Enhancing Access to Behavioral Health Services for the Most Vulnerable in California: Executives' Views and Recommendations

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Introduction

Removing barriers to accessing behavioral health services (BHS) has become a national priority in the United States. The insidious opioid epidemic and the impact of COVID-19 have highlighted the several health policies, infrastructure, and payment and service practices that reduce access to BHS, particularly for historically underserved vulnerable groups (Guerrero et al., 2022; Harris et al., 2022). Although the state of California has addressed macro barriers to access BHS, such as expanding public health insurance coverage and funding comprehensive services for individuals suffering from mental health (MH) and substance use disorders (SUD), attention is needed to align behavioral health policy, structure, and service delivery to effectively serve the hardest to reach populations, including individuals from minoritized and socially marginalized backgrounds (e.g., personal of color and or LGBTQIA+ identified).

Because a BHS system that responds to the service needs of the most vulnerable populations in California requires special arrangements, the California Department of Health Care Services, in conjunction with The Sierra Health Foundation, funded various organizations across the state to implement the Health Equity in Access to Behavioral Health Recovery Services (HEAR US) project. This project sought to build from the SAMHSA Recovery Roadmap framework to respond to the recovery needs of ethnoracial and sexual minority populations in need of BHS in California. The SAMHSA Roadmap for Recovery relies on the following principles, Person-driven, relational, addresses trauma, holistic, hope, culture, peer support, many pathways, respect, and strength/responsibility (See Appendix A). In this paper, we describe the organizing, facilitating, and documenting of constituency-focused generative listening sessions and focus groups with executive leaders of drug and alcohol programs in California. Through the robust community and conversations guided by the Sierra Health Foundation and managed by Health Management Associates (HMA), the research team of the California Association of Alcohol and Drug Program Executives (CAADPE) and the HMA coach gained valuable insights into the current landscape of SUD recovery services, including the definition of SUD recovery services and the needs of this system to effectively respond to the services of the most vulnerable groups in California.

Methodologies

This project relied on a qualitative design, namely online focus groups conducted between March and June of 2023. This study sought to inform the conceptual enhancement of A Roadmap to

Improve Access and Equity for Communities in Recovery in California. The research team used a three-step process to gather feedback from participants to tailor the Roadmap to the recovery needs of minoritized and socially marginalized groups residing in California. Given the exploratory nature of the research questions, the research team gathered several sources of information to build a multi-dimensional understanding of the needs and concerns of providers on behalf of the clients they serve. The research team collected data between March and May of 2023 to understand access to SUD care from multiple perspectives. This study employed a case study approach (Baxter & Jack, 2008), and focus groups took place via synchronous online sessions and were divided between diverse and non-diverse groups (defined below). The study team implemented a two-phase participant enrollment process. In Phase One, through phone and email message invitations (see below under recruitment), providers were invited to provide informed consent and complete a screening questionnaire. In Phase Two, participants who met eligibility criteria (see under Sampling and Inclusion Criteria) were invited to participate in a focus group interview. This procedure was reviewed and approved by the IRB of Research to End Healthcare Disparities Corp (IRB A01-02102023)

Participant Recruitment

A research coordinator led the recruitment efforts, and participants were encouraged to refer other individuals eligible for study participation. Informed consent, followed by initial screening information to assess eligibility to continue participating, was completed by the research staff. Participants received a $30 gift card per each focus group they attended for their participation.

Sampling and Inclusion criteria

Purposive, convenience, and snowball sampling were used to recruit participants for the study using the inclusion and exclusion criteria. Participants completed a brief demographic survey at the beginning of the interview to determine study eligibility. The inclusion criteria to continue participation was current role as director or upper manager of an SUD treatment program. Participants were selected based on their demographic diversity characteristics. We created two different groups – diverse and non-diverse groups. The diverse group included non-white, heterosexual males and females), while the non-diverse group included only white, heterosexual males. We also selected participants representing small and large programs serving urban and rural communities.

Informed Consent and Data Collection

Interested persons were informed that by giving verbal consent and completing the questionnaire, they were providing consent to participate in the study. A total of $n = 33$ providers completed the screening questionnaire. Of those, $n = 23$ met the eligibility criteria and completed a focus group.

Focus Groups Design

Three sessions were completed with two focus groups per session (6 total). These groups lasted 90 minutes each. Topics included equitable access to services and treatment, actions needed, barriers, ways to reduce obstacles, and feedback on the revised recovery Roadmap (Appendix B). Additionally, all names and identifiers were removed from transcripts and other narratives to preserve confidentiality. Primary qualitative findings are presented below.

