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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
March 25, 2021
9:00 AM – 1:00 PM

Mental Health Services
Oversight & Accountability Commission
1325 J Street, Suite 1700, Sacramento, California 95814
Phone: (916) 445-8696 * Email: mhsoac@mhsoac.ca.gov * Website: www.mhsoac.ca.gov

Commission/Teleconference Meeting Notice

NOTICE IS HEREBY GIVEN that the Mental Health Services Oversight Accountability and Commission (the Commission) will conduct a **teleconference meeting on March 25, 2021**.

This meeting will be conducted pursuant to Governor Newsom's Executive Order N-29-20, issued March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic. Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE: March 25, 2021

TIME: 9:00 a.m. – 1:00 p.m.

ZOOM ACCESS:

Link: https://zoom.us/j/96619019742
Dial-in Number: 408-638-0968
Meeting ID: 966 1901 9742
Passcode: 803828

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

***The Commission is not responsible for unforeseen technical difficulties that may occur in the audio feed.**

PUBLIC PARTICIPATION PROCEDURES: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to

comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

1) Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.
2) Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.
3) Catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

Our Commitment to Transparency

Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

- Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

AGENDA

Lynne Ashbeck
Chair

Mara Madrigal-Weiss
Vice Chair

Commission Meeting Agenda

All matters listed as "Action" on this agenda, may be considered for action as listed. Any item not listed may not be considered at this meeting. Items on this agenda may be considered in any order at the discretion of the Chair.

9:00 AM **Call to Order and Welcome**

Chair Lynne Ashbeck will convene the Mental Health Services Oversight and Accountability Commission meeting and make announcements.

9:05 AM **Roll Call**

Roll call will be taken.

9:10 AM **General Public Comment**

General Public Comment is reserved for items not listed on the agenda. No debate nor action by the Commission is permitted on general public comments, as the law requires formal public notice prior to any deliberation or action on agenda items.

9:40 AM **Information**

1: Public Hearing and Update on the Workplace Mental Health Project

Presenters:

- **Carolyn Dewa, MPH, PhD, Department of Psychiatry and Behavioral Sciences, Department of Public Health Sciences, Chair, Graduate Group in Public Health Sciences, University of California, Davis**
- **Garen Staglin and Katy Schneider Riddick, Co-Founder and Senior Director, One Mind at Work**
- **Darcy Gruttadaro, JD, Director, Center for Workplace Mental Health**

The Commission will hear an update on the Commission's Workplace Mental Health project and a panel presentation on the challenges and opportunities related to workplace mental health.

- Public Comment

11:40 AM **10 MINUTE BREAK**

11:50 AM **Action**

2: Approve February 17 and 25, 2021 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the February 17 and February 25, 2021 teleconference meetings.

- Public Comment
- Vote

12:00 PM **Action**

3: San Francisco County Innovation Plan

Presenter:

- **Jessica Brown, M.P.H., Director, Mental Health Services Act (MHSA), Behavioral Health Services San Francisco Department of Public Health**

The Commission will consider approval of $5,400,000 in Innovation funding for San Francisco County's Culturally Congruent and Innovative Practices for Black/African American Communities innovation project.

- Public comment
- Vote

12:30 PM **Action**

4: Legislative Priorities for 2021

Presenter:

- **Norma Pate, Deputy Director**

The Commission will consider legislative and budget priorities related to Commission initiatives, including Assembly Bill 638 (Quirk-Silva) and Senate Bill 749 (Glazer) for the current legislative session.

- Public comment
- Vote

1:00 PM Adjournment

AGENDA ITEM 1

Information

March 25, 2021 Commission Meeting

Workplace Mental Health Panel Presentation

Summary: The Mental Health Services Oversight and Accountability Commission will hear presentations from an expert panel to support its workplace mental health project and to explore opportunities for the state to strengthen mental health in the workplace.

Background: Senate Bill 1113 (Monning) directed the Mental Health Services Oversight and Accountability Commission to establish a framework and Voluntary Standards for Mental Health in the Workplace. That strategy is intended to reduce mental health stigma, increase public, employee, and employer awareness of the significance of mental health, and create avenues to treatment, support and recovery.

The Commission created a subcommittee of Commissioners to lead the project, consisting of Commissioners Keyondria Bunch, PhD (Project Chair) and Mara Madrigal-Weiss. Since 2019, the Commission has engaged employers and employees, subject matter experts, and others to develop standards that support employee wellbeing, reduce stigma, and increase awareness of mental health.

This first public hearing on workplace mental health will feature three presentations to support the Commission's effort to advance workplace mental health across the state. Presentations made during the hearing will help the Commission explore key concepts and develop a shared understanding of challenges related to workplace mental health, approaches that businesses have used to support employees, and strategies and opportunities to reduce stigma, increase resiliency, and improve access to mental health services. Presentation materials are enclosed, along with a hearing brief with more information about workplace mental health and the Commission's project.

Considerations for Commissioners:

- How can workplace mental health strategies enhance a larger prevention and early intervention framework for mental health?
- How could the State support strategies that will increase access to care and decrease stigma given the diversity of California's employer and employee population?
- How should the State incentivize workplace mental health in grant funding, innovation priorities, and in the use of WET funds at the local level?
- What policies and practices should the State target to incentivize mental health parity and quality of care standards across the state?

Presenters:

- Carolyn Dewa, MPH, PhD, University of California, Davis, Department of Psychiatry and Behavioral Sciences, Department of Public Health Sciences, Chair of Department of Graduate Group in Public Health Sciences

- Garen Staglin, Co-Founder of One Mind at Work and Katy Schneider Riddick, Senior Director at One Mind at Work

- Darcy Gruttadaro, JD, American Psychiatric Association Foundation, Director of the Center for Workplace Mental Health

Enclosures (6): (1) Hearing brief; (2) Landscape Analysis; (3) Findings Summary; (4) Presenter biographies; (5) Presenter invitation letters; and (6) Presenter written testimony and supporting materials.

Handout (2): (1) PowerPoint Presentations; (2) Additional biographies or written testimony (if any)

Workplace Mental Health Project

March 25, 2021 Hearing Brief

Overview

This hearing brief provides background information to support the Mental Health Services Oversight and Accountability Commission's (Commission) March 25, 2021 public hearing on workplace mental health. First, a brief overview of workplace mental health will be described (including barriers and opportunities), followed by an overview of the Commission's Workplace Mental Health Project. Then an outline of the Commission's public hearing will be presented, along with questions for consideration by Commissioners as they prepare for and hear presentations by invited speakers. The content in this document reflects interviews and conversations with subject matter experts, employers, and other stakeholders in California and internationally.

Workplace Mental Health

The workplace is an optimal setting for prevention of mental health needs and promotion of mental wellbeing for Californians. Adults spend approximately one-third of their time working.

In best case scenarios, employers are supportive of their employees, offer settings that increase resiliency, and provide opportunities for people to feel fulfilled and thrive. A healthy workplace ensures that all workers can work in a healthy environment and can access the supports they need for mental wellbeing. Supportive work environments include role clarity, positive change management practices, reasonable workloads, opportunities for career growth, and the absence of workplace hostility. Many employers are seeking ways to increase wellbeing in the workplace.

However, for many people the workplace exists as source of stress. Burnout at work is common and often contributes to problems in the family, marriages, and health. Stress is connected to a wide variety of physical health problems, including heart disease and obesity. When the workplace is unsupportive, mental health needs may become exacerbated.

These barriers often are heightened for people of color and other minority groups. Inequities based on race, stigma, and discrimination drive continuing disparities in healthcare outcomes. Structural discrimination makes people of color less likely to receive work-based benefits or access healthcare through their employer.

Thoughtful, research-based mental health support in the workplace improves the mental wellbeing of all community members, regardless of profession or work setting. In turn, families and communities will benefit from a healthy workforce. Ensuring that all workers, regardless of race or income, can work in a healthy environment and can access the support they need matters to the wellbeing of the community.

System Barriers

Inherent barriers deter access to solid workplace mental health practices. Below are some barriers identified by employers and employees:

- **Stigma**: Below the surface, stigma and discrimination are still rampant in society. Employers are often unfamiliar with mental health needs in the workplace, how they may manifest, and about their responsibility and resources to support employees.
- **Difficult Access to Mental Health:** When employers offer mental health benefits, there are frequently barriers to accessing care. Employers or employees may need to call many phone numbers, do a substantial amount of research, and still may not be able to access the right kind of care to meet their needs. When they do access care, co-pays and deductibles are often costly.
- **Lack of Information:** There is a lack of clarity and consistency about best practices for workplace mental health. Many employers and employees are unclear about laws and rights as they pertain to mental health in the workplace. Few models offer reliable, cost-effective solutions. Without standards or guidelines, employers are left to "reinvent the wheel", making their way on their own.
- **Mental Health Workforce Shortage**: Like other states, California has a significant shortage of mental health providers. This affects both the public and private mental health systems. As a result, even employers who provide comprehensive mental health benefits report their employees seeking treatment experience long wait lists and a limited variety of service intensity to meet more complex needs. Time spent waiting for treatment exacerbates mental health needs.

Opportunities

Leadership

The State has an opportunity to provide leadership on workplace mental health through the development and implementation of voluntary standards. Now, more than ever, employers understand the need to support employee mental health. Employers have become increasingly focused over the past 20 years on workplace mental health. COVID-19 has further propelled the conversation around workplace mental health to the forefront of operations, while also highlighting barriers in access to care and inequities in our healthcare system and society. But employers are looking for resources to support this work. The standards provide an opportunity to offer research-based and community defined best practices to employers to bolster their workplace mental health strategies.

Leadership in workplace mental health may also include supporting peers in the workplace, policy changes and adjustment to labor law, the creation of a task force to focus on this issue,

and leaders modeling vulnerability and sharing their own experiences with mental health. All of these opportunities can reduce stigma and discrimination about mental health.

Prevention, Increasing Access to Services and Mental Health Parity

Prevention of mental health challenges can begin in the workplace. Adults who find meaning in their work, experience healthy work environments, and have access to a full continuum of mental health supports can be healthy and thrive. All adults, including people of color, should have access to psychologically healthy work cultures and supports.

The State can play a role in addressing current shortcomings of both the public and private sectors by exploring incentives to enhance mental health benefits. In doing so, the State can explore opportunities to strengthen parity with health benefits. The State can also expand the mental health provider pipeline through incentives like the use of WET (Workforce, Education, and Training) funds or other personnel development opportunities.

Systemic opportunities to enhance mental health benefits, coverage, and improve outcomes are also possible by placing emphasis on the employer-sponsored healthcare industry. Private insurance companies offer the largest source of both physical and mental health benefits for the employed population. Employers who purchase these benefits assume a responsibility to make sure the needs of their employees are met, and their purchasing power can drive improvements in access, availability, and the quality of mental health services.

Through policies that encourage employer involvement, the State can partner with the public and private employers to improve behavioral health care benefits. This partnership may well relieve pressure from the overburdened public mental health system. Private insurance companies, propelled by California employers, can help reduce pressure of the system.

Data and Transparency

Finally, the State can use data to improve mental health care systems in the public and private sectors. For example, the Commission is in the process of linking EDD (Employee Development Department) data with mental health data to explore wage changes and impact of mental health on employment. This research can help drive policy decisions about labor and mental health practices in the workplace. Additionally, employer stakeholders have asserted that increased transparency around managed care plans (particularly process measures and outcomes) would be beneficial in decision making when purchasing mental health benefits.

Ultimately, as adults receive improved support in the workplace and have access to an array of mental health resources, and the mental health system increases its capacity, mental health in California can realize the systems change envisioned in the MHSA.

The Workplace Mental Health Project

The Mental Health Services Act (MHSA) was established to drive transformational change of the mental health system in California. The values articulated in the Act expressed the imperative to fundamentally change how mental health needs are met and how to promote the mental wellbeing of all Californians. The Act envisions prevention and early intervention activities as essential to transformational change. While traditional mental health services provide a safety net for people with severe mental illness, the MHSA dedicates funds to preventing mental illness from becoming severe and disabling and promoting wellbeing.

To support this priority, the Commission is undertaking a project to advance support for mental health in the workplace. This project is mandated by SB 1113 (Ch.354, Statutes of 2018), which directed the Commission to explore opportunities to develop voluntary standards for workplace mental health. Recognizing that over half of all of Californians obtain health coverage for themselves and their families through their employment (2017, California Health Interview Survey), this project also furthers the Commission's emphasis on strategies to support access to high quality mental health services outside of the MediCal system. Efforts to improve access to care outside of MediCal take pressure off California's mental health safety net; and thus, can improve outcomes for all.

This project has multiple goals. While the legislation focused on development of standards for employers, the Commission anticipates many benefits of engaging stakeholders in discussions about workplace mental health. Goals for the workplace mental health project include:

- Research and disseminate information on the benefits of emphasizing workplace mental health (i.e. productivity, less absences, etc.) and learn what additional research is needed,
- Research current practices in workplace mental health and prevention opportunities that meet the needs of employers and employees and reduce racial disparities,
- Identify risk and protective factors for mental wellbeing in the workplace,
- Provide a framework to organizations for creating policies and processes to address mental health in the workplace and incorporate diversity, equity, and inclusion practices,
- Assess the utility of developing a certification/ strategy to support the adoption of the voluntary standards for workplace mental health,
- Support public and private collaboration relative to workplace mental health initiatives,
- Explore incentives for public and private organizations to prioritize and implement mental healthcare approaches in the workplace.

Research Strategy

The Commission contracted with Carolyn Dewa, PhD from the University of California at Davis, to write a brief that provides a landscape and foundation for workplace mental health in California. It addresses the challenges and opportunities for mental health at work and includes summaries of the economic consequences of mental illness in the workplace, the research about risks in the workplace and roles of accommodations and stigma as they relate to disability prevention, and international standards and guidelines for workplace mental health.

The brief is intended to serve as a starting point, to lay the foundation, create a shared understanding of the problem, and offer possible paths forward to develop a framework or standards for workplace mental health.

Stakeholder Engagement

The Commission partnered with One Mind at Work, a non-profit focused on supporting workplace mental health and well-being, to interview employers and subject matter experts and hold virtual listening sessions to obtain input about workplace mental health barriers and opportunities. One Mind prepared a landscape analysis based on these meetings to provide discussion points during a series of public engagement activities.

On May 27, 2020 the Commission co-hosted with One Mind at Work a virtual subcommittee meeting to gather information to support the development of the Standards and communicate project progress. This meeting was held virtually due to the COVID-19 pandemic. Meeting materials are online.

On December 17, 2020 the Commission held an Employer Roundtable with 12 employers. This meeting was designed to gather information about best practices, barriers and opportunities to further inform the development of the Standards. The 90-minute meeting included discussion about mental health prevention in the workplace, stigma and discrimination, challenges with access to mental health services, and opportunities to support employees at work. (A meeting summary will be available shortly.)

Commission staff have been meeting with or interviewed over 65 of employer and employee representatives from across sectors and industries about the needs and opportunities to consider in the development of Standards for workplace mental health. (Participants are listed in Appendix A.)

Future opportunities for engagement will include public meetings with diverse mental health providers (social workers, psychologists, clinicians), diverse chambers of commerce across California, and Diversity, Equity, and Inclusion subject matter experts.

Public Hearing Outline

The public hearing at the March Commission Meeting will provide project updates, including a panel presentation from subject matter experts and lessons learned from our work with One Mind at Work. The purpose of the first public hearing is to support the Commission's understanding of challenges and opportunities related to workplace mental health. Speakers will review how the workplace affects mental health and why the workplace is a strategic environment for mental health prevention and promotion. The hearing will also begin to introduce the opportunities for the workplace to build resilience for all employees, and to increase help-seeking and access to services for those who need more support.

Considerations for Commissioners:

- How can workplace mental health strategies enhance a larger prevention and early intervention framework for mental health?
- How could the State support strategies that will increase access to care and decrease stigma given the diversity of California's employer and employee population?
- How should the State incentivize workplace mental health in grant funding, innovation priorities, and in the use of WET funds at the local level?
- What policies and practices should the State target to incentivize mental health parity and quality of care standards across the state?

Appendix A

Project staff interviewed or held focus group discussions with representatives of the following organizations:

Labor

- California Teachers Association
- SEIU

Academia and Research

- Stanford University
- University of California at Davis
- University of California at Los Angeles
- Tufts University
- FM:3 – COVID Research

Public Employers

- California Government Operations Agency
- California Department of Human Resources
- CalPERS
- Department of Managed Care
- Department of Industrial Relations-Workers Comp
- Department of Rehabilitation
- Department of Social Services
- California Committee on Employment of People with Disabilities
- Los Angeles County Behavioral Health
- San Louis Obispo County Behavioral Health
- Madera County Behavioral Health

Retail and Hospitality

- CVS Pharmacies
- Levi's
- Mulvaney's B&L

Healthcare

- Kaiser Permanente
- Futuro Health
- Alexion
- BHS-Behavioral Health Services
- Morneau Shepell
- Cedar-Sinai Hospital
- Cardinal Health
- Johnson and Johnson
- American Ambulance
- National Alliance of Social Workers-California Chapter
- California Psychological Association

Business Groups

- Business Group on Health
- Pacific Business Group on Health
- Fresno Business Group
- California Chamber of Commerce
- California Black Chamber of Commerce

Banking, Legal, Real Estate, Investment, and Consulting Firms

- Reed Smith LLC
- Bank of America
- Liberty Mutual
- TPG
- Ernst and Young
- Hispanic Realtors Association
- Kearney

Utilities and Engineering

- PG&E
- Northrop Grumman

Education

- California Department of Education
- Student Mental Health Workgroup
- Breaking Barriers

Commissions

- Mental Health Commission of Australia
- Mental Health Commission of Canada

Workplace Mental Health Advocacy Groups

- One Mind at Work
- Center for Workplace Mental Health
- The Steinberg Institute
- The Stability Network
- Empower Work
- Unmind
- Mind Share Partners
- HERO
- Mental Health America: Mind the Workplace
- The Kennedy Forum

Other Mental Health Advocacy

- Young Presidents Organization
- The Steve Fund

Additionally, Commission staff have interviewed all Commission contracted stakeholder groups to learn about cultural diversity in the workplace; needs and strengths that can be leveraged in workplace mental health strategies. These groups include:

- Vision y Compromiso
- African Communities Public Health Coalition
- Hmong Cultural Center of Butte County
- Healthy House within a MATCH Coalition
- Health Access
- VetART
- CALBHB/C
- Boat People SOS
- United Parents
- California Pan-Ethnic Health Network
- NAMI California

Workplace Mental Health In California

A Landscape Analysis

May 2020

Contents

Executive Summary

This landscape analysis of workplace mental health in California was developed from a review of case studies and interviews with experts. This document will inform stakeholders as they discuss the development of voluntary standards for employers to support workplace mental health in the state.

The report outlines three main areas: (1) insights into the current environment, including internal and external drivers, that are informing steps employers are taking and their areas of focus; (2) emerging trends and challenges faced by employers; and (3) recommended actions for the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Some 450 million people live with a mental health condition globally, accounting for 14 percent of the global burden of disease[i] and costing the global economy double the combined cost of cardiovascular disease and diabetes.[ii] Though treatments are available for many mental health conditions, the majority of people do not seek help in managing them.[iii] In California, an estimated 6.5 million adults are living with a mental health condition, and people at lower income levels are disproportionately affected. Over the past years, mental health has become more salient in the minds of employers than ever before, with 72 percent of U.S. workers wanting their employers to advocate for mental health and well-being in the workplace. There is also increasing evidence that promoting workplace mental health is not just good for workers, but also good for the bottom line. According to the World Health Organization, every dollar spent on improving treatment for common mental disorders generates a return of four dollars in improved health and productivity.[iv]

Many employers perceive California to be a leader in employer-led mental health services, leveraging state guidelines that strengthen employee access to mental health care and reduce the stigma associated with it. Employers who were interviewed voiced a goal of deploying a holistic approach to wellness (including mental health) to create environments where people can support themselves so they can perform their best at work. Employers are implementing mental health awareness trainings or awareness campaigns focused on mental health, and some are even making the training mandatory for employees. This is often accompanied by the engagement of managers, since leaders who receive training are more likely to share information and be more supportive of mental health needs. In addition, support networks among peers are a tool increasingly supported by employers to supplement access to mental health care providers, and that can help to normalize help-seeking. Employers shared a common view that language around mental health challenges must be carefully considered from the outset and is a critical part of the development of policies related to workplace mental health.

Looking ahead at emerging trends and challenges for workplace mental health, the impact of COVID-19 and measures taken to slow the spread of the virus must be considered, including lasting changes as a result of the pandemic related to continued remote working, altered workplace environments and new strategies for employee interactions. The global mental health movement is driving forward progress in many areas, though advances may be uneven across geographies. Remote care and digital mental health platforms offer great promise to employers, and their use has been swiftly adopted in the current environment. As younger employees enter the workforce, they have brought more openness and increased expectations for employers to support mental health, although at times these preferences are framed as other benefits. However, in multi-cultural environments, employers report continued issues with stigma, particularly along socioeconomic lines. For some advocates, stigma is better characterized as discrimination because of the barrier it creates for people to enter the workforce or perform to their full potential in their jobs.

Employers are invested in addressing the challenges to accessing care that employees are experiencing and will continue to experience despite increased employer support for mental health. Additionally, employers are seeking more effective ways to measure and analyze the impact of support and services, including through treatment outcomes, to better understand the needs of employees.

Employers in California are interested in partnering with the state on defining the attributes of a workplace that supports mental health in order to set standards and demonstrate best practices, and to share these findings with diverse audiences in ways that support their implementation across work settings. There is a significant opportunity for building up the body of research on workplace mental health interventions deployed in the state to inform employer decision-making. Advocates in workplace mental health would like to see state-level policies

reflect research-based insights into effective strategies for mental health support. Employers also see an opportunity for the state to drive forward higher reimbursement rates for mental health professionals to promote better access, alongside metrics gauging the effectiveness of mental health care delivery. Finally, the state is a critical stakeholder in curbing discrimination against people with mental health conditions through both education and regulation.

With these insights, this report will guide a discussion among key stakeholders to develop a set of voluntary standards for employers in California to implement in their workplaces.

Introduction

Project Background and Purpose

The Mental Health Services Act is the legal framework for mental health in the state and directs the development of strategies to reduce stigma and unemployment for Californians diagnosed with a mental illness or seeking mental health services. Subsequent legislation, Senate Bill 1113 (Chapter 354, Statutes of 2018), directed the California Mental Health Services Oversight and Accountability Commission (MHSOAC) – from here on out to be referred to as "the Commission" – to create voluntary standards for employers that would promote mental health and wellness in the workplace.

The Workplace Mental Health Project aims to improve awareness of and attention to mental wellness by employers and employees in the competitive employment sector as a strategy to reduce stigma and discrimination, prevent the progression of mental health challenges, and improve the early recognition and appropriate treatment of mental health needs. Two core components of this project are (1) to develop a shared understanding of the challenges of and opportunities for improving behavioral health in the workplace and (2) to develop and promulgate a set of voluntary standards.

To support robust stakeholder engagement in the development of workplace mental health standards, the Commission worked in partnership with One Mind at Work, a global workplace mental health nonprofit organization based in California, to produce this landscape analysis. Our aim was to summarize current trends and needs of employers and employees for mental health in the workplace, including differences and commonalities in access to mental health services, organizational culture change, mental health literacy and stigma reduction efforts.

How Will the Landscape Analysis Be Used?

The analysis will be a foundational document as we convene stakeholders to discuss workplace mental health in California and to share best practices that will inform the development of voluntary standards.

Why Focus on Workplace Mental Health?

