CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
Behavioral Health Task Force (BHTF)
March 9, 2021
ACTIVITY SUMMARY

Purpose: COVID-19 and historic on-going racial trauma have deeply impacted the mental health and wellbeing of Californians across the lifespan – most notably in underserved communities with a majority of Black, Indigenous and People of Color (BIPOC) as residents, as well as, vulnerable populations including individuals experiencing homeless, the justice involved and system involved youth. The primary purpose of the first quarterly meeting of the Behavioral Health Taskforce (BHTF) in 2021 was for members to share their experiences and insights regarding how COVID-19 and society's racial reckoning have impacted the behavioral health (BH) of Californians, how that impact can be mitigated and how lessons learned should be applied going forward. The last 14+ months have illustrated substantial gaps in the behavioral health system, clarifying that issues to prioritize must be grounded in aggressively reducing disparities and seeking equity in system delivery and design.

Background: Each of the 30 taskforce members was given a 4 question survey to complete prior to the meeting. The majority did so with 16 surveys submitted, as well as completed surveys from the California Department of Education, the Department of Aging, the Department of Rehabilitation and the Council on Criminal Justice and Behavioral Health. During the meeting taskforce members and participating departments broken into 3 facilitated workgroups with the instruction to now complete the survey questions as a group and identify areas of consensus and priority. Participating public members were encouraged to also complete and submit the survey questions. 4 public surveys were submitted. The following is a summary of all three groups of surveys. In the spirit of transparency and efficiency, this summary attempts to thoroughly represent the perspectives of all respondents, but not repeat similar concepts or comments.

Question: List by priority up to 3 challenges to the availability of behavioral health services due to the COVID-19 pandemic and resulting fiscal and social impacts.

Common Themes: Lack of access, equity and coordinated/integrated care contributes to poor outcomes, especially for marginalized groups

- Lack of disability accommodations to access information, services, and engagement.

- Service capacity and workforce cannot meet the demand for mental health (MH) and substance use disorder (SUD) services broadly, but especially for

underserved populations across the lifespan. COVD-19 caused increased demand with reduced capacity.

- Emergency surge planning did not factor in the needs of COVID+ patients with acute psychiatric conditions needing inpatient hospitalization resulting in reduced capacity at these hospitals due to the need to isolate and social distance individuals being served.

- Individuals placed on LPS 5150, involuntary holds were not redirected away from hospital emergency departments resulting in longer stays in EDs and potential exposure risks.

- There is not a reliable resource list (by county) of available services for individuals in a behavioral health crisis resulting in delayed care for these individuals.

- Lack of integration between the traditional health care system and community defined behavioral health support services reduced access.

- COVID-19 disproportionally affected communities with less income. These communities already have reduced access to healthcare and behavioral health services, compounding an existing crisis further.

- Availability of employment services, as an integral component of behavioral health services, is not consistently available throughout the state, leading to ongoing poverty, continuing to exacerbate behavioral health challenges.

- Many people needing services don't know how to access them or traditional access points have been disrupted. Typical referrals, such as those coming from schools or victims services, are not occurring.

- For the justice-involved population, being released early from jail resulted in an extremely short or nonexistent amount of time to screen individuals for behavioral health needs. For releases from prison there was a lack of time to complete Medi-Cal enrollment, resulting in delayed access to medically necessary behavioral health care.

- COVID-19 exposed an under resourced behavioral health emergency response system. With all healthcare and social welfare systems being stretched (i.e. quarantined workforce, lack of testing and PPE) during the pandemic, behavioral health was often left out of getting relief. If relief was provided, ethnic and culturally specific community-based organizations (CBO) did not get as much as county systems. Timely assessments were problematic, and increased need for crisis care created a bottle neck effect leading to patients staying in inappropriate levels of care because there was nowhere to transition.

- Schools and other community providers should be better supported to play a critical role in preventing crisis and responding to needs. Making schools a hub of resources and using other community locations will help with prevention of disease and improve collaborative care in communities. Looking at *Children Now* survey data, only 50% of kids feel safe at school so there must be other check points in the community for these students. The integration of multiple systems will support addressing the biopsychosocial needs of people in all age groups and diverse populations with behavioral health problems.

- Bureaucratic obstacles resulted due to the structure of contracts. Providers are limited to engagement strategies that create challenges to being responsive to the recent changes due to COVID-19. Some of limitations are due to federal law but as a reimbursement based system, the public system is less responsive to urgent emerging needs and this is a distinction from the commercial system.