Qualitative Data Analysis

Interviews were transcribed by a professional service (REV.com), and the research team removed all identifying information before the analysis process. Data collection and analysis were completed using a generic qualitative approach (Merriam, 2015), meaning that the analysis aimed to describe participants' experiences and perspectives related to their needs and their clients' needs.

Following the completion of the interviews, half of the transcripts were coded line by line by three researchers (LMH & VS). First-cycle codes were clustered by topic to develop the second cycle, thematic codes. The most frequent and significant thematic codes were used to construct a codebook. Dedoose™ (Version 9.0.17, 2021), a web-based qualitative data analysis platform, was used to facilitate data organization and coding (Sociocultural Research Consultants, 2021). The codebook was uploaded onto Dedoose software, and Dedoose's coding functions were used to code fifty percent of the interview transcripts. The finalized codebook was based on iterative discussions of interview transcripts (Hsieh & Shannon, 2005; Joffe & Yardley, 2004).
Next, a thematic analysis was conducted on the coded transcripts, iteratively refining themes until reaching a consensus. Authors maintained memos related to analytic decisions, consulted with other team members, and discussed the relationships among codes that emerged from the data (Charmaz, 2014; Strauss & Corbin, 2015).

Findings

Participants who represented program leaders in the SUD treatment system in California, highlighted three main areas to improve access to a comprehensive system of care; 1) *culturally responsive policy*; 2) *adequate funding and sensible reporting*, and 3) *purposeful coordination across systems*. Because research has shown that leaders' ethnoracial background plays a role in their views and practices related to workforce diversity (Guerrero, 2013; Guerrero et al., 2022), data from two samples (diverse and non-diverse) were collected. The samples varied in terms of race, ethnicity, and gender identity. However, their views on culturally responsive policy, structure, and services did not significantly vary.

Findings showed no significant group differences in culturally responsive themes. Differences were primarily based on the scope of issues and solutions. The non-diverse group had longer tenures in the field and led larger organizations. They emphasized big-picture policy and structural approaches to improve the system. In contrast, the diverse group was heterogeneous in their practice experience and offered insights into specific barriers and innovative solutions. For instance, how the payment system in California and the coordination across systems can improve to provide basic services (e.g., housing transition) to retain and stabilize vulnerable clients. The non-Diverse group offered more nuanced suggestions for measurement and implementation, possibly because of their significant experience responding to systemwide challenges in the provision of care.

Participants reported that for implementation, obtaining and testing the impact of comprehensive, long-lasting funding is critical to sustaining service delivery to the most vulnerable. Funding and supporting aftercare service delivery beyond three months of treatment is imperative to sustaining their recovery. Participants warned about discrimination in funding, eligibility, and reimbursement and to collect baseline data on clients' full-service experiences based on quantitative and qualitative interviewing.

Culturally Responsive Policy

The participants placed a strong emphasis on broad policy and structural strategies to enhance the system. At the same time, the diverse group showed heterogeneity in their practical experience, providing valuable perspectives on specific obstacles and creative solutions. For example, they delved into issues such as the payment system in California and the need for better coordination among systems to ensure access to essential services like housing transition, ultimately aiming to support and stabilize vulnerable clients. One participant illustrated how structural changes can lead to better client outcomes, *"My two cents to add are that there should be enough lanes for access to recovery in the continuum of care to give the most people needing recovery access while not stigmatizing or limiting funding… and helping the whole person in their recovery journey."*

Adequate Funding and Sensible Reporting

Program leaders appreciated the thoughtful questions and the opportunity to bring coherence to a "broken" care system. Participants highlighted that adequate funding meant financial/billing support for culturally responsive practices, including peer support, harm reduction, and a whole-person approach. They believed that by offering financial incentives and support to implement such strategies, the system could transform into a low-barrier system of care. Participants underscored the need for *"payment reform,"* focusing on mainstreaming and harmonizing Medicaid payment and reporting across counties in California to improve access to care for out-of-county clients. One participant outlined the need for payment reform, *"I think it needs to come at the state level where counties aren't so restricted by having to change the county where Medi-Cal is coming from. There are so many barriers there that it's not only for the clients but for the providers."* Another participant shared limitations of the current system, *"Payment reform is not addressing the Drug Medi-Cal carve out."* Another shared a possible solution, *"In health centers, we call them P4P, pay for performance. We maybe eventually be able to address some of those issues."*