Most adults spend one-third of their time at work.[v] The workplace and its leaders have a tremendous opportunity to improve quality of life for all people and play a critical role in driving mental health solutions. Employers also benefit from activities that support positive mental health, as studies have shown that for every dollar an employer invests in improving employee mental health, there is a return of four dollars in increased health and productivity. [iv]

We recognize that employers today are encountering an entirely new environment – particularly with regard to employee mental health – as the impacts of the COVID-19 pandemic are felt by communities around the globe. Even though measures like social distancing and self-isolation are only temporary, the effects of these and other pressures may trigger or exacerbate mental health challenges such as post-traumatic stress, anxiety or depression. This evolving situation may be raising important questions and shifting priorities within your organization, and we would like to use this discussion to explore current activities as well as plans for the future.

Research Methodology

Both primary and secondary research was conducted through literature review, interviews with employers, and Natural Language Processing (NLP) data analytics. Additionally, since 2017, One Mind at Work has developed a variety of insights and recommendations related to workplace mental health in its CHRO Insights Series that were included in this analysis. Building off this material, structured interviews were conducted with a broadly representative array of California employers, in terms of employer size, industry, geography, and sector, so as to better understand their views on workplace mental health, priority areas of focus, and the role the state of California can play in promoting workplace mental health best practices among employers. In addition to employer interviews, we spoke with policy experts, first responders, and healthcare and education professionals to gain an understanding of the mental health landscape in California, including current trends and case studies that cover organizational culture, access to services, mental health literacy and stigma reduction efforts.

We would like to thank the following contributors to development of this report for their time and insights:

- Melanie Eisen, TPG Global
- Monroe Gorden, University of California, Los Angeles
- Tom Insel, Mindstrong Health and Mental Health “Czar” of California
- Caroline Johnson, County of San Luis Obispo
- Lisa Jonsson, Cedars-Sinai Medical Center
- Ken Katz, American Ambulance
- Craig Kramer, Johnson & Johnson
- Maggie Merritt, Steinberg Institute
- Nestor Veloz-Passalacqua, County of San Luis Obispo
- Michael Weiner, EY

Current Landscape

The Global Mental Health Crisis

Around 450 million people currently live with a mental health condition globally, placing mental disorders among the leading causes of ill-health and disability worldwide.[vi] Roughly 14 percent of the global cost of disease is related to mental health conditions – including depression, substance abuse disorders, and other mental illnesses, a figure which is likely an underestimation.[vii] Mental health conditions cost the global economy roughly double the combined cost of cardiovascular disease and diabetes.[viii] The financial cost of poor mental health to employers is most easily illustrated through the sickness absence of employees,[ix] and such absenteeism costs employers $2,650 per salaried employee per year due to lost productivity.[x] Treatments exist for many mental health conditions, but the majority of people with a diagnosed mental health condition never seek help from a mental health care professional.[xi]

However, mental health is not just the absence of a mental health condition, but a "state of mental well-being" as defined by the World Health Organization.[xii] Multiple social, psychological, and biological factors influence individual mental health, and poor mental health is associated with "rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations,"[xiii] as well as certain psychological and personality factors and genetic pre-dispositions.

California-Specific Figures and Statistics

Nearly 1 in 6 California adults experience a mental illness of some kind (roughly 6.5 million adults). One in 24 have a serious mental illness that makes it difficult to carry out major life activities, and 1 in 13 children has an emotional disturbance that limits participation in daily activities.[xiv] In California, the prevalence of serious mental illness varies by income, with both children and adults at lower income levels experiencing much higher rates of mental illness.[xv]

Those with diagnosable mental illnesses represent only a fraction of the working-age adults experiencing mental health challenges related to stress, anxiety and depression. However, roughly two-thirds of adults with a mental health condition in California have not received treatment.[xvi] Compared to the U.S., California has a lower rate of suicide, though the rate varies by gender, age, race/ethnicity, and geographic region.[xvii]

The Business Case for Promoting Workplace Mental Health

According to the World Health Organization, every dollar spent on improving treatment for common mental disorders generates a return of four dollars in improved health and productivity.[xviii] Research suggests that Employee Assistance Programs provided by employers improve employee mental health across a spectrum of disorders and reduce employee absentee rates.[xix] Some 72 percent of U.S. workers want to see their employers advocate for mental health and well-being in the workplace, though only 14 percent of employers report senior leaders discussing the importance of mental health openly.[xx]

The Current Role of the State of California

Employers perceive California to be a leader in employer-led mental health services. Under the Mental Health Services Act, the Commission is to develop guidelines that will help companies strengthen access to mental health care for their employees and reduce the stigma associated with it.[xxi] This includes protections for people with substance abuse issues to help them voluntarily seek treatment to facilitate their return to work. California law also protects employees based on perceived disability under the General Prohibitions Against Discrimination on the Basis of Disability. Even if an employee does not disclose to their employer that they have a mental health disability the employee may claim discrimination on the basis of a perceived disability.[xxii] The Governor appointed a "Mental Health Czar" in 2019 to help improve mental health coordination of efforts across the state. The role is to "inform the state's work as California builds the mental health system of tomorrow, serving people whether they are living in the community, on the streets, or if they are in jails, schools or shelters."

California leverages tax systems and local strategies to direct funding for mental health services. Proposition 63 (the Mental Health Services Act) in recent years has provided $2.5 billion in tax dollars annually for county mental

health services, including programs targeting the most at-risk, such as people who are homeless, as well as incarcerated populations and children. This Act imposes a 1 percent income tax on personal income in excess of $1 million.[xxiv] However, among the 58 different county-level care delivery systems in California, experts report limited coordination and support for people with mental health challenges. Employers are a critical access point to mental health support to prevent mental health needs from becoming severe and disabling, and to build resilience.

Employer Insights and Case Studies

A synthesis of our interviews with California employers, policy experts and healthcare and education professionals elevated six areas that present the greatest opportunities to positively impact workplace mental health:

1. Holistic Approach to Health, Both Physical and Emotional

Increasingly employers are making commitments to care for employees, even when not required by law (such as providing an Employee Assistance Program or EAP) out of recognition that mentally healthy employees are more productive employees. For some, this includes a comprehensive view incorporating "spiritual health [which is broadly defined,] mental health and physical health." Employers voiced a goal of reducing stigma and creating environments where people can support themselves so they can perform their best at work. This was particularly prioritized in high-stakes employment environments, including a proactive and preventative approach to mental health in fields where absenteeism or presenteeism are not acceptable options.

Employers are also reacting to external phenomena, such as the widely reported suicides of Anthony Bourdain and Kate Spade, prompting several business leaders to speak out regarding suicide and mental health to their workforces. Some organizations have trained supervisors worldwide to ensure that all managers understand mental health basics.

Employers are considering ways that they can involve and prioritize families, with leadership communicating that people should strike a balance of time away from work. In one example, an employer participating in a study on resilience expanded the study to include spouses after seeing promising benefits to employees.

2. Reducing Stigma Through Training

Employers across California are implementing trainings and awareness campaigns focused on mental health, including insights on the experience of living with a mental illness, and some are making this training mandatory for all employees. [xxv] Examples include virtual discussions and streamed webinars to disseminate educational information on different mental health issues.[xxvi] One program focused on training employees to interact with external audiences such as clients and customers, which "created a perception of value connected to the training and gave participants a perception of comfort in participation." In addition, employers highlighted the importance of culturally relevant education because employees may hold different expectations and stigmas depending on their background.

Employers stated that trainings to reduce stress and build resilience can be an important element to their mental health programs. One even noting that resilience is the leading determinant of success in their field, but it cannot be the expectation of the organization that these methods would be sufficient for all employees. Similarly, mental health apps available for employers can be a useful tool but may also offer insufficient or ineffective support for mental health challenges and should be integrated into a more comprehensive strategy.

3. Top-Down Approaches and Management Buy-In (Executive Team to Front-Line Supervisors)

Leadership engagement is a critical element of mental health support for many employers – leaders engage in setting the commitment, amplifying messages, and demonstrating an example of attention to mental health in the workplace. Additionally, leaders who receive training share more information about mental health and mental health resources, are more supportive of employees' mental health issues, and actively encourage employees to use available resources. [xxvii]

Employers shared that without support from the top levels of the organization, there will be no meaningful change toward a more mentally healthy workplace. For this reason, leadership support for new initiatives and expanding programs was essential throughout the development phase as well as during implementation. Employers highlighted that they were able to gain buy-in from multiple departments and personalize tailor the concepts for

different organizational functions. They focused on accommodating competing priorities and gaining commitment from across departments so leadership would be supportive. One employer noted an issue with one part of management approving activities but others would not, so the project leads would continuously need to gain buy in from all levels. This meant being very flexible and receptive to the needs of various parts of the organization. Another noted a need to facilitate communication across management on workplace mental health issues, building on a growing interest to align efforts.

Some employers described creating different sets of communication tools, one aimed at leaders and one aimed at the general workforce, discussing support for mental health to reach these core audiences more effectively. Another employer described reorganizing the management team for a mental health initiative in order to better align the organizational leadership in recognition that it would help the effort have greater impact across the employee community.

Some employers said that even without a formal mental health mandate, there is a will among organization leaders to provide high quality, comprehensive coverage to employees and families. Training deployed by employers at the management level explored ways to provide support, including giving examples of tools for various audiences. Additionally, employers noted that it was important to allow time to fully implement new programs and practices, as to not "overwhelm" employees with training and to see effective adoption. Some employers noted a major barrier was the recognition that there were employees with mental health challenges who were not seeking help. In these instances, leaders of the organization were active in the development of a multi-faceted communication efforts to raise awareness about available support and services.

4. Professional and Peer Support

Employers have invested time and energy investigating and attempting to address the barriers related to seeking support, including around the various types of support that employees are willing to engage. Often, employers are deploying a combination of professional mental health support services and peer support networks to meet these needs. Some employers are targeting workforce sections – for instance medical residents and nurses – but also allowing people to self-assess by offering "drop-in" or informal appointments to learn about available support tools and resources. Some employers noted that confidentiality in external employee assistance programs boosts participation; and for employers with an internal network of mental health care providers, employees were connected with a therapist external to the organization to preserve anonymity.

In fields that experience high levels of trauma, employers noted that a high number of employees resist professional services, instead confiding in colleagues or peers who "get it." In particular, these employees seem to be comfortable addressing these traumatic experiences with colleagues who have also experienced them. In some instances, employers have attempted to bridge the gap between peer support and professional mental health services by encouraging peer support specialists to disclose their usage of an EAP as a way to destigmatize help-seeking. Sharing resources in the context of a personal experience helps to demonstrate their value.

Several employers noted that peer-to-peer support was critical in their field because administrators and program directors are closely engaged in workplace mental health. This included a focus on substance abuse disorder, an area of mental health that can be highly stigmatized. Peer networks are a tool for employers in rural communities as well, where there are fewer mental health care providers available, resulting in long wait times to be seen. In these cases, training of managers and other senior staff was used to provide initial mental health support and counseling and elevate more acute cases to clinicians.

5. Access to Services

According to the Society for Human Resource Management, 78 percent of companies in the U.S. offer an Employee Assistance Program (EAP) with mental health resources.[xxviii] Many California companies surveyed have adopted an integrated EAP that provides a consolidated portal with tools, including short-term counseling and advice to improve employee mental well-being. Also utilized were specific online trainings on managing grief and suicide awareness.

In some instances, employees helped organizations to discover that provided insurance coverage on mental health was uneven or inadequate, leading the leadership to investigate the percentage of mental health care

professionals in the network and the number offering telehealth or virtual options. One company shared their finding that 90 percent of physical health care providers were in-network while that was the case for only 20 percent of the mental health care providers, leading the organization to push for more in-network options as well as virtual support meetings and telehealth services for mental health. Employers also noted a strong desire for more data driven treatment approaches and care options for mental health, including routine exams and direct access to mental health therapists.

6. Communication Strategies and Mental Health Information Dissemination

Employers shared a common view that language around mental health challenges must be carefully considered from the outset and is a critical part of the development of policies related to workplace mental health. Employers recommend using words like "wellbeing" and "mental health" rather than references to specific conditions or terms that imply a deficiency. Language should be welcoming and friendly, with some employers recommending moving away from clinical or even mental health terms and reorienting to community-based language understanding in everyday interactions. Many employers are striving to communicate with their workforces in ways that resonate with those specific audiences and using examples that relate to those employees and their situations. Employers also sought continual feedback regarding making materials relevant to employee groups, including how to best tailor information to support its integration into employee activities.

Employers have deployed training modules that focus on providing managers with the skills needed to create a "resilient work environment where all employees feel comfortable discussing their mental health needs, thereby reducing stigma." Others have taken a multi-faceted approach that includes communications, training, interactive meetings and storytelling capturing how individuals in the organization have been personally affected by mental illness.

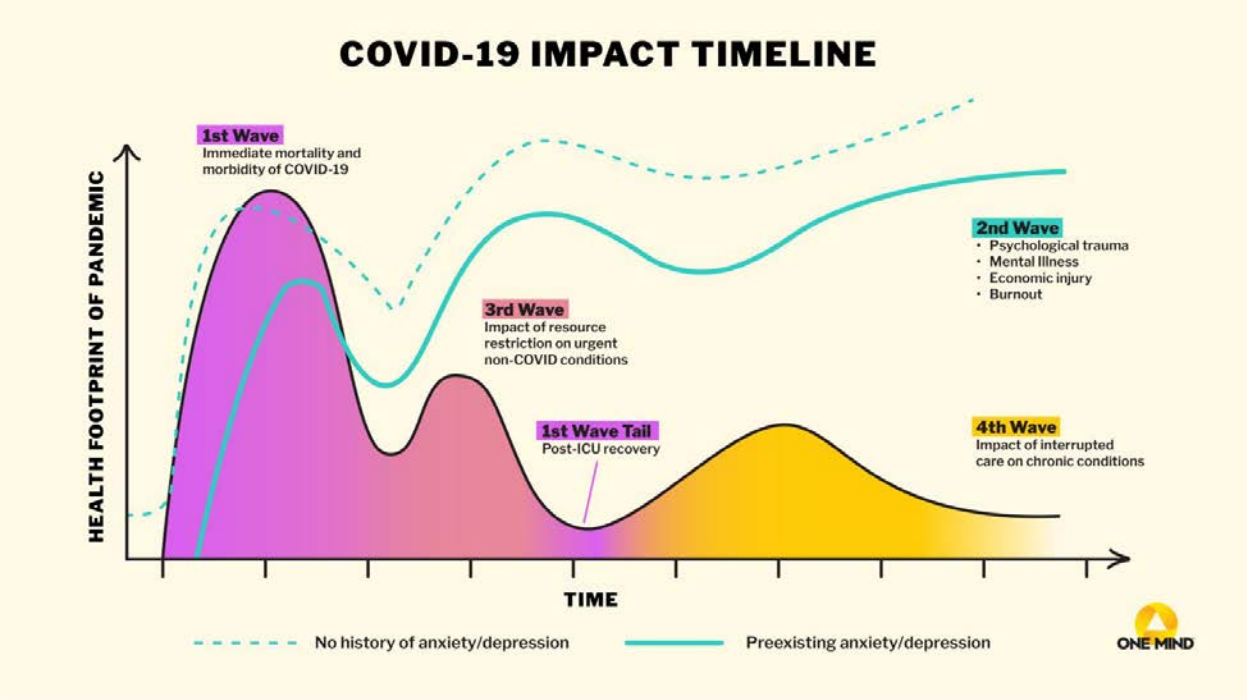
The Impact of COVID-19

The COVID-19 pandemic has lasting impacts on all aspects of society, and the unprecedented public health crisis is having a significant effect on mental and emotional wellbeing. Employers are preparing for lasting changes as a result of the pandemic, including continued remote working, altered workplace environments and new strategies for employee interactions. There has been an increase in the availability of virtual solutions for mental health and changes in employer prioritization and perspectives around mental health that are likely to have lasting impact as well.

Some organizations have been able to transition to an entirely virtual operating model as the environment required, with some employers reporting that increased video conferencing and concern around the effects of quarantining have brought colleagues together.

However, so-called "warm lines" and hotline utilization for mental health support has increased over 800 percent, and there has been an increase in suicide rates. Mental health conditions have been characterized as the "second curve" of the pandemic (the first curve being the incidence of people with COVID-19) driven by stress and anxiety related to the current environment, possible barriers to accessing medications and mental health care providers, or even the loss of insurance and income (see Figure 1). Several studies demonstrate a correlation between a rise in unemployment and an uptick in mental health issues.[xxix] including in people with no history of mental illness.[xxx] Collective grief, prolonged physical distancing and associated social isolation as a result of the pandemic has the potential to trigger widespread mental health challenges. A recent study conducted a cost driver analysis, using national insurance claims data and found that 60 percent of overall medical expenditures are driven by the 23 percent of members who have mental or substance use disorders. An increase in new behavioral health cases will lead to a substantial increase in medical costs for insurers and employers.[xxxi]

Employers shared that contingency planning and the rapid creation of response teams have helped to navigate challenges related to COVID-19. However, despite having emergency plans in place, leaders did not feel fully prepared in their response. Organizations are now testing means of support for employee mental health in remote



environments, including partnerships with mental health care providers outside of their communities (including

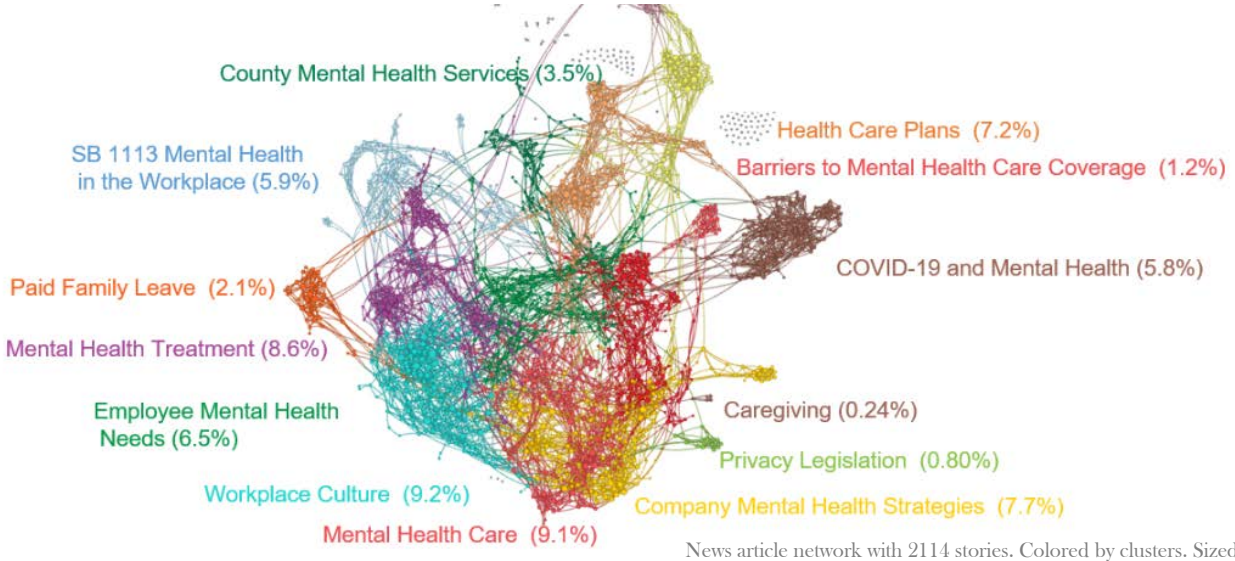
Figure 1. A graphic illustrating the "second curve" of the COVID-19 pandemic, which is characterized by longer-term psychological trauma, mental illness and economic injury that is to follow the immediate impacts of the pandemic.

other states) to meet demand. The Business Group on Health conducted a survey in April 2020, outlining mental health trends of large employers, and finding that over nine in ten respondents (93 percent) are encouraging employees to utilize EAPs during the pandemic and over two-thirds of respondents (68 percent) are actively encouraging employees to use telemedicine during the COVID-19 crisis.[xxxii]

Emerging Trends and Challenges

Trends over the last 6 months demonstrate diverse employer mental health conversations. Top trends in California workplace mental health include: Access to mental health services, Workplace Culture, Mental Health Treatment, Company Mental Health Strategies, and Organizational Culture Change. A Conversational Analysis was conducted to evaluate the state of mental health in California workplaces using a Natural Language Processing (NLP) tool that reads millions of documents including news, surveys, social media, and forums. The analysis (see Figure 2) shows topical clusters of over 2114 stories from the last two months of 2019 and the first four months of 2020.

Figure 2. Results of a Natural Language Processing (NLP) analysis graphically displaying 2114 mental health-related stories into distinct topical clusters. The analyzed stories were published between November 2019 and April 2020.



Advancement of the Global Mental Health Movement

Recently, celebrities and public officials have publicized the struggle of mental illness and made great strides in normalizing the discussions around depression, anxiety and suicidality, among other conditions. Advocacy organizations like Mental Health America have disseminated messaging that has also elevated public understanding of mental health. Globally, initiatives are advocating for improved delivery of mental health services and interventions, particularly in low- and middle-income countries. The movement has gained momentum but also highlighted the persistent issues that remain, including stigma, lack of access to support and services, and the continued disparities between countries.

Employers noted a sense of progress in people willing to connect as human beings rather than coworkers/employees, and in people leading their own mental health advocacy through being open about their own experiences and needs.

Increasing Acceptance for Remote and Virtual Care Options

As a result of the current environment, employers have seen a dramatic increase in the number of people working from home and are strategizing ways to keep them from feeling isolated and ensure they are still engaging as part of the team. The movement to working from home has accelerated a shift that was already taking place to

embrace remote care and telemedicine, options which advocates also state are more convenient for users and delivered less expensively. Remote care is also often a preference for employees who are reluctant to interact with mental health support in the workplace, and employers report building evidence that digital tools can have a beneficial effect, with usage that is on par or greater than more traditional EAP services.

Key challenges remain, however, for digital and remote care, including the difficulty in maintaining individual engagement with app-based support. Employers also questioned the standards for evaluation used for digital platforms and telehealth, calling for sufficient data to demonstrate that the less expensive virtual services still had positive outcomes for users.

Employers were adamant that remote work is changing how they operate for the foreseeable future. They discussed that they are creating new strategies for recognizing mental health issues remotely and providing appropriate support from a manager perspective, as well as trying to identify successful approaches and planning to make appropriate adjustments in the future. From an employer perspective, there was a strong desire to accommodate people who will take advantage of both in-person and remote options, both in their work settings and in accessing mental health.

Shifting Demographics in the Workforce and the Impacts on Culture and Services

Many of the younger employees joining the workforce have brought more open attitudes regarding mental health and different expectations for workplaces. Employers are striving to recruit and retain these workers, with one noting that in the same way they would encourage alumni to recruit from their university, they encourage recruitment from mental health groups as a way to continue to expand representation of people living with mental health conditions. Another employer shared that younger workers are interested in organizations that provide proximal indicators of a positive culture or work-life balance, e.g. generous benefits, support for new parents, and other resources.

A critical contributor for some employers to the development of effective programs and policies was an accessibility network of people with visible and nonvisible disabilities, while others have engaged specialized consultants or legal experts to ensure robust compliance. However, in some multicultural environments, employers may have a greater need for stigma-reduction activities to overcome cultural barriers. Employers were optimistic that remote care and digital tools would continue to reduce the stigma of mental health challenges in these populations, but that socioeconomic disparities would linger.

Mental health advocates have called for mental health to be considered alongside physical health in terms of accommodation (not unlike compliance with the Americans with Disabilities Act) and with the goal of ending discrimination. Employers are responding positively to the message that people living with mental illness can thrive in their jobs and are capable of great achievement with the right support.

Continued Reduction in Stigma, but Discrimination Still Persists

Stigma surrounding mental health conditions prevents many employees from accessing available mental health benefits and resources,[xxxiii] and employers in California view reducing negative perceptions associated with help-seeking as a core priority. An emerging theme in California was the replacement of references to “stigma,” using instead the word “discrimination” to highlight the barriers to workforce participation for people with visible signs and symptoms of mental illness. Advocates related these obstacles to those faced by people with physical disabilities.

