to highlight the traumatic anti-immigrant rhetoric that the Latino community has been facing for a while because it connects to the behavioral health work here. Latinos faced anti-immigrant

rhetoric prior to COVID-19 and this year, the stress includes increased ICE raids and implementation of the public charge rule. The Latino community is blessed by having multigenerational homes, but also mixed status homes. So, when we think about the type of impact that the fears and the stress bring into families, everyone is impacted, from naturalized citizens to green card holders to the undocumented. We need to see immigration status as an increased risk factor that leads to behavioral health issues. And in terms of solutions, we need to think about access and affordability. For undocumented folks, behavioral health is not something they can afford if they want to put food on the table and their mental health and behavioral health needs will be second to keeping their families fed.

We need to think about provider diversity and cultural humility of those providing care. There are some studies that say the Latino adults in need of mental health care are less likely than non-Latino whites to access services. And when they do seek care, it is more likely to be poor quality. In thinking about the fears and the stress and the behavioral issues that are very pertinent to the Latino community, the provider needs to understand where those folks are coming from. I am very inspired by the conversation today. As we move forward, we need to be very intentional about talking about how disparities actually play out in daily life. I am hopeful that we will be able to come up with some great solutions together.

Linnea Koopmans, Local Health Plans of CA: We represent 16 local nonprofit health plans that cover 70% of beneficiaries enrolled in Medi-Cal managed care. These health plans are seeing increased utilization via telehealth consistent with what others are seeing. One thing to note is that the most frequent barrier with regard to telehealth services has been broadband access, particularly for beneficiaries in rural areas. I want to share that plans have been ensuring that members are aware of the resources available to them specifically around behavioral health during COVID. Not only the services that the plans provide, the non-specialty mental health services, but also preventive strategies and services, online resources to help with stress and loneliness, mental health hotlines, and getting creative with radio PSA or podcasts and presentations with their member advisory committees. They are also providing training and education for plan staff to ensure they are sensitive to potential mental health needs and aware of mental health resources available through the plan. We are looking at racial disparities and do not yet have complete data about how these last several months have impacted disparities. We are having conversations about how to move forward, what data we might need to understand disparities, and, how to address them. Really appreciate the conversation.

Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies: Our members represent mental health and substance use disorder clinics across the state. They mobilized quickly to provide care to the most vulnerable when the pandemic struck, but many of our agencies continue to struggle to keep the literal and the virtual doors open. They provide telehealth, which is helpful, but many populations like homeless individuals, older adults and folks in rural areas are still being seen in person. This is quite burdensome on the staff who have their own caregiving responsibilities at home. Burnout is beginning to surface. Also, tangible things, PPE is running out. As an association, we provide tens of thousands of dollars in grants to assist with telehealth, PPE equipment purchase, and some awards to provide services to special populations like veterans, immigrant populations and homeless. We are also looking inward, providing trainings to assist agency leaders to lead discussions about racism and race equity with their staff and we created a work group on equity to strategize about how we promote racial equity and how we impact structural racism by voting. We are weighing in on measures like Prop 16, understanding for ourselves and for our clients, the importance of registering for the census. That is some of the work we are doing and issues we are seeing.

Hector Ramirez, Disability Rights California: I am a consumer of the Los Angeles County Department of Mental Health. I serve on the board of directors of Disability Rights California and