Focus group participants shared several key items that must be considered to measure the successful implementation of healthcare initiatives. Firstly, it is essential to focus on reducing payment differences and eliminating barriers that hinder access to services for individuals. Additionally, despite the challenges of the current state, efforts should be made to establish treatment-on-demand programs to ensure timely and accessible care for all. Adhering to access to care standards can provide valuable insights into the effectiveness of the implementation. Moreover, securing funding to provide comprehensive services that address the holistic needs of individuals is crucial. Testing various aspects of payment reform is essential to determine the most effective strategies. Aligning Medicaid policy with mainstream service delivery and payment methods can improve integration and accessibility. Regular assessments and surveys will enable providers and decision-makers to gather feedback from all involved parties, aiding in identifying successes and areas requiring improvement. They can make informed decisions and continuously enhance the healthcare system by tracking these measures.

Structure: Workforce Development and Coordination Across Systems

During discussions on "workforce development," it became evident that advocating for livable wages comparable to other healthcare positions is essential to attract, retain, and promote talented individuals. Creating different pathways to access care across the continuum of care, with proper structuring and funding, emerged as a recurring theme.

The diverse group emphasized the importance of providing an adequate living wage and developing a comprehensive workforce development plan to retain skilled professionals. They stressed the need for higher parity between payments for medical offices and Department of Mental Health rates, recognizing the significance of treating SUD patients with the same respect as those seeking mental health treatment. The concept of "payment on demand" was also discussed.

The groups agreed on the necessity for treatment on demand, walk-in clinics, mobile crisis, telehealth, and a "no wrong door" policy. Integrating licensing requirements was proposed to achieve low-barrier access, and multi-sectoral collaboration platforms were considered integral to integrated care. Additionally, mobile services and crisis services were suggested to be included in the list of offerings. Improving and implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) was identified as a crucial step in ensuring universal screening, smooth handoffs and referrals to treatment. Transportation was also recognized as an essential factor to consider for improving access.

Addressing the challenges faced by the workforce offering peer support was highlighted, particularly the difficulty in retaining talented individuals with lived experience. The group acknowledged that higher wages in other fields posed a risk of losing skilled professionals to different industries. Specific requirements for peer support specialists were recommended to be removed to strengthen the peer support workforce.

The non-diverse group emphasized the value of incorporating the voices and perspectives of workers with lived experiences. They underscored the need for improved reimbursement to integrate the workforce with lived experiences effectively. Additionally, they acknowledged that the current state of treatment presented barriers to integrating peer support, and thus, creating better pathways was identified as a crucial area for improvement.

Focus group participants identified that measuring successful implementation requires careful consideration of key measures to assess the effectiveness and progress of the initiatives. They identified the following measures for evaluating the success of workforce development and peer support implementation.

Workforce Development Investment: One crucial measure is tracking the level of investment made in workforce development initiatives. This includes funds allocated for training, education, skill enhancement, and professional growth opportunities for peer support professionals. One participant highlighted the need for improved workforce development, "*So, we do a lot in the field to develop projects, but I think basically we have to pay a livable salary, and somehow the SUD system needs to be infused with money to do that.*"

Pipeline Development from High School Level: Evaluating the effectiveness of pipeline development programs that begin at the high school level is essential. Monitoring the number of students engaged in such programs and their transition into peer support roles can provide insights into the success of early interventions.

Community Engagement in Pipeline Development: The involvement of the community in pipeline development, recruitment, retention, and promotion of peer support personnel is a critical measure. Assessing the level of community support and collaboration can indicate the sustainability and acceptance of the peer support workforce.

Certification and Training Hours: Measures should include the number of peer support professionals who have obtained certification and the number of training hours they have completed. This information reflects the commitment of individuals to the field and the extent of their readiness to provide quality support.

Professionalization Processes: Monitoring the implementation of professionalization processes, such as standardized competencies and ethical guidelines, can ensure the growth and credibility of the peer support workforce. The extent to which employers invest in these processes can demonstrate the seriousness of their commitment.

By utilizing these measures, providers and decision-makers can gain valuable insights into the successful implementation of workforce development and the overall progress of peer support initiatives. This data-driven approach can guide further improvements and ultimately lead to a more robust, and more effective peer support workforce.

Conclusions

Organizational leaders' involvement in the HEAR US project contributed to shaping a recovery roadmap for California. The organizing, facilitating, and documenting of constituency-focused generative focus groups was instrumental in identifying barriers and opportunities to enhance access to care for the most vulnerable groups in the state. Robust information provided a view of the current landscape of SUD recovery services. The information obtained from focus groups helped identify opportunities to expand the definition of behavioral health recovery services and address future needs at the system and service delivery levels statewide. Some of the key insights from this effort included 1) adequate funding, 2) sensible policy, and 3) coordination across system actors.

