

**California Health and Human Services Agency
Children and Youth Behavioral Health Initiative
May Revision 2021-22**

Proposal: Transform California's children and youth behavioral health (BH) system into a world-class, innovative, up-stream focused, ecosystem where ALL children and youth are routinely screened, supported and served for emerging and existing BH needs. Services are statewide, evidence based, culturally competent, and equity focused. \$4 billion over five years, including \$2.3 billion one-time and \$300 million General Fund and certain federal matching funds ongoing starting in 2022-23.

Why and Why Now?

- Serving young people and doing it well pays off. Half of all lifetime cases of diagnosable mental illnesses begin by age 14 and three-fourths of all lifetime cases of diagnosable mental illness begin by age 25.
- Historically the adolescent substance use disorder system in California has been under-resourced and under-scaled. The need has never been greater.
- The Covid-19 pandemic has intensified already swelling children's BH issues. Addressing these needs is vital to California's recovery.
- The state's children's BH system is inadequate to meet current needs. There is too little focus on prevention, too few programs, too few behavioral health professionals, too few emergency services, and too few acute care services and beds.
- The most glaring BH challenges are borne inequitably by communities of color, low-income communities, LGBTQ+ communities, and in places where adverse childhood experiences are widespread and prominent.
- The state has the resources now to take a statewide, comprehensive approach to this persistent service gap and major long-term state problem. The opportunity to build a true system of care for all 0-25 year old Californians will change the arc of the lives of the next generation of Californians having the potential to alter the drivers of homelessness, incarceration and poverty.
- This proposal takes advantage of significant one-time investments to create tremendous opportunity for long-term impact on Californian's future community leaders.

State Funding Summary (rounded in millions):

Major Items	Amount over five years	Lead
Behavioral Health Service Virtual Platform	680	DHCS
Capacity/Infrastructure-Health Plans, County Mental Health Plans, CBOs, and Schools	550	DHCS
Develop & Scale-up BH Evidence Based Programs	430	DHCS
Building Continuum of Care Infrastructure	245	DHCS
Enhance Medi-Cal Benefits	800	DHCS
School BH Counselor and BH Coach Workforce	430	OSHPD
Broad BH Workforce Capacity	430	OSHPD
Pediatric, Primary Care and Other Healthcare Providers	165	DHCS
Public Education and Change Campaign	125	CDPH & OSG
Coordination, Subject Matter Expertise and Evaluation	50	CHHS
Total	~\$4,000	

Memo Summary: This memo describes the base assumptions and principles of this proposal, the division of responsibilities for state operations, and the details of this proposal.

Base Assumptions and Principles

1. Services are for children and youth 0-25 years old.
2. Applies to commercial plans and Medi-Cal
3. A minimum set of interactive tools and BH services and supports would be available via a virtual platform 24 hours a day, seven days a week.
 - a. Think "Employee Assistance Program" but a Behavioral Health Assistance Program for children and youth, statewide.
 - b. Voluntary, community-based program that offers free and confidential assessments, short-term individual counseling, group counseling, peer supports, connections to community based organizations and referrals for higher-level follow-up services with their health insurance plan.
 - c. Services address a broad and complex body of issues affecting mental and emotional well-being, including alcohol and other substance use, stress, trauma, grief, family problems, and psychological disorders.
4. Build on existing infrastructure. All plans would still be required to cover all BH essential health benefits.
5. A significant portion of this budget request is focused on short-term (over next five years) investment in infrastructure to ensure success.
6. Build upon the work that has already been done to support collaboration and coordination with educational partners such as the System of Care (AB 2083) work, SB 75 and decades of existing knowledge, lessons learned, and programs that demonstrate effective school-behavioral health partnerships
7. Leverage existing work and knowledge including the Surgeon General's Roadmap to Resilience and the MHSAOC's School Mental Health Report Every Young Heart and Mind: Schools as Centers of Wellness.
8. Partnerships will include agencies and departments outside of CHHS – including K-12 and higher education
9. Build out the currently insufficient workforce to meet the BH of all Californians 0-25.
10. Build out the currently insufficient quantity of BH facilities and crisis services needed for all Californians 0-25.