the California Mental Health Planning Council, as well as being an Access Ambassador. I am hearing from my peers and my community more conversation about suicidality and suicide attempts, especially among youth. This is paradoxical because the data that the County is reporting is indicating lower cases. Similarly, we are talking about instances of domestic violence, and a rise in substance use or self-medication. I hear from my peers, both at the county and state level that there is a problem accessing mental health services. Some are utilizing remote telehealth care for the first time and do not have the equipment or staff that know how to utilize it. We have reports that some trying to get housing, especially homeless and shelter folks, experience disability discrimination in accessing emergency services. Similarly, we see Latinx and Native American communities experiencing disparities in accessing health services. We have a longstanding history of trying to deal with some of these issues and now more than ever, they have become almost erased from the list of priorities of things to be done. This is horrible, given the fact that they are the ones working in the fields, picking the food we eat, driving the buses, cleaning the house, working at the markets. And yet the services that we get are often times the result of advocacy work. Before COVID-19, one out of five people had a mental condition, and nowadays I don't know of one single person who has not experienced anguish, grief, and despair, so that number is significantly higher. And we see stories everywhere that accessing services has been difficult, especially mental health. For people with disabilities trying to get accommodations, we are at a disadvantage. There is a need for a more structured articulation from the state to make sure that services are accessible. I did have two people in my family pass from COVID-19, and that was hard, but we also had five other people in my family test positive and who recovered but developed additional mental impairment. There is discrimination for those people who have survived and difficulty accessing services.

I think there is a lack of focus in the funding for what the needs are needed in the community. I think our priority is Native American, Latinx, and Black communities. LA county passed a measure specifically for Latinx and Black mental health services because unfortunately there is a lack of appreciation or understanding of the needs of those communities and they are trying to provide guidance. We need that at the state level. We need mandates to ensure people with disabilities have access. We need to ensure the Native American, Latinx, and Black communities have access to the needed services right now.

Michelle Doty Cabrera, County Behavioral Health Directors Association of California: The County behavioral health directors are responsible for running the behavioral health safety net for individuals with serious mental illness, individuals who need substance use disorder services, as well as the behavioral health benefits under EPSDT. Inside and outside of Medi-Cal, counties are the safety net for individuals without insurance and for individuals who, for a variety of reasons, are underserved with private commercial coverage. Initially counties were trying to take the pressure off of hospitals and emergency departments. Issues are now coming to the fore of increased numbers of individuals who are COVID positive and need inpatient levels of care, and really the rules, the very rules that we have put into place to try to protect individuals in congregant and residential settings throughout the continuum have resulted in significant bottlenecks while we are dealing with COVID outbreaks at those levels of care. Counties have also been supporting jail and prison inmate releases by providing mental health and substance use disorder recovery services to those individuals when they transition back to communities. We are working to improve channels of communication and thinking about the rebalanced role of the behavioral health safety net as we move individuals back into community. Counties are also supporting Project Room Key and Home Key sites by co-locating and delivering onsite services for individuals experiencing homelessness. All of this has been done with no additional funding specific to these COVID efforts. Like other parts of the delivery system, we have shifted to telehealth, however in-person services within County behavioral health did not shut down.

Field work is still happening, and this has put an incredible strain on frontline workers who often

are not prioritized for PPE. Our revenue streams were hit particularly hard; MHSA revenue is down by 60%, and while we were extremely grateful to the administration for the realignment backfill, even if the federal relief comes through, it will bridge about a quarter of our \$1 billion losses. We are now putting around \$115 billion into Medi-Cal, and this multi-system behavioral health safety net will be around \$8 billion by comparison. We are a key part of the state's recovery with any disaster - behavioral health services are often the first responders, and we are often the last to leave a year or more after the disaster dust has settled. There will be longstanding impacts on behavioral health, which are compounded with longstanding racial injustice. We very much want to continue the work with CalAIM. With respect to health equity, there is a long history of work within the County behavioral health safety net, going back at least to 1994, for us to engage clients and community members in looking at racial and ethnic and other types of disparities. It is really important to look at some of the work that has been done there to center client voices, not just input about services, but looking at what counts as an appropriate intervention. Medi-Cal is extremely important, but it will not pay for everything. The services outside of Medi-Cal, such as MHSA, are really crucial to meeting the equity goals we all share and support. Some of the special populations you are looking at for the Task Force, individuals experiencing homelessness, children, and youth, as well as justice involved populations. In addition to individuals with disabilities, our older adult population is especially impacted in this moment. The usual community support and social interaction that helps folks aging in place and aging well is really being strained. And telehealth is not the silver bullet solution for that population and for others. We are evaluating where telehealth does work, but in other cases it may not be appropriate or sustainable and is not a substitute for the in person types of services. We need a comprehensive statewide strategy and partnership for investing in workforce diversity, provider capacity, access to housing supports and services as well as housing itself. When we are looking to divert, whether it is from our emergency departments or incarceration settings, we need to align as a community to look at mental health and substance use disorder needs. Are we invested as a state? Do our investments reflect the prioritization that we want to see in terms of our behavioral health safety net?