- Telehealth has limitations and inequities, in particular for underserved populations who have less access to broadband and proper equipment.

- Telehealth for substance use disorders is challenging given how much treatment models use social interventions and supports.

- The digital divide leads to social isolation and resulting mental health symptoms. Data shows that seniors are not accessing telehealth services at rates similar to those under the age of 64. For kids telehealth presents a different challenge, as the ability to benefit from telehealth services overtime is not as effective as it is for adults.

- There is a lot to address as it relates to the digital divide. Hardware issues, connectivity issues, privacy issues and lack of the experience and knowledge necessary to navigate digital resources. In some cases in digital deserts with no access, they have to set up telehealth remote locations and transported people to these locations as well as put devices in people hands, but this will not always work. It can be difficult to reach these populations even by phone in their homes to offer telehealth services. For persons with psychiatric illness and cognitive impairment it is even more challenging.

- COVID-19 and the public health emergency (PHE) amplified the (1) existing limited availability of older adult specific behavioral health services in the public mental health system, aging and social service organizations, skilled nursing and residential facilities, and the private sector to meet the need; and the (2) gaps in coordinated/integrated service delivery systems to address in a holistic way the behavioral health, physical health, and social service needs of older adults and their family caregivers.

Question: List by priority up to 3 significant challenges to increasing equity in access to and quality of behavioral health services for diverse constituencies.

Common Themes: Workforce is deficient in diversity and not culturally and linguistically proficient, must build trust with communities and provide resources for the types of interventions and services desired

- One of the biggest equity challenges in BH is the lack of exposure to a civil rights/social justice paradigm for thinking about mental health and recovery.

- For individuals with disabilities, access to quality, fully accessible in person behavioral health services and supports are dependent upon availability of safe and reliable transportation.

- Lack of enforcement and application of accessibility accommodations to ensure that people are not being left out of services and engagement opportunities at the city, county, and state level.

- California needs a state level peer/stakeholder body to support stakeholder (beneficiaries) in equal engagement/education/empowerment.

- Crisis services should be readily available in all communities, operated by local trusted entities.

- The lack of alternatives to police responding to people in mental health crisis is disproportionally negatively impacting BIPOC and other marginalized groups

- There is stigma towards seeking care but also distrust of the BH system to appropriately care for diverse communities.

- Lack of in-person outreach events made it difficult to engage diverse communities. Need more targeted community outreach to populations with greatest disparities with a focus on prevention and early intervention (PEI).

- BH system is not aligned (i.e. funding, facilities, staffing, use of the medical model) with the way communities want to receive care.

- There is inadequate cultural proficiency and knowledge of equitable policies and practices across the BH delivery system.

- There are several structural barriers to equity including inherent racial and social inequities in housing policies and the criminalization of substance use and mental illness.

- BH equity is subjective based on county, leading to a lack of consistency across the system. There is a need to clearly define what we mean by equity.

- Commercial Plans and Managed Care Plans are also responsible for delivering

services and should be part of the conversation on defining what equity means and charting a path to get there.

- County MHPs and MCPs should be incentivized to increase outreach and engagement of the hard to reach populations.

- Local successful efforts/programs should be broadly shared across the state.

- The existing workforce does not reflect the diversity of California, have the language capacity or skills to engage and serve disenfranchised groups - BIPOC, LGBTQ+, justice-involved, the disabled, etc.

- There is a lack of data on diversity ranging from race, age, sexual orientation/ gender identity/expression (SOGIE) to information regarding service type, intensity and outcome. Consistent methodologies for measuring all of these, with quality measures, is needed to track and assess the equity of care delivered.

- Trusted partners/cultural brokers are needed. State and county partners don't typically have those relationships. Institutions need to strengthen their skills in listening to the community. Additional information/training/strategies are needed so public agencies can work to build trust with communities.

- Power-sharing is needed to increase trust. Resource development should mean more deference to trusted community leaders.

- At the beginning of the pandemic resources were rolled out but they were not tailored or framed to specific communities (e.g. by language or trust level). Lack of awareness on what resources are available and information not coming from trusted entities made it difficult to reach these communities.

- For services relying on protective factors like social cohesion, it was a difficult transition moving into an online environment. The integrity of the services was brought in question. Further exploration is needed to understand what worked and did not work in this transition.

- There is not enough diversity in leadership and decision-making bodies. Lack of equitable representation from stakeholders representing people with lived experience from Black, Latino, Native American, Disabled, LGBTQ+, TAY, and systems impacted communities in bodies such as the Mental Health Services Oversight and Accountability (MHSOAC), county mental health commissions and behavioral health boards further entrenches disparities.