The need for adequate funding to support culturally responsive practices that include peer support, harm reduction, and a whole-person approach. Participants specified that offering financial incentives and supports to implement such approaches is critical, so the system could transform into a low-barrier system of care. Such a system would respond to the culturally service needs of underserved, vulnerable populations (Guerrero et al., 2013). By aligning payment and service delivery policies, treatment providers could reduce delay and/or interruption of SUD treatment services to out-of-county, uninsured or underinsured, and or non-English-speaking clients.

Finally, participants emphasized the need to coordinate across multiple state actors (MediCal, insurance administrators, DHCS, criminal legal system; healthcare providers, social service providers) to strengthen the system (improve policy, funding, workforce, standards of care, low-barrier access to care). Such multisectoral partnership would reduce critical barriers to engaging hard-to-reach populations and improve treatment outcomes for all clients.

Recommended Actions

Participants appreciated the thoughtful questions and the opportunity to enhance the roadmap to recovery for the most vulnerable. Although many participants have been asked these questions in previous engagements, they were excited about the HEAR US initiative's intent to fund pilot projects that implement some of the areas presented. Most program leaders were interested in implementing organizational changes that promote diversity in leadership positions and in shaping service delivery to enhance access, improve the standard of care, and improve community health in the communities they serve.

Program leaders generated a range of service and practice recommendations to enhance harm reduction and high-impact interventions:

1. Drug and Alcohol Sobering Centers: Participants suggested the addition of dedicated facilities for drug and alcohol sobering to provide a safe environment for individuals to detox.
2. Safe Consumption Sites: Participants proposed the establishment of safe consumption sites to offer a supervised space for drug use, reducing associated risks and providing resources for users.
3. Education and Advocacy: Participants emphasized the importance of education, continuous learning, and advocacy efforts at various levels, including engaging with higher-level political entities, funders, and foundations.
4. Greater Use of Peers: Participants advocated for increased involvement of peers in the harm reduction process, recognizing their unique ability to connect with and support individuals.
5. Extended Outreach Time: Participants recommended testing longer outreach and connection periods, exceeding the standard 60 days, to foster more substantial and lasting connections with those in need.
6. Expanding Medication-Assisted Treatment (MAT) Options: Participants encouraged the implementation of MAT across diverse settings to offer a broader range of treatment choices.
7. Harm Reduction Strategies: Suggested expanding the list of harm reduction strategies to include syringe exchange programs, naloxone distribution, and fentanyl test strips.
8. Recovery Housing: Advocated for incorporating recovery housing as part of the overall strategy to support individuals in their journey to sobriety.
9. Abstinence-Based Programs: Expressed the desire to add abstinence-based programs alongside MAT, considering MAT the preferred treatment standard.
10. Linguistically Responsive Systems: Highlighted the need to develop systems sensitive to various languages, including American Sign Language, to ensure effective communication and support.
11. Culturally Based Care: Recognized the value of involving "credible messengers" in culturally based care to better engage with diverse communities.

12. Clarify Terminology: Raised concerns about unclear terms such as "community-based models" and "multi-sectoral collaboration platforms," urging more accessible language to avoid jargon and ensure practical implementation.

To effectively implement these recommendations, program leaders suggested the following measures and steps:

1. Evaluate Education Impact: Assess the effectiveness of education and continuous learning initiatives in promoting harm reduction awareness and practices.
2. Utilization of Peers: Measure the extent to which peers are integrated into harm reduction processes and their impact on individuals' well-being.
3. Extended Outreach Testing: Conduct trials to evaluate the outcomes of extending outreach and connection periods beyond the typical 60 days.
4. MAT Options Implementation: Monitor the successful implementation of various MAT options in different settings to expand treatment accessibility.
5. Provider Attitudes Towards Harm Reduction: Examine and understand the attitudes of healthcare providers towards harm reduction strategies to address potential barriers.
6. Provider Attitudes Towards Types of MAT: Investigate provider attitudes towards different types of MAT, including exploring any stigmas surrounding specific treatments like methadone.