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: I think most folks in this discussion believe that behavioral health services are an essential health service, just like the hospital down the street. But we are not always treated in that fashion. We have to look at our policies and standards in residential settings. Public health shuts your doors when you get to positive case three and I don't understand that approach if we are essential healthcare providers. I believe we lack good disaster planning in the behavioral health field. Most regulations for licensing and certification of behavioral health services, not hospital-based, lack requirements around disaster planning. I think we need to look at this and develop standards for providers. Providers were not prepared to respond to disaster is one of the things that clearly came to light. Our bifurcated system, where mild to moderate is handled by the plans and most everything else goes to the counties, and all substance use goes to the counties, has surfaced as a more significant problem, as a result of COVID, than any of us saw before. The sooner the CalAIM discussion starts again, the better because we have some things to fix.

Sonya Aadam, California Black Women's Health Project: I appreciate that the space has been open, but it does feel pressured to hurry up and get back to the regular agenda. Everyone has delivered incredibly important comments. Thank you for giving the space for this to be done. I would even have hoped that the agenda might have only covered this issue, given how important it is. Although I know that there are administrative and operational things that need to continue so maybe a separate meeting could have been set to continue with a normal meeting agenda. On the question of, how can we address racial equity, justice, and disparities in our work, almost every person mentioned the issues of race equity and disparities. There are active sentiments about its impact on how behavioral health care and mental health care is delivered in the state. I

noticed in the mission, objectives, vision, and values created by the Task Force that equity, justice, disparities, race - none of those words are in that draft document. I hope that now we have seen these issues that have plagued us as a state and a nation for so long, we will take that bold step and have the courage to include an anti-racism and disparities lens to the work of this Task Force. And even though there is a focus on children, homelessness and incarceration, it seems like the ghost we are looking at is racial and ethnic and other types of disparities. By not mentioning it, by not being specific about it, we are doing a disservice to ethnic and marginalized populations, LGBTQ, and populations experiencing multiple issues. I would ask that we take this bold step back and think of ways to be intentional about including diversity, equity, and inclusion into the work of the Task Force. A number of organizations drafted a letter to the Governor asking him to issue an Executive Order declaring racism as a public health issue. And I want to elevate the California Reducing Disparities Project. This is an example where the state has made a sizable investment, but considerably more could be done. It is showing significant progress and it highlights the need for community defined evidence practices. There are practices taking place within communities to reach out, support and uplift from a prevention and early intervention standpoint. We can harness resources to be able to serve these populations. I appreciate everything I have heard and look forward to the work that we can all do together.

Reassessment of Behavioral Health Task Force Mission and Objectives Based on Changes in the Environment

John Connolly introduced the discussion and referenced the changed circumstances since the inception of the Task Force. We are now in an era of COVID, with a recession that is the deepest since the great depression, and a time of meaningful inflection points related to anti-racism. He directed members to the red-lined Task Force mission and objectives document sent with meeting materials as the basis for this agenda item. Revisions in the document based on individual conversations with members include:

- Mission Statement: substitute wording of consumers for patients.
- New Item 3: Determine what data exist to better identify and report racial and ethnic disparities and inequities, and identify strategies to eliminate disparities in service access, quality, and outcomes.
- Item 6 – now #7: Add Medi-Cal to the language to read: Determine how the State can better support improved access to and quality of behavioral health services for people with private health insurance and Medi-Cal coverage. These efforts include reviewing enforcement of federal and state parity laws and timely access standards.