Timeline and Division of Responsibilities

The first year of this initiative will focus on research, planning, convening subject matter experts, and engaging with stakeholders to guide program development. In years two through five, the focus will be on developing, launching, and implementing these efforts with continuous quality improvement and evaluation. The funds allocated under this initiative will be available over multiple years.

CHHS

- Lead on cross-departmental coordination.

- Convene and engage with stakeholders, including youth-focused engagement and linkages to discussions at the Office of Youth and Community Restoration and Child Welfare/Foster Youth
- Draft and run procurement for services including subject matter experts (SME)/BH think-tank.
- Commission initiative-wide independent evaluator for all program components to identify best and innovative practices and to inform future policy and program work.

DHCS

- Manage Grants/Incentives: Capacity/infrastructure for health plans, county mental health plans, CBOs and schools
- Manage Grants/Incentives: Develop and scale-up age appropriate behavioral health evidence-based programs
- Additional work to build BH Continuum of Care Infrastructure for children and youth
- Maintain any virtual platform contracts and/or BH Network contracts, including payment
- Implement new Medi-Cal benefits: ACEs screening and Dyadic Services

DMHC

- Provide guidance to plans through All Plan Letters on coverage and reimbursement for offered BH Services.
- Monitor plan compliance through existing oversight processes.

CDPH

- Public Education and Social Change Campaign
 - General Public Acceptance and Awareness – Raising Behavioral Health Literacy and Supporting Youth Empowerment
 - Culturally Specific Campaigns – Developed from the community up and lead by the Office of Health Equity within CDPH

OSG

- Public Education and Social Change Campaign
 - ACEs and Toxic Stress

OSHDPD

- Children and Youth Behavioral Health Workforce, Education, and Training
 - Build out School Behavioral Health Counselor and Coach Workforce to serve students K-12 and at IHE
 - Invest and build out a workforce that is culturally and linguistically proficient and capable of providing age-appropriate BH services
 - Invest and expand workforce capacity to address substance use disorders and co-occurring mental health and substance use disorders
 - Expand effective workforce, education and training models to children, youth and families

Model Overview

Behavioral Health Service Portal			
WHO PAYS	Expand CalHOPE		BUDGET
State (Payer Agnostic)	<p>All children and youth (0-25 years old) have access to virtual BH Services and interactive tools/supports</p> <ul style="list-style-type: none"> • App/Virtual Platform with artificial intelligence (AI) backbone – culturally specific behavioral health information, education, and engagement via age-appropriate apps, games, resources and support services • 24/7 Warm Line • Regular automated assessments/screenings and self-monitoring tools • Tiered model to deliver and monitor BH treatment so that the most effective, least resource-intensive treatment is delivered first (such as educational resources, app-based care, videos, book suggestions, automated cognitive behavioral therapy or mindfulness exercises). • Provides peer supports, individual and group counseling, as needed • Connects to community-based organizations and community wellness programs • Referrals to plans for higher level of services 		<p>App/Virtual Platform with 24/7 Warm Line</p> <p>BH Providers Contract</p> <p>Build statewide CBO network</p> <p>Development of infrastructure, partnerships and capacity via incentives and strategic grants</p> <p>Program development to fuel virtual environment and expand evidence based practices statewide (partner with academic SMEs and BH think tank)</p> <p>Comprehensive public education and change campaign that is age appropriate and culturally and linguistically proficient</p>
Behavioral Health Services			
WHO PAYS	School-Linked BH Services	Plan Offered BH Services	BUDGET
Plans	<ul style="list-style-type: none"> • No changes to multi-tiered system of support • Connect existing or new counselors into a 	<ul style="list-style-type: none"> • Network providers and rates 	Invest in workforce, training and education that is culturally,

	statewide BH School-Linked Counselor* Network <ul style="list-style-type: none"> Statewide fee schedule adopted by all plans to pay for onsite counselor services 	<ul style="list-style-type: none"> Expand children and youth evidence-based practice models 	linguistically, trauma-informed, and age-appropriate Build out children and youth BH and toxic stress continuum of care Enhanced Medi-Cal Benefit: Add ACEs and Dyadic Services
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*School-linked counselors would be employees of school/district, community colleges, universities, community-based organizations or counties. Health plans would pay for their services based on a fee schedule established by DHCS and DMHC. As part of the "Capacity/Infrastructure" proposal, incentive payments could be made to schools/districts to hire school counselors.