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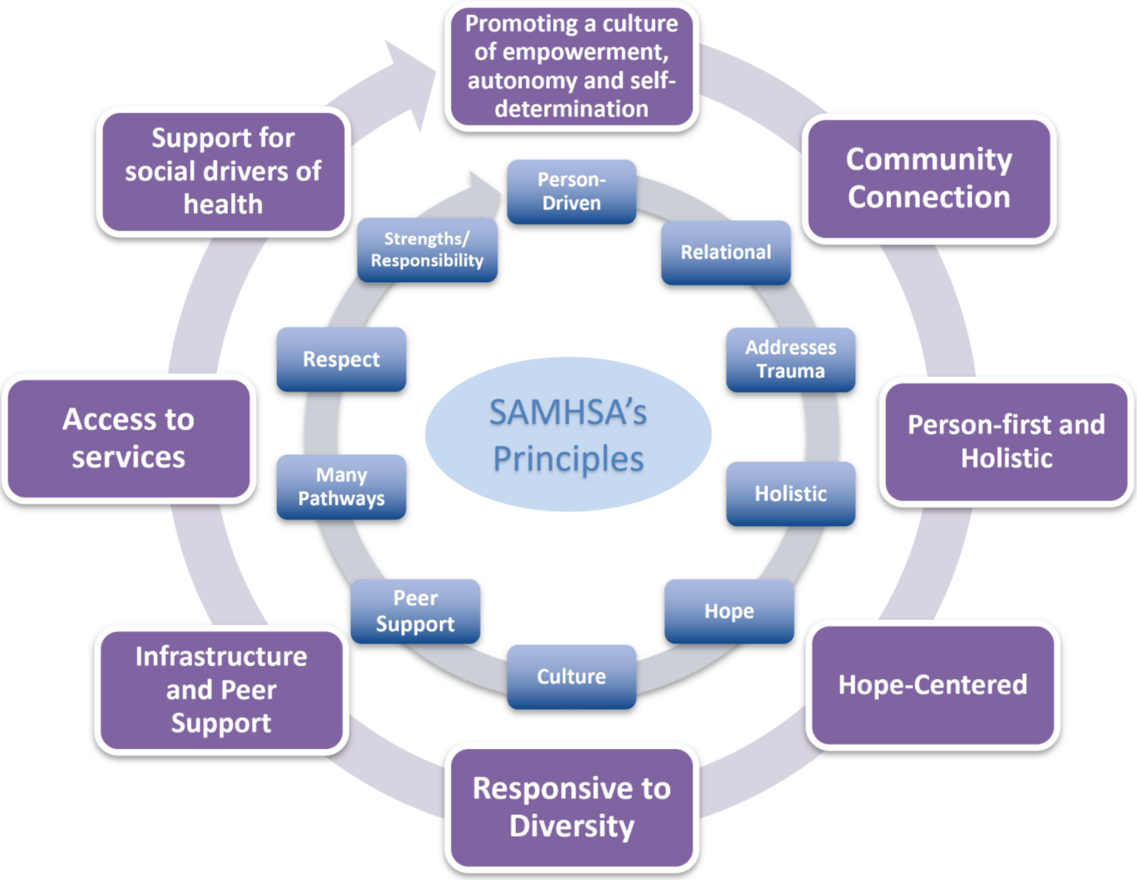
Appendix A. SAMHSA Recovery Principles and Approaches.



Appendix B. Questions asked to the diverse and non-diverse focus groups

Focus Group 1:

Q1: If people had equitable access to resources to support recovery, what would that look like? (ideal state)

Q2: What can be done immediately to help us get to this ideal state? (actions)

Q3: What barriers have you experienced or people you know to access what they need for a successful recovery? (barriers)

Q4: What are some ways to reduce these barriers? (reduce/eliminate barriers)

Focus Group 2: After being shown the Proposed Framework, "Roadmap to Improve Access and Equity for Communities in Recovery," participants were asked:

Q1: Reflecting on the Roadmap, please share what has worked for the community you serve to improve access to care. What has gotten in the way? (e.g., programs, policies)

Q2: Please share how the Roadmap can better reflect the cultural needs of the communities you serve to improve access and equity of care.

Q3: Share examples of how your organization is implementing culturally responsive care. What more do you think should be done? What are some small steps that can be taken to be more culturally responsive?

Q4: Reflecting on the Roadmap, what resources, services, and/or social supports would enable people to successfully achieve their recovery goals? Examples: Community Garden, yoga

Focus Group 3: After being shown "The Roadmap to Improve Access and Equity for Communities in Recovery (Updated Proposed Version)" participants were asked to reflect on each domain of the proposed framework considering two question per domain: **What should be added? Or what is missing? How can we measure successful implementation? What measures are important?**

Q1: Culturally Responsive Services and Systems
Q2: Low Barrier Access to Services
Q3: Integrated Peer Support Across the Recovery Continuum
Q4: Harm Reduction Approach
Q5 Addressing the Needs of the Whole Person

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