Employers raised concerns that attempts to address stigma could be ineffective if they set unrealistic expectations about the ability to self-manage mental health challenges, like grief or depression. In some fields, employers are also encountering “compassion fatigue” which can make an empathetic response to colleagues experiencing a mental health challenge more difficult. Efforts to combat these perceptions included multi-pronged strategies for awareness and support.

Persistent Inequality in Access to Care

Even in countries with an advanced response to mental health, there are inadequate numbers of mental health care providers, and this remains true in California. There are not enough mental health professionals, particularly in non-urban settings, to provide a consistent level of support to every person with a mental health challenge or

condition. One of the challenges employers in California experience is that mental health insurance networks are often not able to meet the demands of the population served.

Reimbursement rates for providers in insurance networks remains a core issue, forcing many employees to seek help outside of the network at high personal cost or to not pursue care. Increasingly, employers are considering virtual care tools, including digital platforms, to fill the gap. Some EAPs have long-standing virtual options but had low utilization until the recently when the environment has forced users to explore this option.

In order to offset needs in the most urgent cases, employers are deploying more resources in settings impacted by crisis – whether directly related to the business (e.g. bank tellers victimized in a robbery) or connected by proximity (e.g. an office located in a city attacked by terrorists.) These critical incident responses target employees for additional mental health support based on their role, location or other factor instead of individual need.

The shortage of professional service providers is a significant factor in lack of access alongside cost barriers. Increases in the number of unemployed people, and therefore people without employer-provided insurance, are likely to further negatively affect access.

Challenge of Measuring Outcomes and Strategies for Success

Organizations have been moving away from utilization of available services as the primary measure for mental health support, instead combining this information with user satisfaction data, including leveraging social media for online feedback opportunities. Others have engaged third party assessors to apply outcome measures in order to understand the impact of available programs and services. Employers predict that this same level of scrutiny will be applied to telehealth and remote care moving forward. Many employers discussed the benefit of implementing mental health programs and best practices, but they continue to need better data to analyze the impact of specific interventions. This lack of quantitative, company-specific evidence can limit employers' efforts in mental health.[xxxiv]

Employers observed that in settings with higher rates of trauma for employees, the impact of mental health support may be obscured, but is still critically important. Professionals at the front lines of crisis response, for example physicians and nurses in the current environment, will continue to work with sick patients and will continue to be retriggered time after time causing their mental health to suffer even while they are engaging with available support.

Recommendations from Employers for the State of California

State-Level Guidance on Mentally Healthy Workplace

Employers in California are looking for state-level guidance that would define the attributes of a workplace that supports mental health, shaped by experts and informed by a diverse consortium of stakeholders to set standards and best practices. Further, employers were interested in partnering to raise awareness through the development of toolkits (preferably by occupation), conferences, virtual events, and the production of research outlining best practices for various sectors and workplace settings.

Quantifying Costs Related to Workplace Mental Health

Employers report having difficulty collecting and analyzing mental health cost data.[xxxv] Further, employers noted few studies specific to employer mental health policies in California. Existing research is largely outdated, and there is a significant opportunity for large-scale research on workplace mental health interventions deployed in the state to inform employer decision-making.

State Mandates for Paid Leave and Other Benefits

Advocates in workplace mental health would like to see state-level policies reflect the research that is available, including for the management of mental health challenges like grief or for people recovering from trauma, which

call for allowing for more paid leave or other specific interventions. Leaders see state and federal legislation and regulation as a key mechanism for bringing about needed change. [xxxvi]

Promote Higher Reimbursement Rates for Mental Health Professionals

Employers also see an opportunity for the state to drive forward higher reimbursement rates for mental health professionals to promote better insurance coverage networks. The state has a key role in convening employers calling for increased reimbursement rates as well as the implementation of metrics gauging the effectiveness of mental health care delivery.

Curbing Discrimination

Finally, the state is a critical stakeholder in curbing discrimination against people with mental health conditions through both education and regulation.

A Strategic Framework

The Commission may consider developing a multi-tiered framework that outlines strategies and supportive services that employers should offer for employees with varying levels of need. For example, there are strategies that are important to offer for all employees that support mental wellbeing and build resiliency. These can be integrated into existing wellness programs. Additionally, organizations should offer additional services and support for employees with emerging mental health needs, time-limited needs, or who are in recovery. Examples of these may include Employee Resources Groups or EAP's. Finally, when employees need acute care, are in crisis, or at high risk, employers should be ready to respond with an array of service options, accommodations, and crisis plans.

About MHSOAC and One Mind at Work

Mental Health Services Oversight and Accountability Commission (MHSOAC)

The Mental Health Services Oversight and Accountability Commission is responsible for overseeing the implementation of the Mental Health Services Act (MHSA) in California, which includes holding public mental health systems accountable; providing oversight for eliminating disparities; promoting wellness, recovery and resiliency; and ensuring positive outcomes for individuals living with serious mental illness and their families. In collaboration with clients, their family members, and underserved communities, The Commission ensures Californians understand mental health is essential to overall health.

Contact:
Anna Naify, PsyD
Consulting Psychologist
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814
(916) 212-5258
Anna.Naify@cashared.onmicrosoft.com

One Mind at Work

One Mind at Work is a non-profit focused on the development and implementation of a gold standard for workplace mental health and well-being. One Mind at Work believes that a committed group of business leaders can transform the way we view and approach mental health, brain fitness and well-being in the workplace, how healthcare is purchased and provided under the new paradigm, and how we can gain equity, collaboration and parity between physical and mental health.

Contact:
Katy Riddick
One Mind at Work
PO Box 680
Rutherford, CA 94573
202-223-2027
katy.riddick@onemind.org

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Workplace Mental Health In California

Summary of Findings

January 2021

MHSOAC
Mental Health Services
Oversight & Accountability Commission

ONE MIND™ At Work

Project Background and Purpose

The Mental Health Services Act provides a framework for California's mental health system and directs the development of strategies to reduce stigma and unemployment for Californians diagnosed with a mental illness or seeking mental health services. Subsequent legislation, California Senate Bill 1113 (Chapter 354, Statutes of 2018), directed the Mental Health Services Oversight and Accountability Commission to create voluntary standards for employers that would promote mental health and wellness in the workplace.

The Commission's Workplace Mental Health Project aims to reduce mental health stigma; increase public, employee, and employer awareness of the significance of mental health; and create avenues to treatment, support and recovery. Two core components of this project are (1) to develop a shared understanding of the challenges of and opportunities for improving behavioral health in the workplace and (2) to develop and promulgate a set of voluntary standards. Improving awareness of and attention to mental wellness by employers and employees in the competitive employment sector serves as a strategy to reduce stigma and discrimination, prevent the progression of mental health challenges, and improve the early recognition and appropriate treatment of mental health needs.

Shared understanding of challenges and opportunities is being developed through a robust stakeholder engagement process. The Commission has partnered with One Mind at Work, a global workplace mental health non-profit organization based in California to conduct that process. In May 2020, the Commission and One Mind at Work released a landscape analysis that described current trends in workplace culture, access to services, mental health literacy and stigma reduction efforts, among other areas. Following this landscape analysis, the Commission held a public convening on workplace mental health to validate the findings in the analysis. The event was held virtually in May 2020 due to the COVID-19 pandemic, attracted nearly 300 participants and featured perspectives from both the private and public sectors. The subsequent phase of work involved interviews with key stakeholders to further examine the internal and external barriers that organizations of any size, industry or demographic face when developing and implementing a workplace mental health program.

Contributions

This summary was developed from the insights shared in several one-on-one interviews held between October and December 2020 and a roundtable discussion conducted on December 17th, 2020. Interviewees and roundtable participants represented private sector employers, business groups on health, non-profits organizations and academic institutions.

We would like to thank the following individuals that contributed to this report through an interview or participation in the roundtable discussion in December:

- Gene Block, UCLA
- LuAnn Heinen, Business Group on Health
- Heather Holladay, Pacific Gas and Electric Company
- Emma Hoo, Pacific Business Group on Health
- Candace Jodice, CVS
- Anuja Khemka, The Steve Fund
- Hannah Lincecum, ReedSmith
- Stephen Liptrap, Morneau Shepell
- Lori Litel, United Parents
- Emily Mah-Nakanishi, CalHR
- Michelle Mitchell, CalHR
- Stephen Parker, Kearney

- Jennifer Posa, Johnson & Johnson
- Misty Rallis, Kearney
- Alex Schuman, Alexion
- Nick Taylor, Unmind
- Beth Theirer, BHS
- Michele Villados, CalHR
- Michael Weiner, EY

Key Themes

To drive long-term change, mental health needs to be ingrained in the values and culture of the organization – and that comes from leadership's commitment to continuous improvement.

The COVID-19 pandemic has catalyzed many changes related to when and where work gets done and how teams interact – two elements that define workplace culture. In addition, the collective stress and anxiety of the pandemic has made mental health a much higher societal priority than it has been in the past. In 2020, many organizations reacted to the pandemic in ways that considered and protected employee mental health. However, long-term commitment to continuous improvement is necessary if employers are to achieve real results in a post-COVID world. Unfortunately, some organizations – even those that have adapted to the challenges of the pandemic – might retain elements of a workplace culture that is detrimental to employee mental health. For instance, unmanageable workloads might drive stress while stigma creates high barriers to taking personal time or discussing mental health issues with managers. Workplace leaders – including executive teams and managers – set the tone for an organization and bring brand values to life for employees. They have a crucial role in eliminating stigma around issues of mental health by sharing personal stories, whether they be about struggle with a mental health issue, burnout, or their own methods of maintaining work and life boundaries. Leaders can also signal organizational commitment and empower employees by framing mental health as an imperative for success.

"Some organizations have a culture that naturally lends itself to the importance of brain health and mental health issues. Others might need to shift how they frame mental health and make it a material brand issue – not just a 'nice to have.'" – Alex Schuman, Alexion

"A lot of times, leadership fails to act on the cultural change they are talking about. It can't just be about not sending an email. When leaders take time off and delegate authority, they demonstrate that it's not only okay to step away from work to prioritize your wellbeing but also that they trust their team. That can go a long way in helping to foster a better culture." – Michele Villados, CalHR

"The message needs to be tailored and simple. For example – we encouraged meeting-less Decembers to give people some time back and make sure they are able to use the time how they need it. That's one thing our organization did to let our employees know we understood the mental health implications of the pandemic and the tough year." – Jennifer Posa, Johnson & Johnson

"There are cultural elements we can improve that can help prevent mental health crises. Having good leaders that champion programs and demonstrate best practices like turning off email on vacation, not sending emails after hours, actually stepping back – that goes a long way in preventing employee burnout." **-** Heather Holladay, Pacific Gas and Electric Company

"Holistic wellbeing should drive workplace strategy. That means physical and mental health along with things like social connection and financial wellbeing. The best programs go beyond physical health and stress management." - LuAnn Heinen, Business Group on Health

Employers have an opportunity to frame and promote mental health as a positive lever for personal and organizational productivity, performance, and success.

For a workplace mental health program to be successful, employees need to do more than buy into the concept; they need to engage with resources and programs. Framing strong mental health as a driver of business results or a way for employees to excel professionally is highly compelling to workers and for front-line managers who are balancing competing priorities. Positioning mental health as a path to self-improvement rather than risk mitigation would also align with the model of physical health promotion – fitness challenges, for instance, often appeal to all employees in an organization, even those that are not at risk for physical health issues. Employers are uniquely positioned to help educate employees and provide resources to help them maximize performance and productivity through better mental health.

"We have 'mental health' from the moment we're born. Mental health is not just the things that are wrong with you – it also drives our creativity, productivity and emotional engagement. There should be a more aspirational model of mental health that illustrates this, along with the understanding that at any time, the environmental, social and physical factors around you have an impact." Nick Taylor, Unmind

"First, an employer really needs to understand what mental health is and isn't. It isn't 'us versus them' – we all are somewhere on the mental health continuum and can fluctuate one way or another at any time." – Misty Rallis, Kearney

Employers who work to reduce stigma, social prejudice and discrimination build robust organizations.

Employers are positioned to encourage help-seeking by individual employees by promoting education that allows them to be able to recognize and accept that they are experiencing a mental health challenge and access to support services that can help. Many industries face a continuing obstacle in instances where discrimination and negative consequences occur in tandem with accessing support, such as positions where help-seeking can limit duties or responsibilities. Other industries facing high levels of stigma may experience under-utilization of available services, risking an escalation of mental health challenges. Overwhelmingly, employers are invested in employee utilization of available support, even where it is limited or has significant gaps.

Increasingly, employers are understanding the urgent need to support employees that have experienced trauma, as a result of racial or societal issues or as an inherent impact of the profession itself – such as in

healthcare or law enforcement. Employers need to be particularly thoughtful in these areas to ensure that the communication and support provided help individuals heal and feel psychologically safe in the workplace.

"It can be really difficult to nurture the multi-cultural pipeline in your workplace, but it is really important. Providing resources, safe spaces and workshops for LatinX, Black and other sub-sets of your workforce that may be experiencing unique stress or trauma from the pandemic or other events going on is a crucial first step." – Anuja Khemka, The Steve Fund

"Lack of diversity among providers is a huge issue. Generally, in mental health, there is a dearth of measures that are commonly used so we are not in a place where we have a complete picture of, for instance, a patient's experience with a certain provider from the lens of race or ethnicity. There's a lot of work to be done to measure outcomes and capture issues of race and ethnicity the same way we do for gender and age." – Emma Hoo, Pacific Business Group on Health

"We are working diligently to address the needs of a diverse workplace. We've created a very active EAP that offers different levels of service based on our employee's needs – for instance the Fire Department program may be different than the Department of Corrections. We also offer a peer-to-peer program to encourage open dialogue between our employees." - Michelle Mitchell, CalHR

Managers are the key to a proactive, preventative approach.

Managers have the opportunity – and responsibility – to be 'first responders' to mental health issues in the workplace, since they are often the first to observe signs of anxiety, depression, insomnia, or any number of other mental health issues. They have a key role in reducing risk factors and considering mechanisms for prevention – for instance, balancing workloads and expectations; using preferred modes of communication that align with cognitive differences; and flagging serious issues that might need professional care. However, it is crucial that – while recognizing the role that frontline managers have in bringing to life a proactive, preventative approach to workplace mental health – employers do not put undue burden on managers. Two key tactics prove to be effective in achieving this:

- **Manager training and resources:** Managers must be equipped with the resources and the information needed to address situations as they arise and make decisions that do not threaten the employee. Role-playing scenarios can help managers understand the solutions available to them so that they do not feel pressured to act as workplace 'therapists.' As an alternative to referring an employee to Human Resources, which can be stigmatizing, some organizations work with external organizations that provide third-party support to managers.
- **Peer support:** Internal peer support groups can be very effective in empowering and educating managers. A network of peers trained in mental health means that a manager can 'safely' disclose a situation and determine the best response.

"Leading edge organizations do a really good job recognizing that frontline managers need support and put in place a system that equips and educates managers with resources to handle a wide range of situations. A manager does not want to bring a problem to his or her boss without a solution and having

a network of trusted peers to reach out to for support and advice in how to address mental health issues they observe within their team is a great way to put prevention into practice." – Stephen Liptrap, CEO, Morneau Shepell

"Our mental health initiative is unique – we characterize it as a task force. They are made up of all different areas of the law firm – including different levels and departments. They partner with other departments and existing programs and are able to plug in and out easy and nimbly – for managers, that means that support is always close by." – Hannah Lincecum, ReedSmith

Employees struggle to access functional, coordinated care even if behavioral healthcare is included in their employers' health plans.

For many employers, a first step in improving access to mental healthcare is offering a health plan that includes benefits for behavioral healthcare. However, employers face numerous internal and external barriers when it comes to ensuring that employees are actually able to receive the care that is available to them. More coordination is needed between employers, payers, vendors and/or providers to overcome these challenges:

- **Low provider availability**: Employees might be able to seek care from a long list of in-network providers, but the actual appointment availability of those providers is extremely limited. Services exist to do the work of validating provider availability within, for example, a two-week timeframe, but they are expensive – sometimes prohibitively so for a small- to mid-size organization.
- **Variability of quality:** Not all providers use recognized, effective, evidence-backed mental health techniques, so quality can vary widely even within one plan. Currently there is no method to ensure the effectiveness or quality of mental healthcare; employers can vet plans, but data tends to be based on small data sets that are not robust enough to indicate if employees received timely, affordable care that led to positive outcomes.
- **Lack of benchmarking among employers:** Many employers are working on solutions to the same access problems, and more sharing of resources, benchmarks, and standards of care in different regions or countries would help provide a "North Star" for organizations that might not know where to start. In a large global organization, internal benchmarking would help achieve a coordinated response across markets.

"There are two things that would help my organization achieve its goals in workplace mental health. The first is data – understanding the trends in society, the benchmarks, how my organization compares to others. The second is the ability to connect with people who run other organizations, to be able to share what works and what doesn't. There is a tremendous amount of value in sharing best practices." – Stephen Liptrap, CEO, Morneau Shepell

The most effective workplace interventions meet employees where they are.

Many organizations take a "point solution" approach to workplace mental health, investing in specific Employee Assistant Programs, digital tools or other services targeted at reducing depression or anxiety, for instance. This approach tends to offer a fixed menu of options which – even if robust – may not serve the diverse and ever-changing needs of a large, multi-generational or geographically disparate workforce. Instead, employers should consider how they can integrate mental health interventions in ways that engage the employee in collaborative solutions and evolve with needs. Early and effective interventions start with listening to employees and depend largely on the system of 'triage' that provides preventative care or manages the vast majority of issues when they are nascent. If needed the system is capable of "scaling up" support for more serious mental health challenges, and in the rarest and most extreme cases is structured to respond to a crisis situation. There should also be careful consideration of return-to-work policies following a mental health challenge to support those in recovery.

Successful interventions increasingly depend on technological innovation. Common examples of early and effective interventions and innovative practices that meet employees where they are include:

- **Employee Resource Groups (ERGs):** Employee-led groups that target specific experiences – such as grief and loss or trauma – can go a long way in meeting the mental health needs of employees, connecting them to the right resources and nurturing leaders and mental health champions from within. ERGs can also take the form of safe spaces for employees from LGBTQ, Black, Indigenous, LatinX or other marginalized communities to help those individuals feel emotionally and psychologically secure at their place of work.
- **Digital tools and apps:** The market for digital mental health tools and apps has expanded dramatically in recent years, and there are a multitude of options for virtual therapy, meditation, mindfulness, sleep, and more. Apps can be incredibly effective in targeting specific needs and many employers are currently – or have already – invested significant resources to test and research which tool best serves the needs of their workforce.
- **Integrated workplace mental health platform:** The need for a full service, integrated workplace mental health platform is pronounced among employers. However, there are few tools available that can display a full range of mental health resources in way that is accessible and intuitive to all employees. For example, this could be imagined as a hub where employees can learn about the organization's Employee Resource Groups; access benefits information or schedule an appointment with a therapist; view a personalized feed of information or even interact in real time with a representative or 'bot' that can direct the employee to the right information or third-party support depending on the need. Platforms that help gather data on performance, absence and other metrics can help employees self-monitor their own fluctuating mental health needs.

"We have rolled out a few behavioral health apps and while utilization is not where we thought it would be, those that have used them report that they are extremely effective. For some people, it's exactly what they want – a light-touch resource that helps them build good habits. Others, though, want to connect with a therapist and go deeper. It just depends on what they need." – Michael Weiner, EY

"The fact is everyone is at risk for burnout. Employers need to be proactive and create resource-rich environments. We do a weekly check-in for mental health with our team – sometimes it's as simple as a moment of gratitude or focus on breathing. We have also created support groups for those that might be at higher risk, such as those isolating alone, parents, people giving care, or people that might be grieving." – Beth Theirer, BHS

Continuous evaluation lays the foundation for future success.

The employers that have experienced the most success in developing and implementing workplace mental health programs and initiatives put processes of continuous evaluation in place. Evaluation looks different across organizations depending on priorities, size and culture. For example, employers with large workforces and a well-resourced HR team might be gathering and analyzing large amounts of data to understand EAP utilization. Others might be more interested in defining Key Performance Indicators (KPIs) for managers to help them maintain awareness of their team's mental health and take action to improve it. Lastly, organizations are increasingly turning to technology to uncover deeper insights about employee behavior to inform future phases of programming or services.

"We do a lot of brainstorming with our EAP vendors. We have over 1000 behavioral and clinical resources we can tap into, and CVS represents almost every demographic, so we work hard to understand use cases. For example, what are some of the scenarios that would lead an employee to seek and utilize these resources? What are the social determinants of health that might be a factor – for example, education level or whether they live in an urban or rural setting?" – Candace Jodice, CVS

"Every project team has a barometer, which looks a bit different across each office, but functions as a regular 'pressure release' for issues that might impact mental health. It helps managers keep a finger on the pulse of the mental wellbeing of their team and lends credibility if an intervention or change in management style is needed since we're collecting that data. For example, highs and lows are understandable, but if the barometer is trending down after a several weeks, it helps flag deeper issues." - Stephen Parker, Kearney

"Telehealth has created a great opportunity for employers. The use of smart technology provides individuals the opportunity to continuously monitor their patterns of sleep, social media activity, locomotive activity, etc. It's a great way to catch issues before they get worse." - Gene Block, UCLA

About the Commission and One Mind at Work

Mental Health Services Oversight and Accountability Commission

The Commission works through partnerships to catalyze transformational changes across service systems so that everyone who needs mental health care has access to and receives effective and culturally competent care in California.

Contact:
Anna Naify, PsyD
Consulting Psychologist
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814
(916) 212-5258
Anna.Naify@cashared.onmicrosoft.com

One Mind at Work

One Mind at Work is a non-profit focused on the development and implementation of a gold standard for workplace mental health and well-being. One Mind at Work believes that a committed group of business leaders can transform the way we view and approach mental health, brain fitness and well-being in the workplace, how healthcare is purchased and provided under the new paradigm, and how we can gain equity, collaboration and parity between physical and mental health.

Contact:
Katy Riddick
One Mind at Work
PO Box 680
Rutherford, CA 94573
202-223-2027
katy.riddick@onemind.org

Bios for Workplace MH Public Hearing

March 25, 2021

Carolyn Dewa, PhD

Dr. Carolyn Dewa is a Professor in the Department of Psychiatry and Behavioral Sciences and the Department of Public Health Sciences at the University of California, Davis. She is an internationally recognized expert in the study of work disability related to mental disorders. Her work also focuses on the provision and access of mental health services and supports to people experiencing mental illnesses. She has more than 125 peer-reviewed publications in these areas and numerous book chapters. Recent publications have examined the successful continuous employment of people with severe and persistent mental illnesses as well as the work retention of workers with depression. She is currently working on a project studying stigma experienced by workers with mental disorders and barriers to work accommodations.

She serves on the editorial boards of the *Canadian Journal of Psychiatry*, the *Journal of Occupational Rehabilitation*, and the *Journal of Mental Health Policy and Economics*. Her awards have included an Ontario Ministry of Health and Long-Term Care Career Scientist Award to study the economics of workplace disability. She also held a Canadian Institutes of Health Research/Public Health Agency of Canada Applied Public Health Chair to develop effective interventions for mental illness and mental health in the working population. At the Centre of Addiction and Mental Health in Toronto, she led the Centre for Research on Employment and Workplace Health. She holds a PhD in health economics from the Johns Hopkins University and an MPH in health services administration from San Diego State University. She was a fellow at the Harvard Medical School.