Behavioral Health Service Virtual Platform

Goal: Implement behavioral health service virtual platform to be integrated with screening, clinic-based care and app-based support services. This virtual platform would support regular automated assessments/screenings and self-monitoring tools and would develop tools to help families navigate how to access help regardless of pay source.

While half of youths report increased anxiety and depression symptoms due to the pandemic, penetration rates in managed care and specialty mental health services remain around 3%. This may be due to young people's hesitance in reaching out for help, long standing stigma, and the lack of a trained and relevant resource that is available in a timely, convenient manner.

This goal is a population health model to deliver and monitor BH treatment so the most effective, least resource-intensive treatment is available to young people who may not need individual counseling, but need help managing stress and building resilience. The platform will provide support and resources, such as interactive education, self-monitoring tools, app-based games, videos, book suggestions, automated cognitive behavioral therapy and mindfulness exercises, all designed to build skills and enhance well-being. Young people with more significant needs would be guided to peers or coaches who can deliver more personal touches, including offering ongoing continuity relationships. Those whose interactions with the platform show they may need clinical services for mental health conditions and/or substance use disorders would be guided to their health plan to set up assessment visits, allowing ongoing continuity relationships with licensed clinicians through telehealth or in-person. The platform also builds in coverage by licensed clinical social workers, so assessments can be performed to determine which children

need ongoing clinical services, and which children have needs that can be met by peers or coaches.

In response to the public health emergency, DHCS launched [CalHOPE](#), a crisis counseling program with multiple components:

- **Media campaign** to normalize stress and guide people to services, with many specific populations of focus based on age, language, race/ethnicity, gender identity and geographies. This program has already resulted in over 1.9 billion impressions, through social media, TV, radio, national magazines, billboards, and other digital media.
- **Web-based resources and services**, including on-line chat with [CalHOPE Connect](#) (again, matched for language, race/ethnicity, and age); specific sections for youth encourage youth to chat, call, or participate in on-line support and educational groups; people can be connected to one-on-one crisis counseling with peers matched by language, race/ethnicity and age. To date, CalHOPE website has had over 2.5 million page views since June of 2020. CalHOPE has provided crisis counseling and educational sessions almost 160,000 times. The CalHOPE Connect Chat service began in April 2021. In the first two weeks of operation, more than 14,000 conversations with peer crisis counselors were conducted.
- **24/7 warm line** to help callers manage stress, and connect them with needed resources, including counseling when needed. An average of more than 500 callers per week use this service.
- **CalHOPE Student Support**, offering training and learning communities in schools to support Social/Emotional Learning. Trainings and tools from the UC Berkeley Center for Greater Good are being delivered in 57 of the 58 County Offices of Education.

The CalHOPE program is similar to a website launched in Canada, [Wellness Together](#).

Working with academic and industry leaders, we propose to leverage the brand and presence of CalHOPE to build out a dramatically expanded suite of app-based and on-line offerings, beginning with regular, age-appropriate, evidence based screenings and assessments which feed into a tiered system of care.

The tiered model will deliver and monitor behavioral health treatment so that the most effective, least resource-intensive treatment is delivered first (such as educational resources, app-based care, videos, book suggestions, automated cognitive behavioral therapy or mindfulness exercises). If the consumer's needs are not met, the care steps up to interpersonal interactions - - one-time or a short series of sessions with an age-appropriate trained peer or BH coach. If needed, care is stepped up to virtual professional counselor sessions or connection to the health plan (or county behavioral health plan for some Medi-Cal services) for more intensive clinical services, using a facilitated hand-off. When evaluated in Europe, this model (Stepped Care) has proven to be at least as effective as traditional care in primary care settings. The model is based on the premises that people should get immediate responses when asking for help, different people require different levels of care, and finding the right level of care often depends on monitoring outcomes.