Member Comments on Mission and Objectives

- Include in the mission statement: addressing health disparities as well as racial equity and social justice.
- Add a safety component for people with disabilities.
- in objective #6 – now #7: the focus on insurance models takes us away from what is effective and unique in the bio-psychosocial model of behavioral health. What is often needed is not covered by insurance. Is there a way to broaden the language to be more inclusive of non-insurance forms of providing services?

- Frustration was shared with the specific focuses on children, people experiencing risk of homelessness and people with criminal justice involvement. At the previous meeting, there was conversation about the limiting scope of that focus, particularly when the underlying issues are poverty and other types of oppression. There was such a robust conversation last time about the importance of addressing root causes. To see it is still not in the statement and that the committees are structured so that a member is only on one committee puts folks who serve marginalized communities in a painful place. There are trans people in the children and foster system; lying on the streets unhoused and at-risk for homelessness and disproportionately represented in the criminal justice system.
- Bobbie Wunsch suggested that the comments related to root causes can be added in the mission statement.
- John Connolly responded that there was a diversity of opinions during the last meeting and in individual conversations about the three groups. Our thinking is that we need to focus on these three groups that have particular vulnerability, and within that work address intersectional topics. For example, youth would include education and child welfare. Justice and homelessness will also require a cross sector approach. The intention is to think through the specific challenges of those groups, to dive into the complexities and the needs of those groups. This does not mean doing this without a lens that explicitly looks at racism and poverty and inequity, but hopefully to solve some of the system problems that are particular to them. Also, without providing sub-groups, it is difficult with a large and diverse group identify specific action points. There were concerns that the Task Force would not make progress as a full group. The groups are to provide a focus by offering the three groups, but I appreciate the feedback and we are open to more conversation about how we speak to the issues and concerns you raised.
- Appreciate the need to streamline, however it is a challenge that these three issues are highlighted without a focus on services to reduce disparities. There should be explicit language related to racial, ethnic and LGBTQ communities, for example. I would suggest using an anti-racism lens. I would add language on reducing disparities for underserved populations into #1 and #5 and consider adding community defined practices.
- Suggestion to leave the three population groups for the committees out of the mission but focus on them in the scope of work and the work plan.
- Suggestion to add in objective #4 that we need to build a diverse behavioral health workforce. Also, in objective #6, where can we improve a culturally competent access to and quality of behavioral health services and add cultural dynamics.
- A call-out to the rights and dignity and choices of people living with mental illness is needed somewhere in the objectives.
- In objective #2: highlight data that is not currently being collected but would be useful if the state would start to collect it.
- Helpful to add words such as equity into the mission because that is really our goal here. For objective #1, reference an equity lens.
- Add something in terms of reducing disparities for underserved populations.

- In objective #6, the integration objective, add other sectors; more broadly than just medical insurance. Think about integration with social services and other departments where children and adults are served.
- There are Californians with neither private insurance nor Medi-Cal. I would recommend that the focus be, all Californians have access to care with particular emphasis on the disparities issue. I want to point out that the statements use the language of behavioral health, but as discussed earlier, sometimes we endorse that language and don't recognize the gaps between the mental health system and addiction coverage. Consistent with the comments about outcomes and integrated care, looking at social services, and highlighting what it is we are actually trying to accomplish in terms of improving access to behavioral health services. Do we really mean mental health and addiction coverage?
- Add: increasing and maintaining meaningful stakeholder engagement throughout the work.
- In objective #1, the issue of mental health parity needs to be highlighted because of comorbidity across physical health and behavioral health. The need for parity in both Medi-Cal, as well as private insurance, is a major concern.
- Bobbie Wunsch suggested members submit any additional input in writing over the next 10 days in order to have a revised version, reflective of both the hopes of Health and Human Services as well as the members in advance of the December meeting.
- John Connolly commented that the feedback is helpful and very thoughtful. This is why we put this on the agenda. We want the document to reflect the advice and input of you all. I am glad to take the document and revise it.