- The surrounding systematic racism perpetuating inequities were in place before COVID-19. There is a need to talk about the redistribution of resources to address inequities. A lot of discussion around this topic is theoretical, it needs to be more practical in order to make substantial change.

- Funding for research and evaluation of community-defined practices should be on-going to result in tangible change from the lessons we learn.

- Cultural competency is the most basic requirement, we need proficiency. Providers should learn how racism impacts behavioral health. Currently providers are not equipped to handle these nuances within their communities. The BH workforce should get ready to effectively address racism related trauma and other forms of trauma.

Question: Provide a few examples of actions that can be taken immediately to address challenges identified in #2 and #3.

Common Themes: Sustainably invest in the capacity and infrastructure of the behavioral health system to achieve equity from workforce to integrated community-based approaches to care that are culturally responsive.

- Immediately invest in the workforce - train primary care physicians on BH screening, contract with CBO's to function as cultural translators providing warm referral and handoff, expand debt and loan forgiveness to support workforce development for people who otherwise couldn't enter the field, expedite the certification and deployment of peer support specialists, and develop retention policies focused on building diversity.

- More training is needed to strengthen the behavioral health workforce to engage and serve justice-involved beneficiaries. Examples include, use of peers to support engagement and treatment adherence (e.g., Forensic Peer Support Specialists); ensuring providers understand the impact of trauma (past trauma, trauma from incarceration, trauma of re-entering after lengthy incarceration); co-addressing criminogenic needs (what they are and how to work with justice system partners such a probation and parole via Collaborative Case Planning); and how to connect individuals to, and work with, other service providers to ensure basic needs can be met (food, clothing, housing).

- Explore policies that allow for reciprocity between California and other states to allow licensed practitioners from other states to practice in CA without having to go through the extensive training, experience and other requirements unique to CA.

- Provide more flexible funding for the training of current front line service providers on emerging issues like violence prevention and racial trauma.

- Build a diverse workforce skilled to work in settings across the BH continuum, and capable of coordinating with systems – education, social welfare, public safety, aging services, health care, etc.Providing behavioral health training

across systems can promote coordination and collaboration in behavioral health service delivery and enhance holistic care.

- If there were an adequate diverse workforce, including linguistic capacities, more unique outreach could be designed to reach those active in their SUD who may have a moment of clarity and are open to treatment.

- Future emergency disaster planning needs to factor in the population with psychiatric conditions needing both acute inpatient and LPS 5150 screening.

- State departments (DDS, DHCS, CDPH, DSS, DSH, CDCR) involved in the field of behavioral health should be engaged in planning for the needs of individuals/providers serving these beneficiaries/consumers during the pandemic.

- Increase housing options across the board from rental assistance to permanent supportive housing to more affordable housing. Ensure that individuals with BH challenges are getting access to assistance with eviction protections and legal counsel.

- Prioritize individuals with mental illness and substance use disorders for vaccines who are at disproportionally high-risk for death or adverse health impacts due to COVID-19.

- Develop more psychiatric residential care for adolescents. It is not uncommon for youth in juvenile hall to spend the entire 72 hours of their hold waiting for bed availability. Prioritize ensuring that youth who are in need of behavioral health care have access to quality care when needed and are not left in detention inappropriately due to a lack of behavioral health/psychiatric options.

- Explore strategies to waive/ remove the federal exclusion of Medicaid in juvenile and adult detention facilities for individuals who need behavioral health care, especially continuity of care to support diversion and successful reentry.

- Increase contracting flexibility to ensure Medicated Assisted Treatment (MAT) programs can be successfully administered in all communities.

- Increase training, funding and expectations for behavioral health assessments for every individual to be conducted within 24 hours of booking into jails or juvenile halls and require discharge plans that address identified needs.

- Capitalize on the heightened interest and concern about mental health and substance use disorders with the widespread use of "mental health first aid" training. This is an important opportunity to educate and mobilize.

- Sustain and expand current flexibilities to ease the delivery of care, address reimbursement issues with telehealth, and invest in strategies to shrink the digital divide, including accessibility of services.

- Educate Local Educational Agencies (LEAs) about strategies to integrate care models within current school structures, such as the State Attendance Review

Board, AB 2083 - Foster Youth Coordinators, Homeless youth populations, alternative education, multi-tiered system of services and special education.