The State would issue an RFP for a vendor to launch and manage a robust platform just for children, youth and their families, linking to relevant CalHOPE resources designed for youth (with seamless experience for users, so it feels like one platform and one experience). The platform would add sophisticated components to appeal to children and youth: turning cognitive behavioral therapy interventions into compelling games and interactive stories, using avatars to guide users through tools, automating screening and self-monitoring tools (like happy/sad faces, brief questionnaires that triage to more services if a child in need is identified) to keep children and youth engaged. Consumers have access to and control their own data, with tools to monitor social activity and moods.

People with warning signs based on response to apps are escalated to texts or chats with peers or BH coaches, who can refer to managed care or county mental health or SUD services where needed. Children and youth can also be connected to community-based organizations and wellness programs locally.

While the platform is designed to screen for mental distress and unsafe substance use, and guide the user to increasingly stepped up levels of care, the program will be much more effective if the platform also links to resources that can address unmet needs such as food or housing insecurity for families, as these are major drivers of mental distress for children and youth. These linkages will be made to the greatest extent possible.

The downloadable app(s) would be heavily promoted to children, youth, and families through primary care, pre-schools, K-12 schools, community colleges, universities, public health campaign, social media and other channels. Features and front doors of the app(s) would be designed for age cohorts. Contingencies for alternate screening approaches would be established if children/youth do not routinely use the app.

In addition, the platform would develop strategies and tools to help people navigate step-by-step and access help regardless of payer source, and would explore ways technology can support locating available services and supports, including to address unmet needs (such as food or housing insecurity) that can lead to anxiety, stress and trauma.

Total budget: \$680M

School-Linked BH Services: Capacity/Infrastructure for Health Plans, County Mental Health Plans, CBOs, and Schools

Goal: Build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services from schools, providers in schools, school-affiliated community-based organizations, or school-based health centers, in collaboration with managed care plans.

Description: This proposal would add \$550M to the Governor's Budget \$400M School Behavioral Health (BH) proposal, creating a \$950M program to ensure a robust system of school-linked behavioral health prevention and services available to all students and families. The additional

funding would allow direct incentive payments to counties, tribal entities, schools, Local Education Agencies, school districts, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers to supplement the \$400M available for Medi-Cal managed care plan incentives.

Funding is allocated to build infrastructure supporting ongoing behavioral health prevention and treatment services on or near school campuses, by expanding access to BH schools counselors, peer supports, and BH coaches, building a statewide community-based organization network and connecting plans, counties, CBOs and schools via data sharing systems.

Funding examples include:

- Administrative costs: capital improvements or new facility costs, planning and project management, training and technical assistance
- Linking plans, counties and school districts with local social services and community-based organizations (such as connecting youth to LGBTQ organizations, connecting survivors of sexual assault to support groups, etc.); funding local wellness programs near schools or expanding evidence based CBO programs
- Incentive payments for hiring BH school counselors and/or BH coaches (two-year associate degree with additional training)
- Implementing telehealth equipment and virtual systems in schools or near schools
- Implementation of data sharing, interfaces, IT investments, etc. to connect plans to BH services onsite at and affiliated with schools
- Flexible funding to address student needs identified by teachers, staff, students and families that, left unmet, are at high risk of progressing to mental illness or substance use disorders.

Total budget: \$550M

DHCS would manage the \$550M budget and allocate grants through a third-party, determined by competitive application.

Plan Offered BH Services: [Develop and Scale-up Age-Appropriate BH Evidence Based Programs](#)

Goal: Support statewide scale and spread of evidence-based interventions proven to improve outcomes for children and youth with or at high risk for mental health conditions, with a particular focus on young people experiencing their first break or first episode of psychosis, and/or developing substance use disorders (SUDs).

Description:

Agency/DHCS in consultation with the new stakeholder workgroup and BH think tank/SME, would select a limited number of evidence-based practices to scale and spread throughout the state, based on robust evidence for effectiveness, impact on racial equity, and sustainability. This proposal would issue the funding through grants counties, tribal entities, commercial plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers. to support implementation of these practices and programs for children and youth. Grants for

county behavioral health departments would be administered through DHCS' Behavioral Health Quality Improvement Project (BHQIP). Grants and incentives for commercial health care and for-profit delivery systems would be administered through a third-party grant administrator, obtained through RFP.