DHCS Presentation of CalHOPE

Due to time constraints, this item will be postponed to the December meeting agenda.

Task Force Work Plan Proposal

John Connolly reviewed the proposed three committees and timeline. He reviewed the process for next steps. Members will be asked to select a number one, two, and three choice for a committee assignment. CHHS will select co-chairs for each committee. The plan for now is that one of the committees will focus on issues of homelessness and people experiencing homelessness. One committee will be on people involved, or at risk of being involved, in the criminal justice system. The third committee will be youth, youth who are vulnerable or at risk, and foster youth. There will be six committee meetings between now and May of 2021. This means two meetings in between each Task Force meeting; two meetings between now and December and then before the March and the May Task Force meetings.

Phase one is the environmental scan and identifying outcomes we hope to see - a really important piece of our work. What outcomes are we striving for? What things do we want to change? Committees will come to the Task Force meeting with a set of recommendations about phase one deliverables, including the content for the environmental scan and the outcomes.

- October - November 2020: Phase 1 will include recommendations on the environmental scan and outcomes to discuss in December Task Force meeting. There will be town hall input on the outcomes.

- January – February 2021: Phase 2 work in committees will address prevention and access to services, timely access to services and develop recommendations for the March 2021 Task Force meeting.
- April-May 2021 Phase 3 work is to develop recommendations on quality of care and recommendations related to multi system integration for consideration at the June 2021 Task Force meeting. Thinking broadly, not just about integrating behavioral health services, but meaningfully and effectively integrating across the healthcare system by engaging other specialty care and primary care. This is also thinking about partners in social services, child, welfare education, criminal justice partners.
- September 2021: CHHS and consultants will develop a draft report for review by September 2021 followed by town hall meetings and public comment
- February 2022: Final draft of recommendations.

Member Comments

- Do you have thoughts about how CalAIM will be incorporated here? The same populations are a focus there and the timeline will overlap with the start-up of CalAIM.
- John Connolly: There are a variety of different convenings that are more narrowly focused. Our idea for this Task Force is to create a roadmap that incorporates that work. Many of you are participating in different bodies and committees and task forces, and we hope that you will bring those conversations to this plan. Certainly, whatever is in CalAIM when we resume work and is eventually submitted to CMS for approval will influence the work of what we do here, but we also want to consider what's going on in the privately purchased insurance space.
- Additional comments can be sent in by email.

Public Comment

Stacey Hiramoto, Racial and Ethnic Mental Health Disparities Coalition: I want to thank you for a very robust and organized meeting. Especially appreciate the facilitator and the order that she chose for people to speak. I would like to echo and support the comments of Sonya Adam regarding the mission statement. I will submit in writing, but I do think it needs to be specified that reducing disparities for people from racial, ethnic, and LGBTQ communities, as well as immigrant and refugee communities, should be explicit. If we do not prioritize or focus on these communities now after COVID and Black Lives Matters have so desperately illustrated the need to reduce disparities, then I don't know when. In the number five objective, I think you should specifically talk about community defined evidence practices that are often preferred and more effective for people from racial, ethnic, and LGBTQ communities. Thank you so much.

Lilyane Glamben, ONTRACK Programming Resources: For those of you who were at the first meeting, you will remember perhaps that I got up in the public comment and called you all out for not having any Black representation on the Task Force. And I was a little crisp about it. And now you may understand why, because Sonya Adam was one of the two individuals I reached out to. Look at the treasure that you have now in your midst. And if you can appreciate that a year ago, listen to me now about this. And if you can get ahead of this, it might make a difference. No one is tracking what is happening to Black and other people of color during COVID in terms of their treatment. Those who were already in the system. I saw that the Steinberg Institute, CBHDA, sent out letters about the funding impacts of COVID like lightning. I have yet to hear the

rain around who are those individuals not being served that created that precipitous drop in revenue. And is there disproportionality in that? And if so, what is being done about that? And that is in terms of those who have already been in the system, and we know folks were already underserved or inappropriately served. And what are we going to do about that? I recommend that there be, with urgency, a taskforce that is appointed to address this specific issue, I would say it could be with all the different groups, but from an African American perspective, I promise you, there are many individuals who feel this way and it would be valuable to address this. We hear about the kinds of crises that happened while people are in lockdown and the atrocities happening behind closed doors. I would suggest that this is urgent.