Garen Staglin

Garen K. Staglin is a private equity and venture capital investor, mental health advocate, and owner of the acclaimed Staglin Family Vineyard, in Rutherford, Napa Valley, California. He has been involved in companies in the transaction processing services and payment technology industries for more than 30 years. He currently serves as Chairman of ExL Services (EXLS), and Board memebr of SVB Financial Group (SIVB), NVoice Payments, Profit Velocity Solutions and Specialized Bicycle Corp. He and his wife founded the International Mental Health Research organization (www.imhro.org) in 1995 and have raised over $200 Million to find the causes and cures for mental illness. In 2009, together with actress Glen Close, they founded BringChange2Mind.org (www.bringchange2mind.org "BC2M") to raise awareness and decrease stigma for people who suffer from mental illness. In 2010, he and Congressman Patrick Kennedy created and founded the One Mind for Research Campaign (www.onemind.org) where he serves as Co-Chairman. One Mind accelerates brain health research and advocacy to enable all individuals with mental health conditions to build healthy, productive lives. Inspired by our founders' lived experience, we work from science to services to society to drive global, collaborative action. He has also served as a member of the Advisory Board at the Stanford

Graduate School of Business, the UCLA Venture Capital Fund, and the Cambridge University Judge Business School in the United Kingdom. He also serves as the Co-Chairman of the UCLA Centennial Campaign. Mr. Staglin holds a B.S. in engineering from University of California, Los Angeles and an M.B.A. from The Graduate School of Business at Stanford.

Katy Riddick

Katy is the Director for Strategy and Engagement for One Mind at Work, and a Senior Director at High Lantern Group. Katy advises business and non-profit leaders and senior staffers across a host of industries and issue areas related to health and mental health. Organizations look to Katy to help them navigate complex operating environments, assess and respond to organizational risks and emerging threats to their industries and identify opportunities for improvement related to their mental health support and services. Before joining HLG, Katy led the Government Affairs team at Alzheimer's Research UK, the largest charitable funder of dementia research in Europe. During her tenure, the UK Government committed to an ambitious goal of a disease-modifying treatment for Alzheimer's by 2025. Katy helped craft the supporting strategy, while also managing multiple issue campaigns on key legislative priorities. She led the development of a program of work focused on the impacts of dementia on women, which established the organization as a thought-leader on the issue. Previously, Katy served as the Deputy Finance Director for a Congressional campaign and later worked in lobbying for a diverse range of municipal and private clients, as well as a large trade association. A native Oregonian, Katy graduated with Honors from the University of San Francisco with a degree in Politics.

Darcy Gruttadaro, J.D.

Darcy Gruttadaro is the director of the Center for Workplace Mental Health. As director, she works with her team in developing high impact trainings, guides, resources, and case studies to support mentally healthy workplaces. The Center's work includes working in consultation and collaborating with employers in raising awareness, creating mentally healthy organizational cultures, and improving access to mental health services and supports. The Center works with organizations of all sizes from Fortune 100 companies to small family-owned businesses in creating effective approaches to improving the mental health and well-being of employees and their families.

Before joining the Center, Ms. Gruttadaro served in multiple senior level positions with the National Alliance on Mental Illness (NAMI). Ms. Gruttadaro has expertise in expanding evidence-based practices, improving early intervention, designing insurance coverage for mental health services, and building an array of effective services and supports that promote resiliency and recovery. She practiced law for the Harris, Beach firm, concentrating her practice in healthcare, mental health, and related issues.

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

February 19, 2021

Carolyn Dewa, MPH, PhD
Department of Psychiatry and Behavioral Sciences
Department of Public Health Sciences
Chair, Graduate Group in Public Health Sciences
University of California, Davis

Letter sent via email

Dear Dr. Dewa:

Thank you for agreeing to present at the virtual public hearing on workplace mental health during the Commission's March 25, 2021 meeting.

The public hearing portion of the meeting will feature three presentations to support the Commission's effort to advance workplace mental health across the state. Presentations made during the hearing will help the Commission explore key concepts and develop a shared understanding of challenges related to workplace mental health, approaches that businesses have used to support employees, and strategies and opportunities to reduce stigma, increase resiliency, and improve access to mental health services.

As a speaker, you will receive Zoom log-in information from Commission staff.

The presentations are scheduled to begin at approximately 9:30 a.m. PST following brief announcements and general public comment. We request that you limit your prepared remarks to 10-15 minutes. This will ensure adequate time for dialogue with Commissioners. Please consider the following topics as part of your presentation:

- Strategies and models in the US and in Canada to address challenges around workplace mental health.
- Workplace mental health as a strategic environment for prevention and early intervention.
- Research about best practices to build resiliency and reduce risk for mental health needs in the workplace.
- Opportunities for implementation of standards to guide best practices.

Please send a brief biography and written response or background materials related to the items above by March 11th to project lead - Anna Naify at anna.naify@mhsoac.ca.gov. Your written response will allow Commissioners and members of the public to review presentation materials prior to the hearing. Please note that written responses and biographies will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.
Executive Director

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

February 19, 2021

Darcy Gruttadaro, JD, Director
Center for Workplace Mental Health
American Psychiatric Association Foundation

Letter sent via email

Dear Ms. Gruttadaro:

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- Effective approaches to expanding evidence-based practices
- Improving early intervention by building pathways to access mental health in the workplace
- Enhancing insurance coverage for mental health services and building a broader array of effective services and supports that promote resiliency and recovery
- National trends in advancing mental health parity

Please send a brief biography and written response or background materials related to the items above by March 11th to project lead-Anna Naify at anna.naify@mhsoac.ca.gov. Your written response will allow Commissioners and members of the public to review presentation materials prior to the hearing.

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February 19, 2021

Katy Schneider Riddick
Senior Director
One Mind at Work

Letter sent via email

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- Overview of why workplace mental matters for business and wellbeing for all employees
- Update on public engagement activities in partnership with One Mind and the Commission
- Trends, strategies, challenges, and opportunities identified by employers to develop workplace mental health standards

Please send a brief biography and written response or background materials related to the items above by March 11th to project lead-Anna Naify at anna.naify@mhsoac.ca.gov. Your written response will allow Commissioners and members of the public to review presentation materials prior to the hearing. Please note that written responses and biographies will be shared as public documents.

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February 19, 2021

Garen Staglin
Co-Founder
One Mind at Work

Letter sent via email

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- Update on public engagement activities in partnership with One Mind and the Commission
- Trends, strategies, challenges, and opportunities identified by employers to develop workplace mental health standards

Please send a brief biography and written response or background materials related to the items above by March 11th to project lead-Anna Naify at anna.naify@mhsoac.ca.gov. Your written response will allow Commissioners and members of the public to review presentation materials prior to the hearing. Please note that written responses and biographies will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.
Executive Director

EVIDENCE FOR SUPPORTING THE MENTAL HEALTH AND WELLNESS OF THE LABOR FORCE

Carolyn S. Dewa, MPH, PhD
University of California, Davis

Karen Nieuwenhuijsen, PhD
Amsterdam University Medical Center

Evidence for Supporting the Mental Health and Wellness of the Labor Force

Executive Summary

During the past two decades, recognition of the link between labor force mental health and the economic health of companies and nations has been growing. In this brief report, we summarize evidence about the mental health of workers and how it can be addressed by the workplace. We begin by describing the economic consequences of mental illness on the workplace. We go on to discuss the research about work-related factors and findings regarding their association with the risk of mental illness. We highlight the roles of work accommodation and stigma in mental illness-related work disability prevention. Finally, we discuss examples of policy level interventions for mental health in the workplace by the United Kingdom, the World Health Organization, Canada, and the Netherlands.

Economic Consequences of Mental Illness on the Workplace

Mental illnesses affect workers, employers, and government. Research evidence shows that mental illnesses lead to decreased work ability impacting both workers and workplaces. The economic losses resulting from work absences and work disability leaves are substantial. But, the often unseen effects of presenteeism are even greater. Mental illnesses also affect the government through disability benefits and early retirement.

Work-related Factors Associated with the Risk of Mental Illness

For the past two decades, most research on the effects of workplace psychosocial factors (e.g., workload, deadlines) on worker health has been guided by the two complementary models: the Job Demand/Control/Social Support (JDCS) Model[1]and Effort Reward Imbalance (ERI) Model.[2] Research shows that high job demands, low autonomy, low co-worker and supervisor support, and a high degree of imbalance between work effort and rewards (e.g., job insecurity) have been found to predict depression, anxiety disorders, adjustment disorder and burnout.[3-5]

Work Accommodations and Stigma

When a worker experiences a mental illness, difficulties with work performance become more pronounced as the severity of symptoms increases.[6] There is evidence that accommodations can be effective at keeping workers at work.[7] However, compared with other workers, those experiencing depression, for example, are less likely to report receiving work accommodations.[8] This may be due in part to the fact that they do not recognize a need for help and consequently do not ask for it.[9] It may also be related to the fact that obtaining work accommodations requires communication and negotiation between managers and workers.[10]

Mental illness related stigma has been identified as a barrier to receiving help.[11,12] Fear of stigma may lead to a reluctance to disclose struggles with mental health to managers.[13] Yet, if they do not disclose their need for help, workers will not receive work accommodations that they may need to do their work.[14,15] Fear of stigma may also prevent workers from seeking treatment.[13]

However, studies show that through workplace training programs, it is possible to impact negative attitudes and behavior.[16-19] In addition, research studies have shown that the cost-savings resulting from stigma training can cover the costs of offering them.[20]

Using Legislative/Policy to Support Worker Mental Health

The United Kingdom Health and Safety Executive, the World Health Organization, and the Mental

Health Commission of Canada through the Standards Council of Canada published workplace standards and guidances. They share a number of commonalities: (1) all are based on the research literature with a focus on the JDCS and ERI, (2) all take a primary risk intervention approach focused on the workplace, (3) all recognize the need for buy-in within the company, representation, and collaboration of all stakeholders, (4) all are voluntary, (5) none provide cut-offs that define a "healthy workplace" but emphasize continuous quality improvement.

The UK standards used research to develop its risk assessment tool. The effectiveness of the risk assessments have begun to be evaluated and the results communicated in the peer-reviewed scientific literature. The Canadian standards are following a similar path. The evidence indicates that the UK and Canadian standards are being implemented and organizations have experienced success. At the same time, because they are voluntary, uptake has not been 100%. In addition, evidence for their effects on worker mental health is still in process. Among the gaps in the literature are the effects of the standards on vulnerable workers in non-traditional sectors.

None of these standards comments on the role of the healthcare system. The Dutch system is an example of how healthcare through occupational health is integrated into work disability prevention. The Dutch Gatekeeper Protocol legislation mandated roles for employers, employees, and occupational health physicians during a disability leave and created employer incentives for work disability prevention.[21]

The importance of the healthcare system and treatment is reflected in the best practices guidelines for mental illness-related disability leave from Canada, the United Kingdom, and Australia that identify access to mental health treatment as a mental illness related work disability leave best practice.[22] Furthermore, this recommendation is made in all these best practice guidelines despite the fact that all have forms of publically funded healthcare systems.

Conclusion

In this brief report, we summarize the evidence for the concern about the mental health of workers and how it is being addressed. It is a challenge faced by employers and workers around the globe. The research evidence describes the significant economic consequences of worker mental ill-health to the workplace. Research also has shown that the organization of work can contribute to the risk of mental illnesses. Three major standards and guidelines from the World Health Organization, the UK, and Canada have been developed based on this evidence. They can provide important lessons and building blocks as California develops its unique approach to promoting and supporting mental health of the State's workforce. As the home to the largest US economy, California can also be a leader by filling the research gaps in the US evidence base for mental health of workers.

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Introduction

During the past two decades, recognition of the link between the mental health of the labor force and the economic health of companies and nations has been growing. Countries around the world are searching for solutions to promote and protect the mental health of their workforces.

In the early 2000s, European Ministers of Health endorsed a detailed action plan calling for employers to "create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles" and also to "include mental health in programs dealing with occupational health and safety".[23] In 2008, the European Union's Pact for Mental Health and Wellbeing identified the improvement of mental health in the workplace as one of its four objectives for action.[24]

In 2006, the Canadian Standing Senate Committee on Social Affairs, Science and Technology[25] raised prevention, promotion and treatment of mental illness as critical issues to be addressed. The Committee identified the workplace as one of the prime areas in which to begin. They asserted, "It is in the workplace that the human and economic dimensions of mental health and mental illness come together most evidently." In 2013, commissioned by the Mental Health Commission of Canada, the Standards Council of Canada published the national standard, *Psychological Health and Safety in the Workplace*.[26]

In 2018, California Senate Bill 1113 authorized the establishment of a framework and voluntary standard for mental health in the workplace to "reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, determined by the commission, to support the mental health and wellness of employees."

In this brief report, we summarize the evidence for the concern about the mental health of workers and how it is being addressed. We include actual cases to illustrate how the concepts could be experienced in the workplace. In Section 1, we begin by describing the economic burden of mental illness in the working and working-aged population. In Section 2, we go on to discuss the research about work-related psychosocial factors and findings regarding their association with the risk of mental illness. In Section 3, we highlight the roles of work accommodations and stigma in mental illness-related disability prevention. In Section 4, we discuss examples of how mental health in the workplace at a policy level by the United Kingdom, the World Health Organization, Canada, and the Netherlands.

Section 1. The Economic Consequences of Mental Illness in the Workplace

In 2010, mental illnesses were identified as the leading causes of disability worldwide.[27] Between 1990 and 2010, the global burden of mental illnesses increased by 38%.[27] Among mental illnesses, depressive disorders account for the largest proportion of disability with anxiety disorders accounting for the second largest proportion.[27]

In the US, major depression is the second leading cause of disability and has maintained this distinction since 1990.[28] In California, major depression was ranked the third leading cause of disability.[28] Based on 2017 estimates, about 17% of US working aged adults between 26-49 years have a mental illness during the year.[29] About 6% of US adults 26-49 years experience a serious mental illness that interferes with daily functioning at either work, home, or school.[29] In 2017, about 8% of US adults between 26-49 years had a major depressive episode. In addition, 5% had a serious major depressive episode in which they experienced impairment.[29]

Contributors to the Economic Consequences Related to Mental Illnesses

By 2030, estimates project that among high income countries such as the US, the economic consequences of mental illnesses will be at least $6 trillion (in 2010 US$).[30] A recent systematic review of literature on the costs of work-related stress in various countries, found work-related stress was related to costs ranging from US$221.13 million to $187 billion.[31] The economic consequences of mental illnesses is driven by losses related to productivity resulting from disability and mortality.[30]

Healthcare Costs. In the US, the annual estimated economic consequences of major depressive disorders totaled $210.5 billion (in 2012 dollars).[32] Approximately 34% of this was attributed to use of medical services.[32] The total excess costs of health services use for adults with depression compared to those without depression was estimated to be three times greater.[33]

Productivity Losses. Decreased work productivity is manifested through work absences, reduced production by workers who are at work, work disability leave, and early retirement.[34] About 48% of the estimated economic losses due to depression was ascribed to workplace costs in the form of work absences (11%) and decreased productivity at work (37%).[32] The excess costs due to reduced productivity was two to three times higher for adults with depression.[33]

Work Absences. Workplace productivity losses due to mental illness related work absences (i.e., sick days) are substantial. For example, depression has been shown to be associated with more work-loss and work cutback days than most chronic medical conditions.[35-38] The average depression-related absenteeism productivity loss is about one hour/week, equivalent to $8.3 billion (USD).[39]

Presenteeism. Presenteeism is another source of work productivity losses. It is defined as showing up to work but working with impaired functioning. Presenteeism days represent a significant proportion of the work-related burden of mental illnesses.[36,40-42] Presenteeism producivity losses associated with depression are estimated to be between 5 to 10 times greater than those for absenteeism.[43]

Presenteeism related losses are due to the fact that mental illnesses can interfere with day-to-day functioning.[44] For example, depression interferes with performance of physical jobs demands an average of 20% of the time and mental inter-personal demands an average of 35% of the time.[45] In addition, workers with versus those without depression can experience more impairment with time management.[46]

Case 1. Effects on productivity

Kevin works in a large manufacturing plant. Recently, Kevin's father was diagnosed with cancer. His free time is spent caring for his father. Kevin's partner is left to care for their two young children. While she tries to be supportive, Kevin sees how the extra burden is taking a toll on her. Kevin has been unable to fall asleep and ruminates about his life situation. His anxiety and stress makes it difficult for him to concentrate. This has led to mistakes – something that is unusual for him. He feels bad about the mistakes and becomes distracted by them. In addition, his company adopted a new 24 hour a day production cycle and his shift schedule has changed. This disrupts his usual sleep patterns and he is becoming more fatigued. At work, he finds that he cannot work as efficiently as usual and is dreading the large looming upcoming deadline that the plant faces.

In Case 1, Kevin's story illustrates how productivity losses could be experienced in the workplace. Kevin works a manufacturing plant. As a consequence of changes in the production processes in his plant, work becomes more demanding for him. The combination of life events and increased work demands makes

Kevin feel more anxious, exhausted, and stressed. Afraid of overtaxing his partner, he feels that he should not rely on his most important source of support. This leads to difficulties working. He cannot focus on the work at hand which in turn, causes him to make mistakes. As he struggles, his productivity declines.

Disability Leave. In contrast to work absences, disability leaves can be defined as an absence from work for a non-work related illness or injury that extends beyond what would be covered by "sick leave". Generally, it is an absence for which a worker must file an insurance claim for income replacement benefits which are often called disability benefits. These benefits may be either publicly or privately sponsored. California offers state-sponsored insurance through the California Sate Disability Insurance (SDI) program. Employers may also offer short-term disability benefits.

Mental ill-health, defined as depression, anxiety, or emotional problems, are one of the top three most reported causes of work disability in US adults.[47] A study using short-term disability claims data from a sample of 260 US medium and large employers found that mental illnesses as defined as a mood or anxiety disorders, were the third leading causes of short-term disability leaves.[48]

The cost of short-term disability claims is associated with three factors: (1) the per diem cost of the leave, (2) the length of the leave and (3) the number of disability leaves. The cost of a single disability leave is driven by the first two factors. Relative to other types of disability leaves, depression-related leaves are longer than those for other types of disorders such as rheumatoid arthritis, heart disease, and diabetes.[49-52] Compared with the costs of the average disability episode, those for mental/behavioural disorders can be double the cost per episode.[53]

The third factor contributing to the total costs of disability leaves is the number of leaves. This is reflected in part to the recurrence of a disorder. Workers who have previously been on a disability leave are more likely to have a future leave.[54-56] Compared to workers with no history of a disability leave, those who had one related to a mental disorder are seven times more likely to have another leave and those with leaves for other types of disorders were twice as likely.[56] Relative to other disorders, workers with a leave for depression were more likely to have another leave.[52,57] High relapse rates has been identified as one of the main factors that contributes to the magnitude of the burden of depression.[58]

Early Retirement. An association between mental illness and early retirement also has been observed (e.g., [59-61]). Workers with poor mental health functioning are more likely to plan early retirement.[61-63] A study of US workers between 53 and 58 years old found that active depression significantly increased the risk of early retirement in both men and women.[64] Similar patterns were observed with older workers more likely to retire or to terminate their employments rather than return to work after a depression-related short-term disability.[65]

Summary. Mental illnesses affect workers, employers, and government. Research evidence shows that mental illnesses that decreased work ability impact both workers and workplaces. The economic consequences of work absences and work disability leaves are substantial. But, the often unseen effects of presenteeism are even greater. Mental illnesses also affect the government and employers through disability benefits and early retirement. As the workforce ages and there are fewer young workers to replace those retiring, more is drawn from pension plans than contributed to them. In the absence of new additions to the labor pool, the remaining workforce will have to pay higher premiums and work for a longer time period to sustain the pension system.

Section 2. How the Work Environment Impacts Mental Health

Psychosocial factors

Workplaces can play an important role in mental health. Work can give individuals purpose, financial resources, and a source of identity; these have been shown to promote positive mental well-being.[66] Conversely, poor working conditions and organizational issues can contribute to the development of mental ill-health.[5]

There is a complex relationship among factors that contribute to mental illness. For example, the most advanced etiological models of adult depression include risk factors related to genetic vulnerability, developmental and neurobiological factors as well as childhood experiences, life events, chronic situations (e.g., work environments), and the presence of other disorders.[67] However, the magnitude of the contribution of each of these types of risk factors to depression and how they interact with one another is not well understood. Thus, it is difficult to definitively determine whether a mental illness was caused by occupational conditions.[68] But, research findings have established that the workplace plays an important role in mental health.[4,5,69] This role is critical to promoting and protecting worker mental health.

The Sherbrooke Model. Using a tetrahedron, Loisel and colleagues'[70] conceptualized the systems that contribute to workers' health in the Sherbrooke Model. The Sherbrooke Model describes workers as being supported by four systems: (1) workplace, (2) personal/personal coping, (3) healthcare, and (4) legislative/policy systems. The workplace system defines the conditions and environment in which work is done. Its components include job content (e.g., workload, deadlines), culture, and organizational policies. It is also important to note that to support workers effectively, the systems must work in concert.[71] Thus, although this report primarily focuses on the workplace system as it impacts the mental health of workers, it also highlights how the other three systems can work with the workplace system.

Relationship between Job Content and Mental Illness. During the past two decades, there has been a substantial growth in the body of research on the psychosocial work factors that can be modified and redesigned to promote worker health. Much of this work has been guided by Karasek and Theorell's[1] Job Demand/Control/Social Support (JDCS) Model and Siegrist's[2] Effort Reward Imbalance (ERI) Model. The two models are complementary[72] and describe the job characteristics that lead to job strain (i.e., experience of job stress). The JDCS model[1] proposes four job types based on the job's degree of psychological demands (e.g., workload, work pressure) and decision latitude (e.g., control over work tasks, the variety of work, and opportunity for skill use): (1) "high-strain" jobs with low decision latitude and high job demands, (2) "low-strain" jobs with high decision latitude and low job demands, (3) "passive" jobs with low decision latitude and low job demands, and (4) "active" jobs with low decision latitude and high job demands. Job demands, decision latitude, and social support from colleagues and supervisors affect the emotional, psychological, and physical strain that workers experience as a result of work.[1] The ERI model[2] adds that a mismatch between the amount of effort that workers invest in their jobs and the amount of reward (financial, status-related, and socio-emotional rewards) receive also affects the amount of work stress experienced.[72] Jobs with a high degree of demand and little decision latitude as well as those that involve a high degree of effort but offer little reward and job security create unhealthy work situations. They also create a risk for mood (e.g., depression) and anxiety disorders (e.g., depression).[3,4]

Case 2. DCS and ERI Models in the Workplace

For the past 10 years, Derek has worked in the finance department of a large organization. He has always been hard-working. He pays keen attention to details and the accuracy of his work is highly valued. His supervisor appreciates the quality of his work. Six months ago, he offered Derek a promotion to become his department's team leader. Since accepting the promotion, Derek's workload has increased substantially and he is responsible for his team meeting department deadlines. In the past, he let off steam by venting to his colleagues. But, the promotion changed things. Now, most of his former peers are distant. Two of them seem to openly challenge his every decision and are not as productive as the job requires. So, Derek works to fill the gap. He tried to get advice from his own supervisor about how to deal with this. But, his supervisor suggested to be patient; things would eventually settle down. Meanwhile, Derek is feeling increasingly anxious and dispirited. His productivity has taken a downturn; he is having difficulty concentrating and is making mistakes. As a result, he is beginning to question his competence as a supervisor and wondering whether he will be fired.

In Case 2, Derek's experiences reflect how the JDCS and ERI models can be used to explain how job content and social support can affect health. Derek is a model employee; this leads to a work promotion. His promotion creates greater job demands. At the same time, he loses some of his autonomy. In the past, he was responsible for his only own performance. Now, he must answer for his team's production as well. He must depend on them to do their work. But, they do not respect him. To make it worse, he no longer has a support network at work. This takes a toll on his mental health. He becomes increasingly anxious and despondent due to his increased workload, his team's decreased productivity, his alienation from his staff, and he is beginning to doubt himself. He is does not feel supported by his manager. Although he is working diligently, his effort is not reflected in his output. He fears for his job.