The grantees would be required to share standardized data in a statewide behavioral health dashboard. The projects can evolve over the course of five years, based on learnings in early years. Probable funding priorities include:

1. **First break or first episode psychosis programs** proven effective in preventing chronic mental illness and disability
2. **Efforts that are tailored and focused on disproportionately impacted communities and communities of color** and where language and other cultural features are needed to enhance effectiveness and penetration.
3. **Youth drop-in wellness centers** proven to improve well-being and outcomes for youth, providing in-person and virtual services
4. **Intensive outpatient programs for youth** (telehealth and in-person), to address alternatives to out-of-home placement for children and youth with mental illness and/or substance use disorders with a focus on continuity and building relational wealth.
5. **Prevention and early intervention services for youth** (telehealth and in-person), to provide safe places for youth to receive evidence-based prevention services

If the project is covered by a learning collaborative offered by the [Mental Health Services Oversight and Accountability Commission](#), such as early psychosis services, grantees would be required to participate in the learning network as a condition of funding.

Total budget: \$430M

DHCS would manage the \$430M budget and allocate funding through the BHQIP and third party grant administrator

Plan Offered BH Services: Building Continuum of Care Infrastructure

Goal: Ensure youth living in every part of California can access the care they need without delay and, wherever possible, without having to leave their home county, by building up sites where they can receive MH and SUD services and care (e.g., urgent care, intensive outpatient, crisis stabilization, crisis residential, crisis stabilization, mobile units, inpatient).

Description: This proposal would issue an additional \$245M through grants to support implementation of BH infrastructure, as part of the BH Continuum Infrastructure project proposed in the Governor's Budget and May Revision. DHCS would issue grants to counties, tribal entities, non-profit entities, for-profit entities, and other entities, as determined by the department, through a competitive RFP process, based on a gap and capacity analysis scheduled to be completed by end of 2021. Grants may be used to add child/adolescent beds to existing facilities, or to set up new facilities or new crisis mobile services. A strong focus would be on offering social model, residential settings, as an alternative to institutional settings, providing crisis

stabilization and crisis residential services in a home-like setting. The goal is to decrease the trauma of the experience and allow youth to build skills that are transferable to community living. This builds on the System of Care (AB 2083, 2018) work and focus on linkages to ongoing community based supports.

Total budget: \$245M

DHCS would manage the \$245M budget and allocate funding through a third party administrator

Plan Offered BH Services: Enhance Medi-Cal Benefits

Dyadic Services: Implement dyadic services in Medi-Cal effective July 1, 2022. This proposal is based on the HealthySteps model of care, a model that has been proven to improve access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting and maternal mental health. HealthySteps has also been proven to be cost-saving. In this integrated behavioral care model, pediatric mental health professionals are available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to offsite behavioral health services. Furthermore, in this model, health care for the child is delivered in the context of the caregiver and family (i.e. “dyadic health care services”) so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to make sure they received the services. HealthySteps is one of several evidence-based models of dyadic care (e.g., DULCE, Parent-Child Interaction Treatment and Child-Parent Psychotherapy).

Medi-Cal would add Dyadic Behavioral Health Visits, as well as, slight modifications to other existing Medi-Cal benefits, including but not limited to: Case Management Services; Psychiatric Diagnostic Evaluation; Caregiver Depression Screening; and Family Therapy.

Total budget: \$ 100M GF and \$100M FF, annually starting 2022-23

Workforce, Education and Training

Without a thorough investment in a skilled, diverse, and supported workforce, the goals of this initiative are not possible. The community of individuals surrounding children and youth, ranging from teachers and school personnel to primary care and trusted community service providers and leaders, all deserve the training and support they need to be active and effective. This section is divided into workforce strategies that will result in increased numbers of capable and diverse providers, while the education and training strategies will focus on providing more resources for natural “helpers” who can support the mental health and wellness of children and youth.

School BH Counselor and BH Coach Workforce

Goal: OSHPD, in partnership with subject matter experts including education and behavioral health, will develop a multi-year plan that will launch and implement a school behavioral health counselor system where students statewide can receive in-person and/or virtual one-on-one and group supports, as needed. Within 5 years, produce up to 10,000 culturally and linguistically proficient counselors and coaches to serve school and college age children and youth.