Nicole Bueno, Bay Area Community Health: I want to concur with two of the topics of discussion. The entire discussion has been very wonderful. I want to applaud the plan and I was pleased to hear John talk about how the broader plan includes looking at the integration to include and reach out to other fields of discipline, including the educational field. And along with that, I think to reduce the inequity of behavioral health services and access to care, integration is what can we do as a discipline, but also what can you do in terms of recruiting a diverse and bilingual workforce? I can say that, especially since COVID, our agency and others have seen an exacerbation in the inequity of access to care based on a lack of bilingual behavioral health providers who are doing the work. The second thing is that I want to concur and appreciate John's feedback to take a look at objective number six. One thing that has become more prominent is a higher demand of services from uninsured persons. It would create more of disparity if the uninsured are not included. I know it's a huge task, but it's exciting.

Steve Leoni: I want to make the point that we talk about having equal access in disparities conversations, and that is absolutely true, but that is often thought of access to the front door. And I want to say that we need to have equal access to outcomes. I am asking that the word access in terms of the front door not be so dominant in the discussions. Using the word access, access to the front door, access to equal respect and access to equal outcomes and wanting to make quick comments brought up by what Mandy said. If you are an advocate versus a person representing an agency or a clinical or administrative position, it is often much harder to pick which issue you will be on. The advocates may need to be on more than one committee - if we can make space for that - because it's much harder as an advocate.

Hellan Dowden, Teachers for Healthy Kids: I have a question based on the comment from the Fresno Unified member. Is training available for community based providers through DHCS, as COVID mental health funds? Are school-based providers covered by these funds, even though schools provide access to families through distance learning, to the internet and equipment. So can this help families get services? Could you let us know how could this be remedied so that schools can get access to training funds for their school based provider?

Bobbie Wunsch: Thank you, Hellan. We won't be able to answer the question today, but we will make sure that the committee on children talks about this issue.

Josephina Alvarado, Safe Passages: I wanted to speak on behalf of Safe Passages, and on behalf of the 35 community based organizations that are part of the California Reducing Disparities Project. As data clearly illustrates in California and across the country, the COVID-19 threat to people of color and to the LGBTQ communities is urgent and deadly. And yet the name of the pandemic does not appear in the objectives for this committee, the intersection of the educational, economic, and health disparities and the brutality of the criminal justice system

historically experienced by people of color and the LGBTQ community are fertile ground for the devastating consequences of the pandemic and disproportionate rates of Black and Brown unemployment, homelessness, hospitalization and mortality. The mental health impact of COVID-19 is acute and far reaching and decades of data demonstrate that clinical mental health strategies will not address the urgent needs of our populations. We cannot continue to invest in the same strategy and expect a different result. We must do different. We are experiencing a tsunami of negative health impacts and threats. Life has changed and will continue to change, but the disparities will not. We share responsibility for reversing this trajectory. We must demand an urgent focus on solutions that disrupt structural racism within the mental health system and create a structural space for community defined evidence based practices that recognize the need for self-determination for consumers and families of mental health prevention and intervention services. I'm imploring this committee and the rest of the state to leverage the infrastructure of the California Reducing Disparities Project. We must build on the existing infrastructure, if we are to meet the challenge and relieve the suffering that we are experiencing within our communities. We cannot do any less.

Chhs.ca.gov also accepts written comments.

Closing Comments

John Connolly thanked members and the public for their comments and input, especially that racism needs to be more present in this body, the recommendations and the outcomes. The committee structure and work plan are drafts and we are glad to take feedback on antiracism and inequity in the system and outcomes for the individual we serve. I look forward to working with you to incorporate that and in the work of the Task Force ahead.