Evidence for the Effects of Job Content on Mental Health. Since Karasek and Theorell[1] and Siegrist[2] introduced their models, a large and expanding body of research has found links among job content, job strain, and mental ill health.[4,5,69] High job demands, low decision latitude, low co-worker and supervisor support, and high degree of imbalance between work effort and rewards have been found to predict stress-related disorders (e.g., adjustment disorder and burnout).[5] Furthermore, there is high-medium quality evidence that supports the association between job strain and depression.[4]

The research evidence also indicates that decision latitude can buffer against the negative effects of high job demands when there is a match between job demands and decision latitude.[69] For example, when high job demand is related to time pressure or workload and decision latitude involves control of the timing, scheduling, or pacing of work, there is a greater likelihood of decision latitude having a significant buffering effect against work demands. There also is evidence that too much decision latitude can negatively impact worker well-being when job demands are high with respect to time pressure and job complexity.[73]

Contribution of the Personal/Coping System to Worker Mental Health

Along with job content, the revised Job Demand Resources (JDR) model[74] incorporates the system that the Sherbrooke Model[70] conceptualizes as the personal/personal coping system. The JDR model considers the role of worker personal resources and suggests these resources can modify the effects of job demands.[74]

Working Hours and Need for Recovery. For example, jobs that do not have well-defined working hours may impinge on home life. If the boundaries between work and home hours are not well-defined, work characteristics such as hours worked, job authority, and non-routine work are associated with increased work-to-home conflict.[75] In turn, increased work-to-home conflict can increase psychological distress among workers.[76]

Long working hours are associated with depression in women.[77] Jobs requiring variable hours are associated with high work stress.[3,78,79] Female shift workers are more likely to have symptoms of depression than females who are not shift workers.[78]

Recognizing that there may be limited opportunity to rest from responsibilities at work, outside of work, or both, there has been increasing interest in the effects of accumulated work-induced fatigue or need for recovery from work (NFR). NFR has been shown to be sensitive to changes in the working environment such that challenging working conditions are associated with higher NFR.[80,81] In turn, high NFR is predictive of chronic physiological stress reactions in workers[82] and prolonged fatigue[80]. There is also evidence that NFR is associated with depression.[83-85]

Work Engagement. The JDR also suggests the degree of work engagement can impact a worker's well-being.[86] Indeed, it has been suggested that some of the differences in the effect of job characteristics could also be influenced by commitment to the organization.[87]

Section 3. Work Accommodations and Stigma

When a worker experiences a mental illness, as the severity of symptoms increases, difficulties with work performance become more pronounced.[6] For example, depression has been characterized by symptoms that include difficulty concentrating, fatigue, and disrupted sleep.[45] As the severity of these symptoms grows, so too do difficulties with managing time, completing tasks, and interacting with people at work.[6] Eventually, the gradual decrease in work productivity attracts the attention of managers and supervisors. However, the decreased productivity may be misinterpreted. Rather than seeing it as signs that a worker needs help and requires support, it may be addressed with disciplinary action. Thus, there is a missed opportunity to offer work modifications or accommodations to support workers to be productive while they struggle with their symptoms of depression.

Work Accommodations

Effective work accommodations match the worker and the job[10]. Work accommodations involve modifications to duties and assignments that enable a worker with a mental illness to fulfill their job requirements.[10,88] There is evidence that accommodations can be effective at keeping workers at work.[7] However, compared to other workers, those experiencing depression, for example, are less likely to report receiving work accommodations.[8] This may be due in part to the fact that they do not recognize the need for help and consequently do not ask for it.[20] It may also be related to the fact that obtaining work accommodations requires communication and negotiation between managers and workers.[10] Often, it is not clear how to begin the conversation and the support for which to ask. There is little in the literature that identifies effective accommodations for either mental illnesses or depression in particular.[89]

Part of the challenge of identifying effective work accommodations is related to the fact that workers can experience depression in a variety of ways.[89] Although determining the presence of depression relies on assessing whether a person is experiencing a summary number and severity of symptoms, each

person with depression may experience the individual symptoms that define depression in a variety of ways. This suggests that rather than focusing on diagnoses, it is more important to understand underlying symptoms.[90] If there are different combinations of symptoms affecting functioning, there could be a variety of solutions. Rather than a single definitively effective way to accommodate workers with depression, they may be many. Thus, the communication between the worker and the manager is critical to the accommodation process.

Case 3. Work Accommodations and Stigma

Aimee has worked with her organization for three years and has been promoted twice during that time. She is known as someone who is always happy. People routinely comment on her enthusiasm, positivity, and sense of humor. She is a good, reliable performer who is detailed-oriented. She has a natural passion for her job. Six months ago, Aimee told her manager and her co-workers that she was getting a divorce. In the past two months, her enthusiasm is feeling more forced. During this time, she begins to be less solicitous and keeps to herself a bit more. She smiles but avoids eye contact. Her work performance begins to decline. It begins with errors involving small details and escalates to significant mistakes. Co-workers begin to complain. Her manager is hesitant to talk with her for fear of upsetting her.

In Case 3, Aimee is struggling at her job. She is known as a positive and helpful person. Her behavior changes. But, everyone is fearful of asking how she is doing. So, she struggles in silence. Aimee does not ask for help and her manager does not know how to begin the conversation for fear of upsetting her. Aimee is afraid to share her struggles because she fears people within her department would treat her differently and view her as incompetent. She also thinks she could lose her position and if anyone knew about her bipolar disorder that was exacerbated through her divorce, it would go in her personnel file. As a result, no one talks about what is happening. Eventually, the organization's human resources (HR) will be called; through several meetings with HR, a disciplinary process will be initiated. Lack of communication prevented work accommodations. Fear of stigma prevented the communication.

Mental Illness-Related Stigma

Mental illness related stigma has been identified as a barrier to receiving help.[11,12] Stigma is comprised of three elements: (1) lack of mental health literacy (i.e., ignorance or lack of knowledge about mental illness), (2) negative attitudes (i.e., prejudice), and (3) negative behaviors (i.e., discrimination).[91] Negative attitudes (i.e., prejudice) are a major component of stigma.[91] Prejudice can turn into discrimination.

Often, negative attitudes are rooted in fear. For example, among the general public, there is fear that mental illness leads to violence.[92] There is also the belief mental illness leads to undesirable behavior or unpredictability.[92,93] These same fears exist in the workplace.[94,95] There is fear that workers with mental illnesses are less reliable and cause additional work for co-workers.[13,95-97] Indeed, managers are often concerned about how the employees with mental health issues will be treated by co-workers.[94,95]

Thus, it may not be coincidental that workers experiencing mental illnesses fear prejudice and discrimination.[98] The fear may lead to a reluctance to disclose their struggles with their mental health to their managers.[13] Yet, if they do not disclose their need for help, workers will not receive work accommodations that they may need to do their work.[14,15] Fear may also prevent workers from seeking treatment.[13] Yet, there is evidence that early treatment can be effective in decreasing disability.[65]

Workers with mental health issues can also struggle with self-stigma that can take the form of negative value judgments about oneself.[99,100] Because of the potential self-stigma, workers do not want to view themselves as either needing help or having difficulty performing because of mental illness.[101]

Facilitators to Help Seeking. Although there are barriers that prevent help seeking, there are also facilitators at work that support it. Managers and supervisors play an important role in a workers decision to seek help.[13,14,102] The decision to disclose the need for help is related to a positive relationship with the manager.[13,103] Feelings of responsibility to their workplaces is another significant motivator.[13] This may also reflect a perceived alliance with managers. Safe and secure work environments promote the decision to seek help.

Studies show that through training programs, it is possible to impact leaders' attitudes and behavior about promoting mental health and reducing mental health stigma.[16-18] There is also evidence that training both managers and their employees can reduce negative attitudes.[19] In addition, research studies have shown that the cost-savings resulting from stigma training can cover the costs of offering them.[20]

Section 4. Using Legislative/Policy Systems to Support Worker Mental Health

The United Kingdom (UK) Health and Safety Executive (HSE), the World Health Organization (WHO), and the Mental Health Commission of Canada (MHCC) through the Standards Council of Canada published workplace standards and guidances. These are examples of how the legislative/policy system can guide the workplace system to promote mental health and prevent mental illness. They share a number of commonalities. First, all are based on the research literature with a focus on the JDCS and ERI. Second, all take a primary risk intervention approach focused on the workplace. Third, all are voluntary. Fourth, none of them provide cut-offs that define a "healthy workplace". Rather, they emphasize continuous quality improvement. With this, they recognize the variability in workplace systems. Fifth, all recognize the need for buy-in within the company as well as representation and collaboration of all stakeholders.

None of these standards comments on the role of the healthcare system. The Dutch system is an example of how healthcare through occupational health physicians is integrated into workplace work disability prevention. In addition, through the Dutch Gatekeeper Protocol legislation, employers became responsible for employee sick-leave for up to two years regardless of cause.[21]

The importance of the healthcare system and treatment is reflected in the best practices guidelines for mental illness-related disability leave from Canada, the United Kingdom, and Australia that identify access to mental health treatment as a best practice.[22] Furthermore, this recommendation is made in all these best practice guidelines despite the fact that all have forms of publically funded healthcare systems.

The UK Health and Safety Executive Management Standards

In 2004, the UK HSE introduced the *Management Standards* to assist organizations to better identify, monitor, evaluate, and manage risks for undue stress in the workplace. The HSE is a government agency charged with regulating and enforcing workplace health, safety, and welfare standards. HSE reports to the Department for Work and Pensions.

The *Management Standards* are not legally enforceable.[104] Rather, they were developed to assist employers in complying with their duty to mitigate risk of health and safety hazards. With this, work-related stress was identified as a health and safety hazard and appropriate for a primary prevention

focus. The *Management Standards* are based on strong research evidence that indicates work-related stress is related to ill health and that it can be assessed and managed by organizations.[105] In addition, it was imbedded in the HSE work-stress priority program.[104] This has been identified as one of its strengths.[106]

The *Management Standards* for work-related stress focus on risk assessment for six areas: (1) demand, (2) control, (3) support, (4) relationships, (5) role, and (6) change (Appendix Table 1). These areas emphasize the design, organization, and management of work and are intended for all organizations.[104] The guidance provides the standard for management practice, "desired states", and ways to achieve the standard for each of the six areas.[107] Based on employer recommendations, the *Management Standards* are short, succinct, sufficiently comprehensive to address work-related stress, and clearly written in plain language.[105]

The HSE recognized the implementation process used for the *Management Standards* was critical to their uptake.[104] The framework that HSE describes is based on their five step risk assessment for health and safety hazards: (1) look for the hazard; (2) decide who might be harmed and how; (3) evaluate the risks and decide on precautions; (4) record significant findings; (5) review the assessment and update if necessary.[108] This approach has been identified as another strength because it recognizes that psychosocial risk factors can be assessed and with that knowledge, the work environment can be modified.[106]

The HSE risk assessment process for work-related stress was piloted by 22 organizations.[105] The HSE developed a workbook called, *Tackling Work-Related Stress Using the Management Standards Approach*.[107] It explains how to prepare the organization for the risk assessment, identify the risk factors, and address the concerns. There is an emphasis on continual quality improvement to achieve the *Management Standards*' "desired states".[105] Thus, "adopting the methodology of the *Management Standards* will normally mean that the organization is doing enough to comply with the Health and Safety law."[105] The workbook also contains suggestions about reviewing organizational policies, communication, and building a business case.

The introduction of the *Management Standards* necessitated the development of a risk assessment tool. After a series of pilot studies and psychometric testing, the HSE offers a 35-item questionnaire that can be used in the risk assessment.[105,109] There is evidence that the dimensions captured by the HSE risk assessment tool are associated with job satisfaction.[110,111] A study of call center employees also suggested that the HSE risk assessment tool results are associated with mental health status.[112] However, a caution has been raised about using the assessment in different cultures.[109]

Despite having the HSE *Management Standards*, in 2017, the UK Prime Minister commissioned an independent review to explore "how employers can better support all individuals currently in employment including those with mental ill health or poor well-being to remain in and thrive through work"[113] The result was, *Thriving at Work* that lays out a framework of "mental health core standards" for every workplace to achieve.[113] The core standards are:

- Produce, implement and communicate a mental health at work plan;
- Develop mental health awareness among employees;
- Encourage open conversations about mental health and the support available when employees are struggling;
- Provide employees with good working conditions and ensure they have a health work life balance and opportunities for development;

- Promote effective people manage through line managers and supervisors;
- Routinely monitor employee mental health and wellbeing.[113]

Furthermore, one of the review's recommendations was that the HSE "revise its guidance to raise employer awareness of their duty to assess and manage work-related mental ill-health"[113] The focus on risk assessment distracts attention from the actual mental health of workers within the organization. The recommendation suggests that employers should not only focus on the cause of mental ill health. Rather, the risk management alone, the objective should include the support of the mental health of all workers.

The World Health Organization PRIMA-EF Guidance

In 2008, WHO published the *PRIMA-EF Guidance on the European Framework for Psychosocial Risk Management A Resource for Employers and Work Representatives.*[114] Its purpose is to offer best practice guidelines in workplace psychosocial risk management.[114] The guidance identifies three levels of risk prevention:

1. *Primary prevention* includes changes to the way work is organized and managed
2. *Secondary prevention* includes approaches that develop individual skills through training
3. *Tertiary prevention* includes approaches to reduce the impact on workers' health by developing rehabilitative, return-to-work systems and occupational health processes

This guidance focuses on primary prevention activities.

Risk assessment is identified as the foundation for the risk management process. The guidance uses the European Commission's[115] definition of risk assessment as "a systematic evaluation of the work undertaken to consider what could cause injury or harm, whether the hazards could be eliminated, and if not what preventive or protective measures are, or should be, in place to control the risks." It identifies five elements of psychosocial risk management as: (1) best practices in organizational management; (2) a continuous process that is a part of normal business operations; (3) ownership by all stakeholders; (4) contextualization and tailoring to the organization in terms of workforce demographics, occupational sector, and size; and (5) evidence-informed practice. It identifies 10 areas to assess for psychosocial hazards: (1) job content; (2) workload and work pace; (3) work schedule; (4) control; (5) environment and equipment; (6) organizational culture and function; (7) interpersonal work relationships; (8) organizational role; (9) career development; and (10) home-work interface (Appendix Table 2).

The Psychological Health and Safety in the Workplace Canadian Standard

In 2007, the Canadian federal government created the MHCC. In 2013, commissioned by the MHCC, the Standards Council of Canada published the national standard, *Psychological Health and Safety in the Workplace*.[26] The objective of the Canadian standard is to specify "requirements for a documented and systematic approach to develop and sustain a psychologically healthy and safe workplace… This Standard provides a framework to create and continually improve a psychologically healthy and safe workplace." It uses the WHO's definition of mental health to define "psychological health" such that

> *mental health* is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[116]

It defines *psychological safety* as the absence of harm and/or threat of harm to mental well-being. The Canadian standard identifies 13 workplace factors that organizations can address to affect the mental health and psychological safety of its employees. They are: (1) organizational culture, (2) psychological

and social support, (3) clear leadership and expectations, (4) civility and respect, (5) psychological demands, (6) growth and development, (7) recognition and reward, (8) involvement and influence, (9) workload management, (10) engagement, (11) balance, (12) psychological protection, and (13) protection of physical safety (Appendix: Table 3).

Between February 2015 and January 2017, 19,172 companies were selected to participate in a survey about knowledge and use of the *Standard*.[117] Of the 1,010 responding companies, 17% indicated they were aware of the *Standard*.[117] This reflected earlier findings that there was limited understanding of the *Standard* with suggestions that they should be better communicated.[117,118] Companies that employed more than 500 people and who were in the government and public administration sector were more likely to be aware of the *Standard*.[117] Those who adopted it identified its greatest benefit as increased job satisfaction and employee retention.

About 2% of the responding organizations had implemented the *Standard* in full and 20% had partially implemented it.[117] Not-for-profit organizations were more likely to have adopted it.[117] The identified adoption barriers were inadequate resources, not relevant to their enterprise, and insufficient knowledge to implement it.[117,119] Employers suggested that the *Standard* might be difficult for small organizations or those that hire staff on short-term contracts.[118] Although organizations saw the value of the *Standard*'s content, they expressed concern with the complexity of integrating the *Standard* into their organizations and getting the requisite leadership buy-in and culture change.[118] There was also concern that the *Standard* could increase the number of disability claims.[119]

The MHCC conducted a three year case study examination of the *Standard* that focused on compliance with five elements for a psychological health and safety management system: (1) commitment, leadership, and participation; (2) planning; (3) implementation; (4) evaluation and corrective action; and (5) management review.[120] The case study looked at 40 organizations that implemented the *Standard*. It found that compliance with these five elements varied between 40-66% depending on the element; the lowest compliance was related to evaluation and corrective action (40%) and management review (42%). At the final implementation, compliance for evaluation and corrective action rose to 58% and management review to 59%.

The Netherlands' Gatekeeper Improvement Act

In the Netherlands, employers and employees share a joint responsibility for safe and healthy work.[121] The Dutch system has been described as a consultative economy in which decisions and policies are based on discussions, negotiations, and bargaining amongst trade associations representing employer groups, trade unions representing employee groups, and government.[122]

Occupational healthcare is paid by employers. It is provided in a system that is separate from the healthcare system which is a universal social health insurance program that covers all Dutch citizens. Employers can choose to engage a broad range of occupational health service providers but are obliged by law to work with experts on working conditions including: occupational physicians, occupational hygienists, safety specialists, as well as work and organization experts. In turn, these experts must work together to reach agreement about working conditions.

In 2002, the *Gatekeeper Improvement Act* was passed mandating roles for employers, employees, and occupational health physicians during a disability leave.[122] The *Gatekeeper Protocol* gives Dutch employers an incentive to be proactive in disability prevention.[21] A key feature of Dutch disability management is the mandated analysis of both medical and social problems underlying a sick leave by an occupational physician after a maximum of six weeks. Within eight weeks, based on the occupational

physician's analysis, the employer is mandated to draw up an action plan in collaboration with the worker. After this, a case manager which can be the occupational physician, is responsible for rehabilitation counseling to support the worker returning to work.

Overall, the *Dutch Gaterkeeper Protocol* decreased disability leave rates by about 40%.[123] The *Dutch Gatekeeper Protocol* had differential effects depending on the business sector and the company size.[123] This may be related to different resources available to invest in observing the legislation.[123,124] In addition, there is heterogeneity between and within Dutch organizations in how disability policies are interpreted and implemented.[124] The flexibility of the Dutch legislation allows organizations to be responsive to the individual needs of workers. At the same time, this can lead to inconsistently implemented policies.[124]

Case 4. A Dutch Example

Jane is a senior consultant at a large consulting firm. She is a high performer and a valued employee. For years, she has been able to successfully manage a heavy workload. She also unofficially mentors new and younger staff. Lately, she has been struggling with feelings of being overwhelmed. She talks with her employer and asks for a lighter workload. Her employer agrees to her request. But within weeks, she calls in sick. Her mental health seems to deteriorate quickly and she is diagnosed with severe depression with psychotic features. She takes a disability leave from work. A period of intensive treatment follows. Her manager keeps in touch with her during this time with a mutually agreed upon schedule of regular phone calls. The purpose of the calls is to keep her connected and feeling that she still belongs. As she improves, her occupational physician helps her and her manager to draw up a return to work plan. Her occupational physician advises her how to carefully build up her workload. She starts with modified work for 3-4 hours a day. She begins working on tasks with no deadlines and that do not require contact with clients. Eventually, she fully recovers and works full-time. The occupational physician never disclosed the medical information to the employer. But, she explained the severity of the condition and what was needed. The employer accepted the information and worked with Jane throughout the process.

Case 4 is an example of what happens to a worker experiencing mental illness in the Dutch system. The approach is grounded in cooperation. The manager's support is recognized and accepted as important to recovery. It is also accepted that the successful recovery is a collaborative process that can involve the healthcare providers.

Summary. The UK, WHO, and Canadian workplace standards all use the research literature as a foundation. They were developed in cooperation with all stakeholder groups including employers, labor, and government with the support of research. The UK standards used research to develop its risk assessment tool. The effectiveness of the risk assessments have begun to be evaluated and the results communicated in the peer-reviewed scientific literature. The Canadian standards are following a similar path. The evidence indicates that the UK and Canadian standards are being implemented and organizations have experienced success. At the same time, because they are voluntary, uptake has not been 100%. In addition, evidence for their effects on promoting worker mental health is still in process. Among the gaps in the literature are the effects of the standards on vulnerable workers in non-traditional sectors.

Conclusion

In this brief report, we summarize the evidence for the concern about the mental health of workers and how it is being addressed. It is a challenge faced by employers and workers around the globe. The research evidence describes the significant burden in the workplace. It also has shown that the organization of work can contribute to the risk of mental illnesses. Three major standards and guidelines from Europe and Canada have been developed based on this evidence. They can provide important lessons and building blocks as California develops its unique approach to promoting and supporting mental health of the State's workforce. As the State tackles this new challenge, it also has the opportunity to lead the way in the US. As the home to the largest US economy, California can also be a leader by filling the research gaps in the US evidence base for mental health of workers.

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APPENDIX

Table 1. United Kingdom Health and Safety Executive Management Standards for Work-Related Stress

	Standard	Desired State
Demand	• Employees indicate that they are able to cope with job demands • There are local systems to respond to any individual concerns	• Given agreed upon hours of work, employee has adequate and achievable demands • People's skills and abilities are consistent with job demands • Jobs are designed within the capabilities of employees • Employees' concerns about their work environment addressed
Control	• Employee has a say about how they do their work • There are local systems to respond to individual concerns	• Where possible, employees have control over work pace • Employees are encouraged to use their skills and initiative to do their work • Where possible, employees are encouraged to develop new skills to help them undertake new and challenging pieces of work • The organization encourages employees to develop their skills • Employees have a say over timing of breaks • Employees are consulted about their work patterns
Support	• Employees indicate they receive adequate information and support from colleagues and supervisors • There are local systems to respond to individual concerns	• The organization has policies and procedures to adequately support employees • Systems are in place to enable and encourage managers to support their staff • Systems are in place to enable and encourage employees to support their colleagues • Employees know what support is available and how and when to access it • Employees know how to access the required resources to do their job • Employees receive regular and constructive feedback
Relationships	• Employees indicate they are not subjected to unacceptable behaviors (e.g., bullying) • There are local systems to respond to individual concerns	• The organization promotes positive behaviors at work to avoid conflict and ensure fairness • Employees share information relevant to their work • The organization has agreed policies and procedures to prevent or resolve unacceptable behavior • Systems are in place to enable and encourage managers to deal with unacceptable behavior • Systems are in place enable and encourage employees to report acceptable behavior
Role	• Employees indicate they understand their role and responsibilities • There are local systems to respond to individual concerns	• The organization ensures that as far as possible, the different requirements it places on employees are compatible • The organization provides information to enable employees to understand their role and responsibilities • The organization ensures that as far as possible, the requirements it places upon employees are clear • Systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have in their role and responsibilities
Change	• Employees indicate the organization engages them frequently when undergoing an organizational change • There are local systems to respond to individual concerns	• The organization provides employees with timely information to enable them to understand the reasons for proposed changes • The organization ensures adequate employee consultation on changes and provides opportunities for employees to influence proposals • Employees are aware of the probable impact of any changes to their jobs. If necessary, employees are given training to support any changes in their jobs • Employees are aware of timetables for changes • Employees have access to relevant support during changes

Source: hse.gov.uk/stress/standards Accessed October 30, 2019.