Description: Educators and students need support and access to behavioral health counselors and coaches trained to provide a variety of interventions. These include universal prevention (e.g. positive school climate, universal screening, mental health literacy, trauma-informed practice, and mindfulness), early intervention (small group instruction; social skills, toxic stress/trauma and substance use groups), and, if needed, provide or refer children and youth with more serious behavioral health conditions to more appropriate and intensive services. These counselors and coaches will be skilled and focused on improving health outcomes by enhancing the ability of educators to improve educational outcomes. Furthermore, it is critically important that behavioral health school counselors and coaches reflect the communities they serve and that they can function as trusted messengers and cultural brokers. Several strategies will achieve this objective including providing robust professional support mentorship, covering tuition and other training and educational costs, as well as providing a stipend for two years of service.

Students will need different levels of intervention so behavioral health counselors and coaches recruited and trained will have various levels of existing knowledge to build upon. For example, a student in community college could receive an additional 12 weeks of specialized training as a Behavioral Health Coach while a recent masters level social work graduate can complete a Pupil Personnel Services Credential (PPSC) certificate and serve as a resource on mental health and substance use issues to teachers and administrators on campus.

Much of the work counselors and coaches will be doing is virtual. Kids will have choice in how, where and when they receive services, including services that secure privacy and provide anonymity. This could take the form of morning, evening, during school or weekend services and will be virtual – this flexibility will be key. As described above, the virtual system would connect children and youth to additional on demand behavioral health services, including counseling, support groups, etc., and if appropriate behavioral health counselors and coaches will provide linkages to in-person services.

Total budget: \$430M

Broad BH Workforce Capacity

Goal: Build and expand workforce, education and training programs to support a workforce that is culturally and linguistically proficient and capable of providing age-appropriate services. Through OSHPD coordination, link back to partners implementing the student behavioral health counselor system to leverage efforts, exchange information and lessons learned, and strategize on sustainability and innovation.

Description: Build upon existing efforts underway at OSHPD to invest in the diversity and range of behavioral health providers needed, including investments to support the staff with age-appropriate skill sets and cultural and linguistic proficiencies, including a focus on SUD counselors and providers, working with families, and treating complex co-occurring mental health and substance use disorders. Historically, the majority of OSHPD investments in workforce, education, and training have been limited to a mental health focus because the funding source was the Mental Health Services Act (MHSA). A substantial investment in the SUD workforce can help close the parity gap between investments in SUD and MH workforce, education, and training programs. Identified programs could include but are not limited to:

- Youth SUD Counselor/Specialist: build as part of a new certificate/training program/credential
- Psychiatric Nurse Practitioners: work with nursing and other health professional schools to provide or develop enhanced online stimulated training – provide free tuition and stipends for 5000-7500 RNs or other appropriate professionals to become Psych NPs to serve in CA for at least 5 years
- Earn and Learn Apprenticeship Models: provide tuition support and on-the-job training at a behavioral health provider organization while attending school (post-secondary). The employer would provide a position for the graduate and there would be a period of service obligation. The program would provide financial support to the employer to supervise and mentor the student. A range of providers would be created with these programs including SUD counselors, Community Health Workers, and Psychosocial Rehabilitation specialists.
- Specialized training to serve Justice and System-Involved Youth: provide enhanced training to existing and new staff across a variety of sectors including child welfare, education and probation on effective BH strategies with justice and system involved youth – including preventing such involvement among high-risk vulnerable youth and their families.
- Peers Support Specialists: train, recruit, and provide stipends as well as a specific skills for youth peer support specialists and family and caregiver support specialists
- Social Workers: expand certificate programs at Higher Educational Institutions that train Child and Adolescent Social Worker and Child Welfare Workers.
- Sustain and Grow the WET Psychiatric Education Capacity Expansion Program: open additional funding cycles to support psychiatry residency and psychiatric mental health practitioner training programs.