- Allow for digital BH technologies to be counted as cost of care and not administrative expenses. For Medi-Cal health plans, this would enable digital care extenders to be counted in the rate setting process. Most digital technologies today do not lend themselves to traditional fee for service reimbursement. Digital health expenditures should be treated similar to quality improvement activities in the medical loss ratio calculation.

- There are too many "one-time" funding initiatives in behavioral health rather than sustained investments. Proposals in the state budget for BH infrastructure and student mental health are examples of issues/areas that need on-going state support.

- Target outreach, through funding and initiatives, to enroll low-income and BIPOC populations in Medi-Cal or Covered CA.

- Increase collaboration across all community systems and providers. Peers/ promotores can assist with navigating across systems and provide informal and more formalized treatment options.

- Sustain support for the California Reducing Disparities Project (CRDP) and dedicate resources to address disparities with culturally appropriate services, and fund community-defined practices.

- Support a statewide public information and stigma reduction campaign paired with culturally responsive outreach efforts to engage individuals in services. Utilize/build on the recommendations in the "California Strategic Plan on Reducing Mental Health Stigma and Discrimination" targeting all age groups and diverse populations.

- Use quantifiable outcomes to measure equity and reduce disparities (provide incentives and enforce sanctions).

- Strengthen relationships between BH providers and Continuums of Care (COC)s that are the gatekeepers to many housing services and supports. Help each system have a better understanding of each other and the sensitive needs of the BH population, especially those with complex vulnerabilities like justice system involvement.

- Better utilize pharmacists who could do more to reduce disparities as they are "neighbors in the neighborhood" and have relationships with their community members. Pharmacists can provide behavioral health screenings and support Whole Person Care.

Question: Provide one example of an immediate action that can be taken to meet the moment for behavioral health in each of the following areas:

Prevention and Early Intervention Across the Lifespan
- Utilize managed care to incentivize more access to BH and promote service utilization
- Provide plan/provider incentives to increase prevention and early intervention utilization for plan members or fee-for-service (FFS) beneficiaries
- Expand the array of PEI services that can be claimed within Medi-Cal
- Enforce mental health parity
- Start Adverse Childhood Experience Screenings (ACES) with new parents and pregnant individuals and tie to trauma-informed parenting
- Address maternal mental health (MMH) care similar to the current proposed bill to create a psychiatric consultation system for MMH
- Improve access to SUD services especially for youth, increase harm reduction approaches, increase funding for SUD services and contingency management, and address the rising rates of methamphetamine use
- Create and fund a toll free 24-hour question line that has access to both facts and treatment avenues for those with SUD related questions and needs. Use a triage model similar to how crisis calls are handled where one set of responders handles crisis and the other more routine/informational inquiries
- Leverage First Episode / Early Psychosis efforts to identify youth who are at risk of or diagnosed with schizophrenia, bipolar disorder and schizoaffective disorder and establish a high-quality standard of care, and ideally prevent potential substance use disorder conditions, at onset and into adulthood.
- Fund needed telehealth equipment, increase internet access especially broadband, and support individuals to effectively use equipment to access services
- Double down on suicide prevention efforts (especially for older adults and youth) and dedicate more resources, particularly in rural counties which have some of the highest suicide rates in the state, to address gaps in the crisis care continuum. Implement the recommendations in "California's Strategic Plan for Suicide Prevention, Striving for Zero (2020-2025)" targeting all age groups and diverse populations.
- Invest in justice involvement prevention programs for youth to prevent initial interactions with law enforcement and justice systems.
- Offer health and behavioral health screenings as a universal support, especially when school returns, to gauge need and direct students and families to appropriate levels of care within the school and community
- Schools should invest in training for staff to recognize the signs and symptoms of behavioral health disorders and create referral partnerships with CBOs so that the entire family can engage in treatment. Training for parents and caregivers would also be helpful
- Train "gatekeepers" in aging services and social service programs to identify and provide prevention and early intervention services to older adults and person with disabilities across diverse populations who are at risk for or are exhibiting early

signs/symptoms of depression, alcohol/substance misuse and other behavioral health symptoms using evidence-based prevention and early intervention programs/services.