Table 2. PRIMA-EF Guidance on the European Framework for Psychosocial Risk Management

Work-Related Psychosocial Hazard	Description
Job Content	• Lack of variety or short work cycles • Fragmented of meaningless work • Under use of skills • High uncertainty • Continuous exposure to people through work
Workload and Work Pace	• Work overload or under load • Machine pacing • High levels of time pressure • Continually subject to deadlines
Work Schedule	• Shift working • Night shifts • Inflexible work schedules • Unpredictable hours • Long or unsocial hours
Control	• Low participation in decision making • Lack of control over workload, pacing, shift work, etc.
Environment and Equipment	• Inadequate equipment availability, suitability or maintenance • Poor work environmental conditions such as lack of space, poor lighting, excessive noise
Organisational Culture	• Poor communication • Low levels of support for problem solving and personal development • Lack of definition of, or agreement on organizational objectives
Interpersonal Relationships at Work	• Social of physical isolation • Poor relationships with superiors or co-workers • Interpersonal conflict • Lack of social support
Role in Organisation	• Role ambiguity • Role conflict and responsibility for people
Career Development	• Career stagnation and uncertainty • Under promotion or over promotion • Poor pay • Job insecurity • Low social value to work
Home-Work Interface	• Conflicting demands of work and home • Low support at home • Dual career problems

Source: World Health Organization. *PRIMA-EF Guidance on the European Framework for Psychosocial Risk Management*

Table 3. Psychological Health and Safety in the Workplace National Standard of Canada

	Indicators
Organizational Culture	• all people in the workplace are held accountable for their actions • people at work show sincere respect for others' ideas, values, and beliefs; • difficult situations at work are addressed effectively; • workers feel that they are part of a community at work; • workers and management trust one another
Psychological and Social Support	• the organization offers services or benefits that address worker psychological health; • workers feel part of a community and that the people they are working with are helpful in fulfilling job requirements; • the organization has a process in place to intervene if an employee looks distressed while at work; • workers feel supported by the organization when they are dealing with personal or family issues; • the organization supports workers who are returning to work after time off due to a mental health condition; • people in the organization have a good understanding of the importance of worker mental health
Clear Leadership and Expectations	• in their jobs, workers know what they are expected to do; • leadership in the workplace is effective; • workers are informed about important changes at work in a timely manner; • supervisors provide helpful feedback to workers on their expected and annual performance; • the organization provides clear, effective communication
Civility and Respect	• people treat each other with respect and consideration in the workplace; • the organization effectively handles conflict between stakeholders; • workers from all backgrounds are treated fairly; • the organization has effective ways of addressing inappropriate behavior by customers or clients
Psychological Demands	• the organization considers existing work systems and allows for work redesign; • the organization assesses worker demand and job control issues; • the organization assess the level of job control and autonomy afforded to its workers; • the organization monitors the management system to address behaviors that impact workers and the workplace; • the organization values worker input particularly during periods of change and the execution of work; • the organization monitors the level of emphasis on production issues; • the organization reviews its management accountability system that deals with performance issues and how workers can report errors; • the organization emphasizes recruitment, training, and promotion practices that aim for the highest level of interpersonal competencies at work
Growth and Development	• workers receive feedback at work that helps them grow and develop; • supervisors are open to worker ideas for taking on new opportunities and challenges; • workers have opportunities to advance within their organizations; • the organization values workers' ongoing growth and development; • workers have the opportunity to develop their "people skills" at work

	Indicators
Recognition and Reward	• immediate supervision demonstrations appreciation of workers' contributions; • workers are paid fairly for the work they do; • the organization appreciates efforts made by workers'; • the organization celebrates shared accomplishments; • the organization values workers' commitment and passion for their work
Involvement and Influence	• workers are able to talk to their immediate supervisors about how their work is done; • workers have some control over how they organize their work; • worker opinions and suggestions are considered with respect; • workers are informed of important changes that can impact how their work is done; • the organization encourages input from all workers on important decisions related to their work
Workload Management	• the amount of work workers are expected to do is reasonable for their positions; • workers have the equipment and resources needed to do their jobs well; • workers can talk to their supervisors about the amount of work they have to do; • workers' work is free from unnecessary interruptions and disruptions; • workers have an appropriate level of control over prioritizing tasks and responsibilities when facing multiple demands
Engagement	• workers enjoy their work; • workers are willing to give extra effort at work if needed; • workers describe work as an important part of who they are; • workers are committed to the success of the organization; • workers are proud of the work they do
Balance	• the organization encourages workers to take their entitled breaks; • workers are able to reasonably meet the demands of personal life and work; • the organization promotes life-work harmony; • workers can talk to their supervisors when they are having trouble maintaining harmony between their life and work; • workers have energy left at the end of most workdays for their personal life
Psychological Protection	• the organization is committed to minimizing unnecessary stress at work; • immediate supervisors care about workers' emotional well-being; • the organization makes efforts to prevent harm to workers from harassment, bullying, discrimination, violence, or stigma; • workers would describe the workplace as being psychologically healthy; • the organization deals effectively with situations that can threaten or harm workers
Protection of Physical Safety	• the organization cares about how the physical work environment impacts mental health; • workers feel save about the physical work environment; • the way work is scheduled allows for reasonable rest periods; • all health and safety concerns are taken seriously; • workers asked to do work that they believe is unsafe, have no hesitation in refusing to do it; • workers get sufficient training to perform their work safely; • the organization assesses the psychological demands of the jobs and the job environment to determine if it presents a hazard to workers' health and safety

Source: Canadian Standards Association and Bureau de normalisation du Quebec. *Psychological Health and Safety in the Workplace*

AGENDA ITEM 2

Action

March 25, 2021 Commission Meeting

Approve February 17 and February 25, 2021 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the February 17 and February 25, 2021 Commission teleconference meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (2): (1) February 17, 2021 Meeting Minutes, (2) February 25, 2021 Meeting Minutes

Handouts: None.

Proposed Motion: The Commission approves the February 17 and February 25, 2021 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

Lynne Ashbeck
Chair
Mara Madrigal-Weiss
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
February 17, 2021

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

974-7226-0775; Code 513141

Members Participating:

Lynne Ashbeck, Chair
Mayra Alvarez
Ken Berrick
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Khatera Tamplen
Tina Wooton

Members Absent:

Mara Madrigal-Weiss, Vice Chair
John Boyd, Psy.D.
Assembly Member Wendy Carrillo

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Brian Sala, Ph.D., Deputy Director, Research and Chief Information Officer

CONVENE AND WELCOME

Chair Lynne Ashbeck called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:10 a.m. and welcomed everyone.

Commissioner Tamplen asked for a moment of silence in honor of Janet King, Native American Health Center, who recently passed away. On behalf of the Commission,

Chair Ashbeck shared memories of and gratitude for Janet King's work and accomplishments in the mental health field.

Chair Ashbeck reviewed the meeting protocols.

Announcements

Chair Ashbeck provided the announcements:

- The next MHSOAC meeting is scheduled for February 25th and will include a panel presentation on prevention and early intervention.
- Applications for members of the public to serve on the Client and Family Leadership Committee (CFLC) or Cultural and Linguistic Competence Committee (CLCC) are posted on the website.
- The next CLCC meeting is scheduled for March 11th.
- The next CFLC is scheduled for March 18th.
- The March 25th Commission meeting will include an update on the Workplace Mental Health Project.
- The next Regional Listening Sessions for the Prevention and Early Intervention Subcommittee are scheduled for February 22nd, March 1st, March 3rd, and March 8th.
- The California Department of Human Resources (CalHR) has authorized that state offices reopen at 25 percent as of February 1st.
- New staff member Heather Barr, Triage Research Project Manager, joined the Commission staff since the last Commission meeting.

Roll Call

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

GENERAL PUBLIC COMMENT

Stuart Fiedler, Client Network, shared their experiences in trying to navigate the system.

Susan Gallagher, Executive Director, Cal Voices, agreed with public commenters in the Rules of Procedure Subcommittee meeting earlier today that the Commission should not only be listening to clients and stakeholders but should be acting accordingly. The speaker stated one of the things they kept hearing from staff and Commissioners is that the Commission cannot please everyone. Very rarely has the Commission changed action based on the public comment given. The speaker urged the Commission to listen to stakeholder feedback and to take it into consideration when making decisions.

Susan Gallagher stated the Rules of Procedure are being rushed through so the Executive Director can continue acting as he has without these rules. The speaker stated the Executive Director has already been doing these things without the revised

Rules of Procedure in place and without stakeholder input. In the meantime, programs that matter such as Ambassadors are being defunded. The Commission is getting into technology suites and Innovation incubators that clients do not care about.

Susan Gallagher encouraged the Commission to get back to the business it is commissioned to do – to respond to stakeholders, make a system that is recovery-oriented, and to listen to communities that matter.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked Commissioner Tamplen for asking for a moment of silence in honor of Janet King.

Stacie Hiramoto stated the hope that there will be consideration for allowing members of the CLCC from last year to be reappointed since there was only one meeting last year.

Stacie Hiramoto thanked Chair Ashbeck for facilitating the difficult Rules of Procedure Subcommittee meeting earlier today. The speaker stated they wished more Commissioners were in attendance.

Poshi Walker, LGBTQ Program Director, Cal Voices, and Co-Director, #Out4MentalHealth, thanked the Commission for taking a moment of silence to honor Janet King. The speaker stated may her memory be a blessing.

Poshi Walker echoed the previous speakers. The speaker stated stakeholders' restricted ability to speak with staff, Commissioners, guests of the Commission, and each other due to the COVID-19 pandemic has been difficult. The speaker asked for a way that stakeholders can speak with each other or to exchange contact information during Zoom meetings.

Elizabeth Oseguera, Senior Policy Analyst, California Primary Care Association, asked if the public will have an opportunity to learn about the feedback received in the Regional Listening Sessions and how that has influenced the priority setting for prevention and early intervention services as directed in Senate Bill (SB) 1004.

Chair Ashbeck asked staff to follow up with Elizabeth Oseguera offline to answer these questions.

Vernon Price stated they will email a document to the Commission and representatives of different branches of nonprofit organizations called "The Five Faces of Oppression." The speaker stated one of the types of oppression is powerlessness. The speaker discussed the culture of silence and asked how individuals can be effective advocates and activists with lived experience with a needed voice in the community when they feel that they are powerless and that their voices are being circumvented.

Lorraine Zeller, Mental Health Services Act (MHSA) Steering Committee, County of Santa Clara; Coordinator, Community Living Coalition, stated the importance of committee participation in supporting the Commission to do its work. The speaker urged the Commission to act on Cal Voices' suggestion expressed in their letter of February 11th to create an Innovations Committee to review Innovation plans and a Community Planning Committee to develop a model community planning process, which can help define what meaningful stakeholder participation looks like.

Commissioner Berrick stated his understanding of the problems with the chat feature as it relates to public comment. He stated another Board he serves on assigns email addresses so Board members can easily receive correspondence. He stated he has benefited from conversations he has had with advocates at past in-person meetings to better understand issues and that have affected his decision-making. He suggested receiving communications from the public as individual Commission members.

Chair Ashbeck agreed with Commissioners being available to the public. She stated the chat feature is not possible during Zoom meetings because it does not equitably engage participants who do not access through Zoom.

Commissioner Berrick asked the Commission to move Item 3 up in the agenda in consideration for individuals who participated in the Rules of Procedure Subcommittee meeting prior to this meeting.

Chair Ashbeck stated Item 2 includes presentations from elected officials and cannot be moved.

INFORMATION

1: Budget Overview

Presenter:

- Norma Pate, Deputy Director

Chair Ashbeck stated the Commission will be presented with an update of the Governor's proposed budget for fiscal year 2021-2022, and a mid-year update of the Commission's current year budget. She asked staff to present this agenda item.

Norma Pate, Deputy Director, reviewed the Highlights of the Governor's Proposed Budget for 2021-22 document, which was included in the meeting handouts, and provided an overview, with a slide presentation, of the Commission budget as of February 3, 2021. She noted that a column has been added to the Commission's Three-Year Comparison of Expenditures to show the actual expenditures for prior years.

Commissioner Questions and Discussion

Commissioner Danovitch asked why funds had not been allocated for research and communications for the coming year.

Deputy Director Pate stated the research and communications allocation will be included in her July budget report after the Governor's May Revise.

Commissioner Berrick suggested adding a column to Chart 1 of the budget showing outyears that have already been committed for comparison.

Public Comment

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, asked for an update on the $2 million COVID-19-related funding allocation.

Deputy Director Pate stated an expenditure plan for the COVID-19 funding allocation was presented at the last meeting. She stated the program is being modeled after the existing Solano County Innovation Project to address racial disparities. More information will be provided at a future meeting.

ACTION

2: Legislative Priorities

Presenters:

- Senator Anthony Portantino
- Estefani Avila, Legislative Aide, Assembly Member Wendy Carrillo
- Toby Ewing, Executive Director

Chair Ashbeck stated the Commission will consider legislative and budget priorities related to Commission initiatives, including Senate Bills 14 and 224 (Portantino) and Assembly Bill 573 (Carrillo), for the current legislative session. She asked Senator Portantino to present his bills.

Senator Anthony Portantino provided an overview of SB 224, which underscores the need for mental health education. He stated there is a tremendous stigma associated with mental health, which often causes individuals to ignore, dismiss, or rationalize a child's true need for help. Mental health education is one of the best ways to increase awareness and empower young people to seek help while reducing the stigma associated with mental health challenges.

Senator Portantino stated SB 224 proposes to ensure that students between grades one and twelve receive mental health education from a qualified instructor at least once during elementary school, once during middle school, and once during high school. He asked for the Commission's support for SB 224.

Senator Portantino provided an overview of SB 14, which is about school employee and pupil training in pupil health and is a companion bill to SB 224. He stated teacher training is not a new topic but what is not known is the effects of the COVID-19 pandemic on students and teachers. COVID-19 has increased the feelings of isolation and loneliness and has exacerbated the youth mental health crisis. He stated the need for as many allies and as much discussion as possible on this issue.

Senator Portantino suggested a braided funding and strategic partnership as is listed in the Commission's strategic plan. He stated the need to ensure that members of schools and communities are equipped with skills and knowledge to recognize and respond to

signs of mental health and substance use challenges. He asked for the Commission's support for SB 14.

Chair Ashbeck asked the representative from Assembly Member Carrillo's office to present AB 573.

Estefani Avila, Legislative Aide, Assembly Member Wendy Carrillo's office, provided an overview of AB 573, which is about establishing youth mental health boards and continues the Commission's work on schools and mental health. She stated the bill seeks to support youth leadership, particularly in times of increased mental stress and challenges due to the COVID-19 pandemic.

Ms. Avila stated this bill seeks to require each community mental health service to have a local youth advisory board and to simultaneously provide young people with a platform to better advocate for effective and quality mental health programs. She asked for the Commission's support for AB 573.

Commissioner Questions and Discussion

Commissioner Bunch asked what the SB 224 mental health curriculum will look like and who would be initiating it.

Senator Portantino stated it would go through the normal curriculum process for the state.

Commissioner Bunch stated the need to ensure that the curriculum process includes an emphasis on multiculturalism.

Commissioner Alvarez asked why schools are such a critical partner in ensuring that young people are receiving the mental health services and supports that they need during this time.

Senator Portantino stated the time young people spend in school is a significant part of their lives and not every influence that a child has at school is a productive one. He stated these bills seek to ensure that prudently productive influences and learning about and destigmatizing mental health are injected into the school experience and that teachers and school staff have access to training to recognize warning signs and to provide a nurturing environment for students.

Commissioner Tamplen stated the Youth Innovation Planning Committee prioritized Senator Portantino's bills last year focusing on mental health in the school setting. She stated the youth would be thrilled to work with Senator Portantino's office on this.

Commissioner Tamplen stated appreciation for including the peer support piece at the schools. She stated this will be a powerful resource for students to have access to. She stated the hope that the mental health principles discussed in the bills will focus on the resiliency of the youth and the strength that they bring.

Commissioner Gordon stated his appreciation for Senator Portantino's dedication to ensuring that schools become centers of wellness.

Commissioner Gordon stated his appreciation for Assembly Member Carrillo's proposal on youth. He stated Sacramento County is just beginning a youth committee that

reports to the board of supervisors. He noted that the input received from the young people is extraordinary.Commissioner Wooton asked if Senator Portantino will be including the suicide prevention information developed by the Commission in his bills or in the curriculum.

Senator Portantino stated it has not expressly been defined in the legislation as the bill will not create the curriculum, but suicide prevention should be a large piece of mental health curriculum.

Public Comment

Daniel Offer, National Alliance on Mental Illness (NAMI) California, spoke in support of SB 224 and stated NAMI California is ready to work with the Commission on implementation of this bill. The speaker encouraged the Commission to support SB 224.

Isabella Valentine, Transition-Age Youth (TAY) Action Team Member, and part of the Youth Empowerment Network, advocated for mental health education in elementary, middle, and high school. She spoke in support of SB 224.

Adrienne Shilton, Senior Policy Advocate, California Alliance of Child and Family Services, spoke in support of SB 224.

Christine Frey, Founder, Youth Mental Health Project and Community, Brain XP, representing the youth voice on several councils, including the California Behavioral Health Planning Council, spoke in support of SB 224.

Mandy Taylor spoke in support of SB 224 and SB 14. The speaker stated the hope that federal funding will be sought to help fund the implementation of these bills. The speaker stated the need for more information on how AB 573 plans to nest the youth boards both at the state and local levels within the requirements that are written into the MHSA. Also, the state is required to pay for anything it requires and may run into challenges in implementing anything that will cost money for state and local governments.

Stuart Fiedler stated one of the root causes of mental illness is bullying. He suggested as a deterrent holding parents accountable for their children who bully others and financially responsible for damages.

Marisol Beas, Project Coordinator, Mental Health America of California, spoke in support of SB 224.

Rachel Velcoff Hults, National Center for Youth Law, spoke in support of SB 224.

Lorne Wood, Board Member, California Youth Empowerment Network (CAYEN), spoke in support of SB 224.

Richard Gallo, consumer and advocate, spoke in support of the legislation.

Elia Gallardo, Director of Governmental Affairs, County Behavioral Health Directors Association (CBHDA), spoke in support of SB 14.

Aracely Navarro, Children’s Partnership, spoke in support of SB 224.

Herman DeBose, Ph.D., former member of the CLCC, spoke in support of SB 224 and SB 14. The speaker stated the hope that the curriculum deals with issues related to institutional racism and trauma. The speaker asked about the criteria for selecting the 15 members of the youth advisory panel to ensure representation of California's diverse population.

Xiayuan Zhang, Board Member, CAYEN, spoke in support of SB 224.

Mariel Mastrili, CAYEN, spoke in support of SB 224.

Susan Gallagher stated it was unkind to stop Stuart Fiedler's comments since many commenters talked about things that were not exactly related to the bills.

Susan Gallagher stated the California State Auditor's Report about the local educational agencies and the lack of mental health services points to the fact that there is no infrastructure to provide those services. The mandate is on the education department to provide those services.

Susan Gallagher stated, since moving the requirement to provide those services through mental health back into the education system, the rates of individual education plans (IEPs) have substantially gone down. These are things that need to tie into this legislation. Individuals can be educated about mental health needs but, if there are no services or not enough services to connect people to, it can be harmful. The speaker stated, although they support these bills, the infrastructure needs to be in place before implementing the legislation.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Berrick, that:

- *The MHSOAC supports and/or cosponsors Senate Bill 14, Senate Bill 224, and Assembly Bill 573 depending on the authors' needs and staff capacity.*

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Brown, Bunch, Danovitch, Gordon, Mitchell, Tamplen, and Wooton, and Chair Ashbeck.

10 MINUTE BREAK

ACTION

3: <u>Amendments to the Rules of Procedure</u>

Presenter:

- Filomena Yeroshek, Chief Counsel

Chair Ashbeck stated the Commission will consider adopting amendments to its Rules of Procedure. She summarized the background of the amendments to the Rules of Procedure. She stated staff undertook the update and revision of these rules largely to bring some of them up to day, to reflect the Commission's practice, and to more clearly

define terms such as “quorum” and “attendance.” These are issues that came out of the strategic plan.

Chair Ashbeck stated, based on comments received in this morning’s Rules of Procedure Subcommittee meeting there is concern about the proposed changes regarding outreach, engagement, and committees and the authority of the Executive Director to spend independently of public action. She suggested approving the proposed amendments to the Rules of Procedure with the exception of the two areas of concern. She suggested creating a Subcommittee to work with staff on those two areas of concern.

Filomena Yeroshek, Chief Counsel, stated many changes were made to the Rules of Procedure to address the public comments and concerns received since January of 2020. She stated, as per Chair Ashbeck’s proposal, today’s proposed motion would be to approve the proposed amendments to the Rules of Procedure with the exception of the two areas requiring additional discussion. Thus, the current composition of the Committees would stay at two consumers, two family members or care givers, and two representatives of unserved and underserved communities, and the current contract authority at $100,000 for contracts and $200,000 or less or interagency agreements would remain.

Commissioner Questions

Commissioner Berrick moved to approve the proposed noncontroversial amendments to the Rules of Procedure.

Commissioner Danovitch seconded.

Commissioner Alvarez asked staff about the number and types of Commission contracts above $200,000 to better understand the number and types of contracts that go through a more transparent process.

Commissioner Alvarez stated the need to ensure that the contracts made through delegated authority remain consist with the Commission’s strategic plan, projects, priorities, and processes, and reminded everyone that those priorities and processes have been agreed upon in principle by the Commission and informed with stakeholder input. She asked staff to provide information that can demonstrate this based on past contracts to help inform the discussion on the areas of concern.

Chief Counsel Yeroshek stated a rudimentary list of all current contracts dating back to fiscal year 2018-19 have recently been posted on the website and includes the contract number, the name of the contractor, the dollar amount, and a brief summary of the work. She stated the goal is to make the list more dynamic, similar to the Fiscal Transparency Tool, with search capabilities, links that can be clicked to download documents, etc.

Public Comment

Susan Gallagher stated stakeholders are in consensus; it is the Commission that does not agree. The speaker provided an example of an approved Innovation project that is being used as a glorified emergency department, where the Commission and

stakeholders were unaware of this when it was approved. The speaker stated more scrutiny is required for Innovation projects because these kinds of things tend to happen. This is an example of why the process of approving Innovation projects should not be marginalized and why public input cannot be limited on these projects. Things tend to get pushed through public processes. This kind of accountability is essential. Advocates are forced to dig for public records due to the lack of transparency.

Susan Gallagher provided another example of the social finance contract that the Executive Director approved. The speaker stated appreciation that staff is putting the Commission contract information on the website. The speaker stated the need for increased transparency and contracts that are vetted through a public process. The speaker asked how the public can weigh in on where funding should go to best serve the community when contracts are chosen without a competitive bid and they are sole-sourced.

Herman DeBose referred to Rule 6.1, Structure, under Committees / Subcommittees / Other Multi-Member Bodies, and stated the concern that the proposed language changes the word “shall” to “may.” The speaker stated the CLCC has not met on a consistent basis. The word “may” means that the Commission could decide it does not need input from the CLCC, while the word “shall” means it must occur.

Herman DeBose echoed the previous speaker about Innovation projects. The CLCC was not given an opportunity to look at and provide input on the Solano County Innovation project. Sixty percent of the population of the state of California is individuals of color; the Solano County project does not reflect that. The speaker stated changing the language from “shall” to “may” does a disservice to the majority of the population of the state of California.

Karen Vicari, Director of Policy, Cal Voices, stated Cal Voices is in support of postponing the vote on the two items of concern – the Committees and the delegated authority. The speaker asked the Commission to include Rule 2.6, Authority to Approve Innovation Projects, as an item to be discussed further. The rule change allows the Executive Director, working with the Chair, to approve an Innovation project as long as it has been approved in the past three years in another county. The speaker stated this goes against the purpose of Innovation to create new projects, against local control, and against the community planning process where a community is supposed to determine what their needs are. The speaker strongly requested adding Rule 2.6 to the amendment as something that will be further discussed in the Subcommittee and voted on at a later date.