Many people laid off from the service sector with a customer service orientation may not be able to afford the advanced degree needed to be a licensed behavioral health professional, but they could become excellent coaches or counselors, allowing career advancement and filling a significant workforce gap. Training them in existing evidence-based curricula (Community Health Worker, Peer Support Specialist, Behavioral Health Coach, Substance Use Counselor, and Rehabilitation Specialist) would help diversify the workforce by many important measures – language, race/ethnicity, geography, gender identity, and system involvement. As California continues to strengthen our ability to build cultural, linguistic and accessibility competencies,

these are the professionals we need. We are already developing sustainable financing for their services (e.g., CalAIM/Medi-Cal Reform).

Total Budget: \$430M

Pediatric, Primary Care and Other Healthcare Providers

Goal: Provide opportunities for primary care and other health care providers to access cultural proficient education and training on behavioral health and suicide prevention.

Description: Pediatric, primary care and other healthcare providers are well situated to recognize and identified signs and symptoms of behavioral health care need. In addition, leveraging current programs can strengthen the ability of health care providers to play an integral role in preventing behavioral health crisis and intervening early to stop the progression of more serious conditions. The provider might be additionally trained to address the issue within their own skill set, or trained on how to screen and referral the individual to appropriate care.

A core part of this strategy will be to build out a statewide eConsult/eReferral service with the requisite professional workforce to support the service to allow primary care pediatric and family practice providers to receive asynchronous support and consultation to manage behavioral health conditions for patients in their practices. The workforce that will support the eConsult/eReferral service will be part of the statewide network of providers supporting the Behavioral Health Service virtual platform described above.

Total Budget: \$165M (at DHCS)

Comprehensive and Culturally and Linguistically Proficient Public Education and Change Campaign

Goal: Raise the behavioral health literacy of all Californians to normalize and support the prevention and early intervention of mental health and substance use challenges. Teach Californians how to recognize the early signs and symptoms of distress and where to turn to ask for help. Empower children and youth to take charge of their mental health and wellness. Tackle disparities and inequities by empowering diverse communities to develop their own culturally and linguistically appropriate tools to break down the stigma associated with behavioral health conditions and increase help seeking behavior.

Description: In 2011-12, California launched a multi-year statewide effort to prevent suicide, reduce stigma and discrimination and improve student mental health, known as the Prevention and Early Intervention (PEI) Statewide Projects. Using MHSAs funds, the counties through CalMHSA (joint power authority) implemented over 30 different programs and 2 social marketing campaigns. These efforts were comprehensively studied by RAND and demonstrated significant promise, including an analysis of the costs that could be saved by preventing the negative outcomes associated with not receiving behavioral health care until a crisis, including school

dropout, hospitalization, incarceration, homelessness and even death by suicide.¹ In 2016 when RAND assessed the impact of the effort, they documented increased knowledge, skills, awareness but in order to achieve behavior change efforts would need to be sustained. As RAND noted *“California's progress toward broader goals — including reducing suicide, improving early receipt of needed services, reducing discrimination, and avoiding some of the negative social and economic consequences associated with mental illness — will require a long-term commitment to a coordinated PEI strategy that is continuously informed by population needs, evidence regarding promising and best practices, and indicators of program performance and quality.”*

Considering the need and urgency, lessons learned from this effort can guide and build a more effective public education and change campaign appropriately resourced to reach and impact California's populous and diverse state. The campaign will take a strategic and effective public health approach to behavioral health led by CDPH with support from the OSG and close collaboration with DHCS among other agencies and departments participating in this initiative. The Office of Health Equity (OHE) and the new Office of Suicide Prevention (OSP) will play important roles ensuring efforts are developed and implemented through a lens of reducing disparities and addressing inequities. The comprehensive campaign will have four components:

- 1) General Public Acceptance and Awareness – Raise Behavioral Health Literacy, Increase Help Seeking Behavioral.
- 2) ACEs and Toxic Stress – Raise awareness about prevention, recognizing the signs and self-care strategies.
- 3) Culturally Specific Campaigns – Led by Office of Health Equity in partnership with community leaders, build on existing or promising local efforts.
- 4) Youth Empowerment – Create local youth-led BH focused engagement and education efforts that use social media and other popular apps/programs to create positive messaging by youth, for youth.

Total: \$125M (CDPH and OSG for ACEs and toxic stress component)

¹ RAND published dozens of studies on the PEI statewide project which are summarized in this report - https://www.rand.org/pubs/research_briefs/RB9917.html