Services for Vulnerable/ High Risk Populations (i.e. at risk youth, individuals who are homeless or at risk of homelessness, and individuals who are justice-involved or at-risk of such involvement)

- Conduct law enforcement, emergency management services and hospital emergency departments listening sessions from the front lines to determine current gaps and challenges working with these populations
- Prioritize these populations for housing and housing supports including Project Homekey and Roomkey. Invest in a variety of options beyond permanent supportive housing and rental assistance such as sober living and residential facilities for intermediate care needs
- Prioritize the vulnerable in child welfare, older adult/protection, and welfare to work programs. Include victims of domestic violence, child and elder abuse, and severe trauma as vulnerable populations
- Create a framework that sets expectations for BH crisis continuum development, requiring service alternatives to emergency rooms, police responders and involuntary detention. Publish each county's continuum of care compared against that recommended framework along with each county's rates of involuntary detention
- Continue to support and prioritize programs like the Family Urgent Response System (FURS) which seeks to provide 24/7 trauma-informed support, including mobile response, for current and former foster youth and caregivers to reduce placement changes, hospitalizations, and the criminalization of traumatized children
- Increase linkages between juvenile systems and CBOs to provide continuity of care once a child ages out of the system
- Incarcerated individuals need to receive timely behavioral health assessments with identified release plans targeting their needs
- Partner with Domestic Violence (DV) and community service providers to access high-risk vulnerable populations, listen to the voices of community and provide the services they need
- Parity payment between behavioral health and developmentally disabled adult residential facilities (Board and Care homes) in the community
- Robust public education campaign enlisting cultural brokers and community leaders to help address the stigma and rampant miseducation about the COVID-19 vaccine
- Expand funding for the behavioral health safety net to continue offering vital services as Medi-Cal enrollment is predicted to surge post pandemic
- Support Community Health Clinics (CHC) to move towards the value based care model so care can be provided to patients where they are instead of requiring a clinic visit. CHWs / promotoras could also be used outreach and engage the homeless population and other vulnerable populations in the community
- Extend Telehealth flexibilities post-pandemic to increase access

- Reduce paperwork standards required by counties for providing services
- Utilize an Agency Wide (CHHS) approach, similar to the AB 2083 (Foster Youth) efforts to address issues of wrap-around services for individuals being served through behavioral health
- Require specific and effective outreach for vulnerable populations through community engagement that links them to services and reduces barriers to getting access (e.g. transportation, location, impairment criteria, timely appointments, language barriers). Provide behavioral health services where individuals across the lifespan and in diverse populations are comfortable receiving services.
- Fund and expand supported employment opportunities for individuals with serious mental illness (SMI) and SUD conditions
- Ensure sufficient Mental Health Services Act (MHSA) "Community Services and Supports" funding for the Full Service Partnership (FSP) Programs and supportive housing for children/youth, transition age youth, adults, and older adults with serious mental illness (SMI), to provide "whatever it takes" to prevent hospitalization, institutionalization, homelessness, incarceration, and other negative outcomes of SMI. Determine if existing MHSA funding is addressing the need/demand for these intensive services.

Reducing Racial/Ethnic/Cultural Inequities & Disparities
- Provide more training on implicit bias and anti-racist practices in service delivery and administration
- Require performance targets with incentives to plans/providers to reduce inequities and disparities, target the BIPOC communities with the greatest inequities/lack of access
- Reimburse more community defined practices under Medi-Cal, provide state resources to evaluate these programs
- Invest in Community Health Workers/ Promotoras to help bring hard to reach communities into care and undue stigma around BH services
- Build awareness and application of *Cultural Proficiency* and trauma informed practices
- Invest in programs like Mental Health First (Sacramento), which encourages a non-police response to mental health crises
- Invest and partner with local culturally competent CBOs to recruit and retain a diverse workforce
- Support the sustainability and extension of the CRDP
- Require reducing disparities as a mandated component within Community Services and Supports (CSS) programming which is part of MHSA
- Stakeholder advocacy contracts could include a focus on policies and system change especially at the state level and not just the local level
- Create an Office of Health Equity within DHCS to better inform data collection and disparities reduction quality improvement efforts
- Support the Dept. of Health Care Services (DHCS) in creating a Reducing Disparities/Cultural Competence Advisory Committee made up of primarily

knowledgeable people from the community to advise on policies and practices, and provide more support to the County Ethnic Services Managers

- CHHS should form a community defined evidence practices (CDEP) advisory committee comprised of experts in CDEP, the Department of Public Health, DHCS, providers, and consumers. Together with stakeholders develop a plan to reimburse behavioral health services based on community-defined evidence
- Ensure culturally and linguistically competent and trauma-informed services are available and funded (including American Sign Language)
- Invest in more peer specialists from an array of racial/ethnic/cultural groups. Mental/behavioral health is understood and experienced differently among varying groups and these peers will be more effective at engagement and support