Mandy Taylor asked Commissioner Berrick to amend his motion to include Rules 4.12, Voting, and 4.13, Public Comment, as items for further discussion in the Subcommittee.

Poshi Walker stated many Commissioners have the perception that this process has been great and that they have done their due diligence. She gave the analogy of a professor giving a test where most of the students failed. It is not the students who did not perceive the test properly; it is the fault of the creator of the test. While Commissioners and staff may have wonderful intentions about including public comment, all members of the public who provided public comment at the Rules of

Procedure Subcommittee meeting earlier today stated they did not feel good about this process. The speaker stated something is wrong and it may be that something is wrong with the test and not the test-takers.

Poshi Walker requested that Rule 4.13(C), addressing public comment, be included in the motion as an item for further discussion in the Subcommittee. The speaker stated concern about items that have been struck, such as the sentence “public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings” and others about the Committee Chairs’ responsibilities to report back to the Commission. The speaker stated that sentence would not be struck unless it was meant to limit public comment. The speaker suggested moving this section to the Rules of Procedure dealing with Committees.

Stacie Hiramoto agreed that Rules 2.4 and 6.1 are controversial and require further discussion. The speaker spoke in support of Karen Vicari’s and Cal Voices’s requests to set aside Rule 2.6 and Mandy Taylor’s request to set aside Rule 4.13, particularly 4.13(B).

Elizabeth R. Stone, CFLC member, stated they disagreed with the way the Executive Director reframed the concerns about the Committees. Concerns are not just around the membership; it is also that the CFLC only met once or twice last year and is about the proposed “shall” versus “must” language in the Rules of Procedure. The speaker stated the need for regularity in Committee meetings with sustained, consistent input.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, echoed the comments of the previous speakers, especially Stacie Hiramoto.

Elissa Feld, Senior Policy Analyst, CBHDA, stated the need to ensure that Rules 6.1(A) and (B) are set aside. The CBHDA has concerns that there is not guidance about when the added language to Rule 6.1(B) should be followed versus setting up a Committee. The speaker stated the term “multi-member body” does not have specifications about the use of consumers and stakeholders who are driving equity, which is important.

Eba Laye, President, Whole Systems Learning, echoed Stacie Hiramoto’s comments regarding Rule 4.13. Providing public comment before the Commission is of vital importance. The speaker encouraged the Commission to include Rule 4.13 in the motion as an item for further discussion in the Subcommittee.

Steve McNally, citizen and family member, stated the Commission is hearing from individuals who feel safe enough with this group to provide public opinion on a topic. The speaker stated the MHSA is simple on paper and yet very few individuals attend meetings or, even if they attend, very few individuals provide public comment out of fear of retribution from local agencies. The speaker stated advocates need to understand what the Commissioners’ “why” is for being on this Commission, what drives Commissioners, and what they are trying to accomplish. The speaker stated Commissioners could help stakeholders organize locally.

Vernon Price agreed with previous speakers to set aside additional rules for further discussion in the Subcommittee.

Andrea Crook, Advocacy Director, ACCESS California, stated the overall consensus among stakeholders is to leave the Rules of Procedure as they are. The speaker stated the need to pause to ensure everyone is working together. The speaker encouraged the Commission to take no vote today and to strive for consensus with community stakeholders.

Commissioner Discussion

Commissioner Bunch asked for the exact language of the motion on the table.

Chief Counsel Yeroshek stated the motion is to approve the proposed amendments to the Rules of Procedure except the increase in the delegated authority for contracts in Rule 2.4 and the changes to the Committee membership composition in Rule 6.1.

Executive Director Ewing stated staff is working to provide email addresses for all Commissioners to strengthen communication. They should become available next week.

Executive Director Ewing stated the Commission is committed to the kinds of transparency issues that stakeholders are asking about. Commission contracts will be posted online so individuals can review them over time. He stated the goal is to have an active link to each contract so individuals can sort through when contracts were agendized or approved through delegated authority and the number of contracts that are ministerial types of contracts such as the contract with the paper shredder versus contracts of concern to stakeholders.

Executive Director Ewing stated not all concerns raised today will be addressed through the Rules of Procedure, such as concerns about the consistency of county Innovation plans and how they are operationalized with what was proposed. He stated this is difficult, in part because of the time that the Commission has to dedicate to this work. He stated the Commission wants to create opportunities for better communication, clarity on the work that the Commission is doing, and the outcomes and impacts of the Commission's work and decisions.

Executive Director Ewing stated the kind of listening to stakeholders that Commissioner Gordon championed through the Schools and Mental Health work all the way through legislative and budgeting priorities happening in the Legislature today is an example of why Commissioners join the Commission. The Commission is trying its best to streamline the process to best value Commissioner time and energies in these meetings with community input and guidance.

Executive Director Ewing stated one of the things that he and staff are taking away from the discussions today is that staff must do a better job of communicating on all the community engagement that is happening. He spoke in support of continuing to dialogue if the Rules of Procedure are not yet right.

Commissioner Berrick stated appreciation for the concerns raised and for requests to set this entire agenda item aside but stated there have been substantive comments made in the past about noncontroversial areas in the Rules of Procedure. He stated Chair Ashbeck's proposal allows the Commission to move forward and still allows for further dialogue on areas of concern.

Commissioner Danovitch agreed. He stated he heard a theme and sharp critiques of the Executive Director and the Commission of distrust and lack of confidence. It is incumbent upon the Commission to communicate more clearly on Commission activities.

Commissioner Danovitch stated the Executive Director has performed his job incredibly well and consistent with the strategies the Commission has set forth as transparently as possible through strategic planning meetings and other meetings within the Commission. He stated he has a lot of confidence in the Executive Director's intelligence and the coherent effectiveness with which Executive Director Ewing has been pursuing both the Commission's short- and long-range goals.

Commissioner Danovitch testified to the depth and sincerity of the Executive Director's personal passioned commitment to the Commission's values, including listening openly to all voices and listening to the critique, even when it is difficult to hear.

Commissioner Berrick strongly agreed and stated appreciation of the forum for continued input. He suggested that county Innovation project processes be included for discussion in that forum.

Commissioner Brown echoed the comments of Commissioners Berrick and Danovitch. He stated this is about balance – balance between the work of government and the input of the community. It is not unlike what happens at city council meetings, the Legislature, and anywhere else in society where there is a task of conducting business and listening to input. The Commission needs to be respectful and needs to listen but it also needs to understand that the balance is boiling down to public comment, in this case, and agenda and time management in terms of the Commission.

Commissioner Brown reminded everyone that the Commission is comprised of volunteers, almost all of whom have other full-time jobs, which are demanding. Time must be balanced as well in terms of what Commissioners can do. The attempts at modifying how the Commission does its business have been made in good faith and in the best interest of time to balance and achieve the best possible outcomes with the limited amount of time available and the large number of topics and tasks the Commission is charged with.

Commissioner Brown reminded everyone that Commissioners are here because they share a passion with stakeholders and advocates for helping individuals with mental illness. Commissioners are working to do the best that is possible and are listening to stakeholders. He stated there is a diversity of opinion and thought from individuals who provide input both inside and outside of these meetings. No one likes the present situation of being unable to meet in person and interact together, but the Commission is doing the best it can.

Commissioner Brown also reminded everyone that Commissioners have a professional staff of individuals led by the Executive Director to assist Commissioners in making these decisions. The Executive Director and his team are talented, competent, caring, and professional. They act in the best interests of this cause as well. They do the best they can in providing Commissioners with recommendations. Commissioners do the best they can in supporting, modifying, or opposing those recommendations.

Commissioner Brown stated the reality is everyone is on the same page. This needs to be recognized, but there must be a compromise over limitless input and limitless amounts of time to spend on these subjects.

Commissioner Brown emphasized that the Commission listens to stakeholders and values and encourages stakeholders to take advantage of and to come and provide public input.

Commissioner Gordon underscored the last few comments and recognized the balance mentioned by Commissioner Brown. He stated the Commission has made great strides in a number of areas – most recently, criminal justice and education. There always is a balance listening to stakeholders. He stated he appreciates hearing from stakeholders and, at the same time, he stated he appreciates the nimble and thoughtful leadership of the Executive Director and the team he has assembled.

Commissioner Gordon stated the Executive Director is here for exactly the right reasons – he is here to move the cause forward and to move the work forward. The struggle for the Commission to hear the best it can and also to move the agenda the best it can will never be eliminated. He stated he agreed with the revised motion.

Action: Commissioner Berrick made a motion, seconded by Commissioner Danovitch, that:

- *The Commission approves the proposed amendments to the Rules of Procedure except the increase in the delegated authority for contracts in Rule 2.4 and the changes to the committee membership composition in Rule 6.1.*

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Alvarez, Berrick, Brown, Bunch, Danovitch, Gordon, Mitchell, and Tamplen, and Chair Ashbeck.

The following Commissioner abstained: Commissioner Wooton.

INFORMATION

4: <u>Staff Report</u>

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Dawnté Early, Ph.D., Chief of Research and Evaluation

Chair Ashbeck tabled this agenda item to the next meeting.

ADJOURN

Chair Ashbeck thanked participants who joined the 8:00 a.m. meeting and everyone who joined the 9:00 a.m. meeting.

Chair Ashbeck asked everyone to leave the meeting in remembrance of Janet King. She shared the sentiment given by Poshi Walker for Janet King: may her memory be a blessing.

There being no further business, the meeting was adjourned at 12:22 p.m.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

Lynne Ashbeck
Chair
Mara Madrigal-Weiss
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
February 25, 2021

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

998-4035-9076; Code 948547

Members Participating:

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mayra Alvarez
Ken Berrick
John Boyd, Psy.D.
Sheriff Bill Brown
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Khatera Tamplen
Tina Wooton

Members Absent:

Keyondria Bunch, Ph.D.
Assembly Member Wendy Carrillo

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Brian Sala, Ph.D., Deputy Director, Research and Chief Information Officer

CALL TO ORDER AND WELCOME

Chair Lynne Ashbeck called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:05 a.m. and welcomed everyone.

Chair Ashbeck reviewed the meeting protocols.

Announcements

Chair Ashbeck made the following announcements:

- The next Commission meeting is scheduled for March 25th.
    - The March 25th Commission meeting will include an update on the Workplace Mental Health Project.
- Tomorrow is the last day to apply to serve on the Client and Family Leadership Committee (CFLC) or Cultural and Linguistic Competence Committee (CLCC). Applications are posted on the website.
- The next CLCC meeting is scheduled for March 11th.
- The next CFLC is scheduled for March 18th.
- New staff member Sarah Yeffa, Communications and Public Engagement Officer, joined the Commission staff since the last Commission meeting.

Roll Call

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

GENERAL PUBLIC COMMENT

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated concern for the lack of clear direction or mention in Commission's Prevention and Early Intervention Subcommittee meetings and projects about the primary purpose of Senate Bill (SB) 1004, which was to narrow and focus the priority populations of county prevention and early intervention programs. The speaker read a portion of the bill mandating the Commission to establish priorities for the use of prevention and early intervention funds. The speaker stated this has not been mentioned nor has the public been asked to provide input on the list of priority populations to be developed by the Commission.

Stacie Hiramoto stated REMHDCO has deep concerns with the prevention and early intervention language of the transition-age youth (TAY) population with the priority on funding only for TAY who attend college. While REMHDCO supports more mental health programs for TAY, it strongly objects to the priority on TAY attending college. The speaker suggested a robust discussion of the specific and clear purpose of SB 1004 and asked the Commission to solicit feedback on the language for priority populations in focus groups and forums.

Andrea Crook, Advocacy Director, ACCESS California, a program of Cal Voices, stated concern that, under Assembly Bill (AB) 1976, counties must divert critical mental health resources to assisted outpatient treatment (AOT) programs regardless of community needs and despite the unprecedented challenges faced from the COVID-19 pandemic. The speaker stated, although counties can opt out, county directors are being encouraged not to due to political pressures. The speaker asked how the Commission will ensure accountability that counties have a stakeholder process and that the required client services, peer support, data collection, and mobile teams will be upheld.

Poshi Walker, LGBTQ Program Director, Cal Voices, and Co-Director, #Out4MentalHealth, echoed the comments and questions from the previous speakers about AB 1976 and SB 1004. The speaker thanked the Commission for starting up the Committees again but stated the applications for Committee membership were only posted one week ago. The speaker requested an extension on the Committee application deadline – eight days is not long enough.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, a program of Cal Voices, echoed Andrea Crook's comments about AB 1976 and the pressure that counties and advocates are feeling respecting the adoption of this law. The speaker stated concern that prioritizing funding for involuntary services further stigmatizes mental health and discourages clients from seeking services for fear of being ordered into treatment. The speaker stated statewide involuntary treatment does not promote the evidence-based practice of client-driven and recovery-oriented services that utilizes shared decision-making and client empowerment that the Mental Health Services Act (MHSA) upholds.

ACTION

1: <u>Approve January 28, 2021, Commission Meeting Minutes</u>

Chair Ashbeck stated the Commission will consider approval of the minutes from the January 28, 2021, teleconference meeting.

Public Comment

Poshi Walker stated they made public comment on February 27, 2020, that the only way to access the minutes is by going to the Commission meeting packet and that revisions are not reflected in the minutes that are posted on the website. The speaker stated, at that time, Chair Ashbeck asked about the process for revising the minutes and reposting the approved version. Stakeholders were told that a page of the motions and approved minutes would soon be added to the website. This has not yet happened. The speaker requested that, when corrections are made to the minutes, those minutes be posted separately.

Chair Ashbeck asked staff to post the revised and approved minutes on the website.

Chair Ashbeck asked for a motion for approval of the minutes.

Commissioner Berrick made a motion to approve the January 28, 2021, teleconference meeting minutes.

Commissioner Danovitch seconded.

Action: Commissioner Berrick made a motion, seconded by Commissioner Danovitch, that:

- *The Commission approves the January 28, 2021, Teleconference Meeting Minutes as presented.*

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Boyd, Brown, Danovitch, Gordon, Tamplen, and Wooton, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

INFORMATION

2: <u>Prevention and Early Intervention Panel Presentation</u>

Presenters:

- Deryk Van Brunt, Dr.PH, University of California, Berkeley, School of Public Health
- Sergio Aguilar-Gaxiola, M.D., Ph.D., Center for Reducing Health Disparities, UC Davis
- Matt Diep, Community Youth Organizer, Center for the Pacific Asian Family and Youth Innovation Committee Member
- Jordan Pont, MA, LMFT, Director of TAY and Adult Mental Health Services

Chair Ashbeck stated this project was initiated by SB 1004, which directed the Commission to establish additional priorities for MHSA prevention and early intervention programs and to develop data monitoring and technical assistance strategies. The Commission created the Prevention and Early Intervention Subcommittee, which met twice prior to the COVID-19 pandemic, has recently held two virtual Regional Listening Sessions, has scheduled three additional Regional Listening Sessions in March, and is holding forums on prevention and early intervention beginning in March. She stated information on those meetings is posted on the website. Written summaries will be produced for all events.

Chair Ashbeck stated, in addition to the Regional Listening Sessions and forums, the Commission will hold two hearings on prevention and early intervention to support this project. Today's hearing is the first. She stated the Commission will hear a panel of subject matter experts on key concepts and opportunities for population-based prevention and early intervention, particularly mental health awareness and identifying and removing barriers to access to appropriate services.

Chair Ashbeck stated the second hearing will be on April 22nd and will highlight opportunities across the lifespan and within key settings such as schools and workplaces.

Chair Ashbeck stated Commissioners and the public can read an overview of the hearing topic and the Commission's Prevention and Early Intervention Project in the handouts for today's meeting. She asked Vice Chair Madrigal-Weiss and Commissioner Alvarez to provide opening comments.

Vice Chair Madrigal-Weiss thanked staff for their help in setting up the listening sessions and forums and the community for their participation in the events and for identifying priorities for the state.

Commissioner Alvarez echoed Vice Chair Madrigal-Weiss's comments of thanks to staff and the community for their participation and support. She stated the opportunity to hear from even more individuals during these events has been powerful and highlights the need to redefine prevention and early intervention to ensure that the Commission is responding to the needs of communities.

Chair Ashbeck introduced the members of the panel and asked them to give their presentations.

Deryk Van Brunt, Dr.PH

Deryk Van Brunt, Dr.PH, University of California, Berkeley, School of Public Health, provided an overview, with a slide presentation, of mental wellbeing pre-pandemic, impacts of COVID-19, early intervention, and the population-based mental wellbeing approach. He stated that it is not just mental illness and no mental illness. This continues the stigma. It is about flourishing. He also mentioned that technology is a vehicle that can be used to make a big impact. He shared numbers around basic questions such as if prevention and early intervention works in the area of mental health and if there are examples to guide the work moving forward.

Dr. Van Brunt stated COVID-19 has made the mental health problem worse, resulting in depression, anxiety, and ongoing mental health impacts. He stated there is ample evidence that prevention and early intervention works and needs to be added to the important work of providing specialty services. He noted that there is a communication gap in most counties between public health and behavioral health. He recommended that the Commission work to foster communication between behavioral health and public health in all counties. He made the point that this is about engagement not about posting content and having technology. He recommended partnering with experts that have done this and understand how to pull people in and get them engaged.

Commissioner Questions

Commissioner Boyd stated the need to include diversity and overcome barriers such as access to technology. He asked about outcome measures that define success specifically to the world of technology and partnership.

Dr. Van Brunt stated mobile access is critical. He stated approximately 60 to 65 percent of users are mobile. Also, he noted that 40 to 50 percent of individuals who use these technologies are doing so on behalf of a friend or family member. He stated his group tags and displays information they collect, but noted that there is a lack of source material.

Dr. Van Brunt stated he thinks of outcome metrics in three buckets: engagement, self-reported outcomes, and non-self-reported outcomes such as claims data and other kinds of clinical metrics, which will require longer-term research.

Sergio Aguilar-Gaxiola, M.D., Ph.D.

Sergio Aguilar-Gaxiola, M.D., Ph.D., Center for Reducing Health Disparities, UC Davis, provided an overview, with a slide presentation, of the preventive opportunities early in life, mental health risks, and the impact of COVID-19 on youth mental health. He stated prevention, early intervention, and community engagement are key. He suggested broadening the scope of prevention to include the social and economic determinants of health, focusing efforts on health promotion and disorder prevention, and implementing screenings to identify individuals at highest risk. He also suggested increasing availability of primary care clinicians and mental health professionals, using digital interventions, and focusing on families and communities to creatively restore the approaches by which they have managed tragedy and loss over generations. All of this needs funding for mental health. He stated one of the lessons learned from the COVID-19 pandemic is to focus much more attention on prevention.

Commissioner Questions

Commissioner Wooton asked how the Commission can help reduce youth suicide.

Dr. Aguilar-Gaxiola stated that the Commission already has this as a focus on this work.

Commissioner Danovitch stated psychological injury or growth can happen after any crisis. In the spirit of trying to promote psychological growth, he stated, in addition to the identification and early intervention, on the cultural side, there is something to the stories told about what is going on that enable people to contextualize their experience and promote growth. He asked two questions related to that: are there things the Commission should be doing or thinking about to tell more effective stories about what is happening to enable such frameworks, and, on the measurement piece, is there a way to measure the resilience and psychological growth in the spirit of incentivizing through measuring?

Dr. Aguilar-Gaxiola agreed that that continues to be neglected – efforts are often focused on the deficits. Much more seldom are efforts focused on the positive side of the illness health continuum. He stated it is critically important to tap into the strengths and assets that human beings have. One of those assets is resilience. He suggested focusing attention on resiliency. He asked to be a part of that conversation in the future.

Commissioner Tamplen asked about things the Commission should be doing in the elementary, middle, and high school areas for prevention and early intervention.

Dr. Aguilar-Gaxiola stated there have been three reports put together by the National Academy of Sciences on prevention. One of those reports was released this past year. Those three reports are full of examples of success when starting early in life.

Matt Diep

Matt Diep, Executive Director and Founder, Psypher LA; Community Youth Organizer, Center for the Pacific Asian Family; and Youth Innovation Committee Member, stated

his presentation will focus more on sharing his story and the different systems and challenges he has identified. He tries to advocate through his lived experiences with the goal of helping everyone recenter the importance of listening to youth lived experiences in addition to the outcomes-based approaches. He provided an overview, with a slide presentation, of the TAY perspective, challenges and missed opportunities in navigating the mental health system, the Youth Innovation Project Planning Committee, and policies and practices that increase mental health awareness and access to resources.

Mr. Diep recommended listening to youth and their families, investing in youth-led prevention efforts, and investing in community collaboration.

Commissioner Questions

Chair Ashbeck thanked the speaker for telling such a powerful story of resiliency.

Commissioner Boyd thanked the speaker and stated his deep respect and gratitude.

Commissioner Berrick stated intervention is often done through law enforcement, especially for an acute crisis. He asked what the first point of contact should be for crisis in a school setting and how youth, through school, could quickly get help in a way that was not stigmatized and that was easily accessible.

Mr. Diep stated the answer lies in a community-based participatory research (CBPR) approach, where community members, community organizations, and researchers are partners and share a reciprocal exchange of information to find answers to difficult questions such as the question asked by Commissioner Berrick.

Vice Chair Madrigal-Weiss stated the hope that the difficulties faced last year will cause everyone to see education as a system and that it cannot continue to function in the way that it traditionally has. To a certain degree, the discipline was arrogant in that it quickly designed tools, parent resources, and academics, but there was little pause. She noted that that came later, when it was realized that success is getting students in a place where they are stabilized and feel safe so they can engage. She stated the question now is why students do not come to class or why they are not engaged. This was not a focus before COVID-19 and should not be expected now. Everything the panel members discussed will help bring further understanding.

Vice Chair Madrigal-Weiss stated she liked Mr. Diep's Psypher LA Voices of 1,000 Survey that includes the ACE's scale, as well as open-ended questions that explore risk and protective factors for youth mental health. She stated this survey needs to be done in other communities instead of relying on the California Healthy Kids Survey. She stated the need to get relevant data that is designed by cultural experts, who are the youth, where education is a service to youth, not the other way around.

<u>Jordan Pont</u>

Jordan Pont, MA, LMFT, Director of TAY and Adult Mental Health Services, Felton Institute, provided an overview of the Felton Institute's TAY Acute Linkage Program,

which began in 2019. She stated certain criteria must be met by clients in order to be accepted into the program and specific referral sites include psychiatric emergency services and hospital psychiatric in-patient units. Individuals in the program are 16 through 25 years of age with severe mental illness who are not linked to or are not well-connected to care or have complex needs requiring more support or consultation than the care they are currently receiving. The program is short-term – up to 180 days.

Ms. Pont summarized early intervention activities delivered at Felton Institute, lessons learned from delivering services to try to prevent repeat or new crises, early system support weaknesses and failures resulting in mental health crises, and policies and practices that promote community access and partnerships to advance the prevention and early intervention work.

Ms. Pont stated Felton Institute has learned that a team made up of clinical and peer support staff has been valuable in connecting with clients. Felton Institute has also learned that immediate engagement, usually within 24 hours of receiving the referral, meeting clients where they are, and having the referrer explain services rather than Felton Institute reiterating what they can do is best. It helps clients to have realistic expectations and to set realistic goals.

Ms. Pont stated teaching clients how to use and linking them to different modes of communication and technology such as cell phones or tablets has helped to increase engagement. She stated client access to web-based self-help groups or other Zoom groups has helped clients access other ways of getting help. She stated Felton Institute tries to communicate with clients through their preferred mode such as text, phone, video call, or face-to-face.

Ms. Pont stated meetings focus on clients' strengths. Felton Institute sets the agenda and works with support systems, which helps engage clients and keeps them on track for achieving their goals. Clients who participate in the program have experienced a decrease in utilization of crisis services, in-patient hospitalization episodes, and visits to emergency departments.

Ms. Pont stated early system and support weaknesses and failures that have resulted in mental health crises include poor communication between providers, multiple psychiatric emergency service visits with no prior referral to the program, clients discharged on a weekend when the program is not in operation, and last-minute referrals.

Ms. Pont stated the need for lower-threshold programs where clients can access intensive-case management services without being in crisis. She stated, although TAY services help bridge the gap between children and adult systems, many clients tend to get lost in the follow-up. She stated the need for improved communication between systems and even better linkages for continuity of care. She stated, because electronic health records do not interface between systems, clients' important stories are often lost.

Ms. Pont stated Felton Institute has conducted outreach and given presentations to referrers to improve relationships, has smaller caseloads, has access to TAY-specific

psychiatry within the California Department of Public Health (CDPH), and provides links to ongoing mental health care services.

Public Comment

Tiffany Carter stated appreciation for the panel presentations, particularly Matt Diep's testimony.

Poshi Walker added to Matt Diep's examples of intrinsic racism within the system. The speaker stated it is important not to forget this when discussing prevention and early intervention. The speaker highlighted Dr. Aguilar-Gaxiola's comments about school failure increasing during the COVID-19 pandemic, especially in communities of color. The speaker stated the need to focus on all youth, not just youth who happen to be in college. Often, youth fail before they get to college age.

Poshi Walker stated it is not only in policing that mental health trauma happens. Children of color and children who are perceived to be LGBTQ are more likely to have school detentions and to be punished and the punishment is more severe for the same offenses. They are much more likely to be expelled from school and to be in the school-to-prison pipeline.

Poshi Walker stated concern that no one is screening LGBTQ youth for the unseen abuse and harm that they suffer from families who may love them but are doing rejecting behaviors that are just as abusive as physical abuse. The speaker stated the need for screenings for rejecting behaviors along with the adverse childhood experiences (ACEs) screenings.

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, thanked Matt Diep for pointing out areas for growth within the system and ways to meaningfully collaborate and engage with communities to develop interventions that really work and that are affirming and appropriate for communities.

Mandy Taylor spoke about the idea of individual self-care that Dr. Van Brunt brought up and the division of mental health services into individualized self-care or professional services. The speaker stated there is inherent class privilege and the ability to be resourced that goes into access individualized self-care and using a western model of individualism when discussing mental health and wellness.

Mandy Taylor stated community and collaborative care are a middle ground in under-resourced communities that is crucial for prevention services. This is how under-resourced communities get mental health services. They do not need what the medical model calls "professional services." Instead, they need the crucial services that support individuals without resources to engage in individualized self-care. The speaker stated the need to consider this when discussing prevention – it is not individual self-care or professional care, but that community collaborative models of care are crucial for under-resourced communities.

Mandy Taylor echoed Dr. Aguilar-Gaxiola's comments regarding using a public health model. That is so important and the partnerships are important. The speaker stated the Office of Health Equity and the Department of Health Care Services (DHCS) will be partnering on the Community Mental Health Equity Project, where individuals will offer

training to county behavioral health systems on creating cultural competency plans. That community collaborative model is vital.

Stacie Hiramoto thanked the Commission for convening a diverse and stimulating panel. All presentations were valuable. The speaker stated Matt Diep's presentation was moving, compelling, and inspiring. The speaker stated all implementation pilot projects that are a part of the California Reducing Disparities Project (CRDP) are community-based organizations that are embedded within the community that Matt Diep discussed in his presentation.

Stacie Hiramoto thanked Mandy Taylor for her comments about focusing on the individual as opposed to the community and family when, in many communities of color, the individual is not stressed the same way as it is in western culture.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation, one of the CRDP Phase 2 contractors, echoed the comments of previous speakers. The speaker asked the presenters what they think about the legislative lack of emphasis on non-student young people in the current prevention and early intervention agenda. The speaker stated many individuals in California will not be college students but may go to technical schools or be a part of apprenticeship programs. These individuals' mental health needs are also valuable.

Laurel Benhamida suggested accessing the video of yesterday's Sacramento County Board of Supervisors meeting where they discussed a 9-1-1 alternative response and call center program.

April McGill, Director of Community Partnerships and Projects, California Consortium on Urban Indian Health, stated they appreciated Dr. Van Brunt's presentation on the research around population-based mental health. The speaker stated it is important to understand that prevention and early intervention for many California Native individuals in urban communities starts with self-care. Self-care is an evidence-based practice for the Native American community because starting with early intervention has connection to culture. Traditional healing practices are integrated into everyday life beginning from birth. It is important to see this as a model and as evidence for prevention.

April McGill stated they appreciated hearing about technology as a vehicle for prevention because, during this time of COVID-19, Native Americans use technology to have cultural programming online. The speaker stated the high rate of depression in the community goes down when connected to culture.

April McGill stated Dr. Van Brunt talked about portals for each population. The speaker stated the Native American community is in their own portal because they have their own ways of practicing and dealing with mental health and prevention. It starts with engagement. Engaging the American Indian community is important since they are always left out of the statistics.

Geoffrey McLennan, a Member of the CFLC, stated 9-8-8 will replace 9-1-1 on July 16, 2021. The speaker encouraged everyone to call Michelle at the Federal Communications Commission (FCC) at 202-418-0388 and their cellular providers to ensure this system begins with all resources and input.

Vice Chair Madrigal-Weiss thanked the members of the panel for sharing their expertise and experience. She stated the Commission will reach out to panel members with additional questions to continue the conversation.

Commissioner Alvarez thanked the members of the panel for their presentations and recognized that they are a part of the Commission's network and family. She stated she looks forward to staying in touch with the panel to ensure that the work being done around prevention and early intervention reflects panel members' expertise and perspectives and that their thoughts and teaching will be incorporated into future listening sessions and town hall meetings. She stated she looks forward to a strong outcome because of the panel members' participation.

10-MINUTE BREAK

ACTION

3: Santa Clara County Innovation Plan

Presenter:

- Jeanne Moral, Program Manager III, County of Santa Clara Behavioral Health Services

Chair Ashbeck stated the Commission will consider approval of $1,753,140 in Innovation funding to support the Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities Innovation Project. She asked staff to start the presentation on this this agenda item.

Sharmil Shah, Psy.D., Chief of Program Operations, provided an overview, with a slide presentation, of Santa Clara County's community planning process and identification of the problem.

Jeanne Moral, Program Manager III, County of Santa Clara Behavioral Health Services, continued the slide presentation and discussed the proposed project to address the problem, learning goals, and budget and evaluation of the proposed Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities Innovation Project.

Commissioner Questions

Commissioner Brown stated his understanding that the genesis of the proposed project was an underutilization of services by African American and Vietnamese residents of the county due to a feeling of not being welcome in existing programs and the proposed program is more of an adjunct to what exists now in the behavioral and wellness department. He asked what is missing in existing programs if they are not viewed as being culturally competent.

Commissioner Brown stated the concern that this would result in a segregation of parts of the community, not from programs that are lacking but from programs that are not being properly utilized. He asked if there is a long-term goal to either integrate the two of these to end up with a presumably more culturally competent and more utilized set of services from the behavioral wellness department.

Ms. Moral stated the county has made progress in African American and Vietnamese utilization but it needs to be better. One of the lessons learned is that most members of these communities gravitate toward their own community members. She stated the proposed project is a supplement to the existing system where providers will do engagement and collaboration so it will be a seamless part of the system. Although the proposed project targets specific populations, the providers and partners will work with behavioral health to ensure that everything is seamless so that when there is a linkage that is needed, they know who to go to.

Chair Ashbeck asked about the term “co-located” and the geography of the county. She stated her sense is that communities live in neighborhoods.

Ms. Moral stated “co-location/partnership” is where the community-based organization brings services to service centers or where the population is going.

Public Comment

Tarab Ansari. Behavioral Health Contractors Association (BHCA), spoke in support of the proposed project.

Mark Karmatz, consumer and advocate, stated the Promotoras Program in Los Angeles County is similar to the proposed project. The speaker suggested that the Commission also look at that program.

Mark Karmatz stated the Western Recovery Conference will be held on March 12th and 13th via Zoom. The cost is $25 to join the meeting and $5 for individuals with scholarships.

David Hai Tran, Policy Director, San Jose City Council, and Board Member, Santa Clara County Behavioral Health Board, spoke in support of the proposed project.

Tiffany Carter spoke in support of the proposed project. The speaker asked where peers will be used in this plan. They are not reflected in the budget. The speaker stated the general standards reflected in the proposal have the client and family-driven general standard combined. The speaker stated the need to contract with community-based organizations with understanding that these are two separate general standards and are empowered with understanding why these are separate.

Asha Albuquerque, Patients’ Rights Attorney, Law Foundation in Silicon Valley, stated they had several concerns about this project. It is important that findings that come from research and interviews from this project are specific and nuanced in light of the unique needs for each of the populations.

Asha Albuquerque stated the team should not convey both experiences of trauma and stigma as being the same experience for both the African American and Vietnamese groups. The speaker recommended caution and recognition of differences in both

cultures. This should underline any research done over the next few years. While it is undeniable that many Vietnamese and Black Americans face different day-to-day interactions and have different socioeconomic and cultural experiences, it is crucial to understand how the history of both groups state their position in society today in comparison to their white peers.

Asha Albuquerque suggested connecting with professors who have studied colorism and systematic oppression as the speaker is concerned about some of the framing of what systematic oppression is in the work shown so far. The speaker asked the county to consider why they are examining the African American and Vietnamese communities at once and grouped together. The speaker stated the need to ensure that the county looks at and understands what oppression and systematic oppression of the individual identified is in bi-racial and multi-racial individuals in collaboration with professors who have published in this area.

Laurel Benhamida mentioned a prior project that focused on African immigrant populations and asked if African immigrant populations are included in this project.

Tiffany Le, parent, spoke in support of the proposed project. It is important to educate parents and family members of individuals with lived experience.

Chair Ashbeck asked the county to respond to comments and concerns brought up during public comment.

Ms. Moral responded to Tiffany Carter's question about the use of peers. She stated peers are important to the county. This program includes a stipend component that each community-based organization can access.

Ms. Moral responded to Asha Albuquerque's comments around research and ensuring the context of culture. She stated this is why it is important for the county to select community-based organization providers for each community that have that lived experience and are a part of the community. These community-based organizations will provide services to the community and will be a part of the evaluation process. The proposed project will inform how to better engage communities in terms of planning for future programming.

Ms. Moral responded to Laurel Benhamida's question about linking this project to earlier work. She stated the earlier work is still going on. It is now called the Cultural Community Wellness Program, where mental health peer support workers, family members, and consumers go out into the community to conduct mental health first aid training.

Commissioner Discussion

Commissioner Mitchell asked the county to consider co-locating together. It builds strength for community-based organizations to collaborate and to support each other. It would help represent what society needs to do – to learn about each other and to work together.

Commissioner Alvarez stated the Commission has heard that many Innovation projects are innovative because of their culturally specific approach. She stated the hope that it

gets to a point where this is not an innovative addition but is a core function of how counties operate. The Commission should expect counties to integrate vital programming for their communities in all funding streams.

Chair Ashbeck asked for a motion to approve Santa Clara County's Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities Innovation Project.

Commissioner Alvarez moved to approve the project.

Vice Chair Madrigal-Weiss seconded.

Action: Commissioner Alvarez made a motion, seconded by Vice Chair Madrigal-Weiss, that:

The Commission approves Santa Clara County's Innovation Plan, as follows:

> *Name: Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities*
>
> *Amount: Up to $1,753,140 in MHSA Innovation funds*
>
> *Project Length: Three (3) Years*

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Brown, Danovitch, Mitchell, Tamplen, and Wooton, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

ADJOURN

Chair Ashbeck responded to comments heard in General Public Comment about extending the deadline beyond tomorrow to apply to serve on the CFLC or the CLCC. She stated the deadline will remain as is. She explained that moving the application deadline would necessitate moving subsequent Committee meeting dates. The Committee dates have been set for the remainder of the year and are posted on the website.

Chief Counsel Yeroshek responded to comments heard in General Public Comment about posting approved meeting minutes on the website. She stated approved meeting minutes have been posted separately on the website under the Events tab for the past year. Staff is working to better publicize this and to make the approved minutes more accessible.

Chair Ashbeck asked staff to show a screencap on how to access the minutes at the next meeting.

There being no further business, the meeting was adjourned at 12:49 p.m.

AGENDA ITEM 3

Action

March 25, 2021 Commission Meeting

San Francisco County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of San Francisco County's request to fund the following new Innovative project:

1. **Culturally Congruent and Innovative Practices for Black/African American Communities**

San Francisco County is requesting up to $5,400,000 of Innovation spending authority to implement changes to existing mental health practices that have not been demonstrated to be effective including but not limited to, adaptation for a population.

The County will identify, implement, and test non-traditional methods of treating/healing mental illness, reduce stigma, incorporate culturally adaptive interventions to service the Black/African American communities, and develop a Wellness Curriculum Training Manual emphasizing elements of the Sankofa framework (see p.14 in the Innovation Plan) to enable staff to provide successful practices to their clients. San Francisco County plans to test innovative and culturally congruent interventions that have not previously been offered to the Black/African American communities.

San Francisco County identified the following difficulties for treating the Black/African American population in their community:

1. Staffing Mental Health workforce including peers and behavioral health staff that do not reflect the diversity and inclusiveness of the Black/African American community in San Francisco.
2. Lack of delivery of culturally responsive and faith-based services.
3. Lack of awareness of how to access and types of services available; and
4. Need to hire and/or train the workforce in traditional and non-traditional healing practices.

San Francisco County states that one of the three specialty clinics serving Black/African Americans has not been successful in increasing penetration rates in over a decade, having served only 18 males with Severe Mental Illness (SMI), annually. The County's mental health providers do not reflect the diversity and inclusiveness of the Black/African American populations, nor provide culturally relevant and faith-based services, or address the barriers that inhibit access to care.

The County plans to hire peer specialists representative of the population to assist with program development, evaluation, planning and implementation. **(see p.14 in the Innovation Plan)** The peers are a vital component to the development, details, and implementation of the work plan. The County proposes to research and implement non-traditional practices to increase and improve culturally specific and relevant culturally traditional practices to decrease stigma and increase access, awareness, and retention of services for those underserved.

The proposed non-traditional practices may include:

1. Outreach in the streets, churches, barbershops, and other places where Black/African American communities congregate.

Proposed non-traditional treatment methods may include:

2. Expressive arts, storytelling, community rituals spiritual practices, and trauma-informed healing circles.

San Francisco County states that they will implement and adapt to all COVID guidelines and restrictions.

San Francisco County will focus on providing identified services through hiring peer experts to complete the research, develop the plan, make informed recommendations, and implementation of evidenced-based and non-traditional options for the Black/African American community. The services will be based out of three civil service clinics within San Francisco's Behavioral Health Services.

The project further proposes to fulfill the following goals:

1. Implement and evaluate new outreach and engagement practices for Black/African American clients including those who are currently underserved by the County mental health plan.

2. Implement and evaluate culturally adaptive interventions and practices that increase consumer satisfaction, efficacy, and retention.

3. Implement and evaluate the efficacy of using peers with lived experience who represent the Black/African American communities and have specialized expertise working with this population.

4. Develop a wellness-oriented manualized curriculum that emphasizes elements of the Sankofa framework.

As part of the County's local community planning process, this project was posted for the 30-day public comment period from February 6 through March 9, 2020, and all comments were incorporated into the plan (see pg. 8 in the Innovation Plan).

Commission staff originally shared this project with its six stakeholder contractors and the listserv on October 20, 2020. The final version of this project was again shared with stakeholders on February 10, 2021.

Comments received in response to Commission sharing the plan with stakeholder contractors and the listserv are listed below in its original format:

"It appears that the drafters have the best of intentions but lack knowledge of the subject. Sadly, a string of currently fashionable buzz-words and phrases does not produce a viable plan. San Francisco enjoys a wealth of talent and knowledge. The City needs to engage people with those qualities to rewrite its proposal and to staff the programs to be proposed."

"I just have a few questions. Maybe I missed those parts but will this be like a rapid response team for the African American community in SF? Or drop in center to better naviagte (sic) the mental health services offered around the city? Will they have clinical staff/peer support onsite? Will it serve all ages or just a specific age group? Like I said those questions might have been answered but I went directly to the objectives and budget and those questions came up. Overall from the first few pages I did read it looks like a program that should be there ongoing not just five years. Just my thoughts."

"For the past 16 years, TGIJP has been been (sic) centering Black trans lives with special emphasis on transgeneder (sic), gender variant, gnc, and intersex folx (sic) coming out of jails, prisons, and other locked facilities. There are three core pillars to our highly acclaimed re-entry program: 1) ***housing*** *(placement of our unhoused BIPOC trans / TGI clients into permanent sustainable housing) 2)* ***socio-economic support*** *- job training, leadership development, and job placement immediately upon release from the carceral system so that a person can get out of jail on a Friday and have job and paycheck to come to on a Monday, for instance. 3)* ***supportive services -*** *we have have (sic) a staff of case managers, navigators, and a soon-to-be-hired behavioral specialist / social worker. We noticed that our Black trans-led organization was not on the list of partners in the proposal but we would sure like to be as this is the work we've been doing for the past 15 years and the only Black trans-led organization with longevity."*

Enclosures (3): (1) Biography for San Francisco County's Innovation Presenter; (2) Staff Analysis: Culturally Congruent and Innovative Practices for Black/African American Communities ; (3) PowerPoint Presentation.

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

https://www.mhsoac.ca.gov/sites/default/files/SanFrancisco_INN_Proposal_CulturallyCongruentPractices_.pdf

Proposed Motion: The Commission approves San Francisco County's Innovation plan, as follows:

Name:	Culturally Congruent and Innovative Practices for Black/African American Communities
Amount:	Up to $5,400,000 in MHSA Innovation funds
Project Length:	Five (5) Years

Biography of Jessica Brown, MPH

Jessica Brown, MPH is a public health professional specializing in public and mental health program development and management. Her primary expertise is in program implementation and evaluation; strategic planning development; operationalizing racial equity and workforce initiatives; and community-based participatory research and administration. With over 10 years of public and behavioral health experience, Ms. Brown has worked in a variety of health services such as genetic newborn screening, HIV prevention and surveillance, and community behavioral health. Currently, she is serving as the Interim Director for the San Francisco Department of Public Health (SFDPH), Behavioral Health Services (BHS) Office of Equity and Workforce Development (OEWD), where her responsibility is to oversee strategic planning, organization, implementation, and evaluation of equity and workforce programs across the SFDPH and BHS.

As the Interim Director of OEWD, Ms. Brown is responsible for integrating a racial equity framework and policy throughout BHS while managing various programs and projects including staff supervision, cultural competency activities, ADA-related efforts, language services, client and community communication, consumer relations, staff and community-based training, workforce development, employee engagement, staff wellness, and human resources projects for BHS. She is also working with the San Francisco Human Rights Commission's (HRC) Office of Racial Equity on implementing the City's Racial Equity Ordinance and serving on the HRC task force to develop strategies on the reallocation of police funding into Black/African American communities throughout San Francisco.

In her permanent role, Ms. Brown serves as the SFDPH, BHS Mental Health Services Act (MHSA) Director where she is responsible for collaborating with community stakeholders to transform the public mental health sector with a racial equity framework. Throughout her career, Ms. Brown has been committed to developing strategies to address health inequities that drastically impact Black/African American and Latinx communities throughout Northern California. She is dedicated to comforting the impacts of racism and how it contributes to inadequate treatment, misdiagnosis, and the undervaluing of the trauma and pain of Black/African American communities. Ms. Brown received her master's degree in Public Health at San Jose State University and has committed her career to closing the gap on health and racial inequities.

STAFF ANALYSIS—San Francisco

Innovation (INN) Project Name:	**Culturally Congruent and Innovative Practices for Black/African American Communities**
Total INN Funding Requested:	**$5,400,000**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**March 25, 2021**

Review History:

Approved by the County Board of Supervisors:	September 22, 2020
Mental Health Board Hearing:	May 20, 2020
Public Comment Period:	February 6, 2020 – March 9, 2020
County submitted INN Project:	February 11, 2021
Date Project Shared with Stakeholders:	October 20, 2020

Project Introduction:

San Francisco County is requesting up to $5,400,000 of Innovation spending authority to implement changes to existing mental health practices that have not been demonstrated to be effective including but not limited to, adaptation for a population.

The County will identify, implement, and test non-traditional methods of treating/healing mental illness, reduce stigma, incorporate culturally adaptive interventions to service the Black/African American community, and develop a Wellness Curriculum Training Manual emphasizing elements of the Sankofa framework (p.14 of the innovation plan) to enable staff to provide successful practices to their clients. San Francisco County plans to test innovative and culturally congruent interventions that have ***not*** previously been offered to the Black/African American communities.

What is the Problem?

San Francisco County identified the following difficulties for treating the Black/African American population in their community:

1. Staffing Mental Health workforce including peers and behavioral health staff that do not reflect the diversity and inclusiveness of the Black/African American community in San Francisco;
2. Lack of delivery of culturally responsive and faith-based services;

3. Lack of awareness of how to access and types of services available; and
4. Need to hire and/or train the workforce in traditional and non-traditional healing practices.

San Francisco County states that one of the three specialty clinics serving Black/African Americans has not been successful in increasing penetration rates in over a decade, having served only 18 males with Severe Mental Illness (SMI), annually. The County's mental health providers do not to reflect the diversity and inclusiveness of the Black/African American populations, nor provide culturally relevant and faith-based services, or address the barriers that inhibit access to care.

San Francisco County reported that they are experiencing high penetration rates, limited or non-existent Culturally responsive and congruent services, lack of follow-up for crisis services, lack of Black/African American providers, and systemic racism.

County may wish to identify what is specifically not working in the community and what they are currently doing to address these problems.

How this Innovation project addresses this problem:

San Francisco intends to **"**hire staff who have the time and expertise to conduct research and create an innovative program that produces culturally appropriate, evidence-based practices that demonstrate better outcomes for San Francisco's Black/African American communities."

The County plans to hire peer specialists representative of the population to assist with program development, evaluation, planning, and implementation. (p. 14 of the innovation plan) The peers are a vital component to the development, details, and implementation of the work plan. The County proposes to research and implement non-traditional practices to increase and improve culturally specific and relevant culturally traditional practices to decrease stigma and increase access, awareness, and retention of services for those underserved.

The proposed non-traditional practices may include outreach in the streets, churches, barbershops, and other places where Black/African American communities congregate. Non-traditional treatment methods may include expressive arts, storytelling, community rituals spiritual practices, and trauma-informed healing circles. ***San Francisco County states that they will implement and adapt to all COVID guidelines and restrictions.***

San Francisco County will focus on providing identified services through hiring peer experts to complete the research, develop the plan, make informed recommendations, and implementation of evidenced-based and non-traditional options for the Black/African American community. The services will be based out of three civil service clinics within San Francisco's Behavioral Health Services.

The project further proposes to fulfill the following goals:

1. Implement and evaluate new outreach and engagement practices for Black/African American clients including those who are currently underserved by the County mental health plan.
2. Implement and evaluate culturally adaptive interventions and practices that increase consumer satisfaction, efficacy, and retention.
3. Implement and evaluate the efficacy of using peers with lived experience who represent the Black/African American communities and have specialized expertise working with this population.

4. Develop a wellness-oriented manualized curriculum that emphasizes elements of the Sankofa framework.

Community Planning Process (Pages 6-9)

Local Level

San Francisco County offered 19 community events in the Fall of 2019 in various parts of the county to hear public concerns regarding pressing mental and behavioral health related needs, resulting in 27 Innovation ideas. San Francisco combined the following four ideas, submitted by committee members: 1) Expansion of ICM services at Mission Mental Health Alternatives 2) Recruit African American Mental Health Staff at SOMA Mental Health ACT 3) Propose Non-Traditional Mental Health Services in churches 4) Address Mental Health Needs of African American Parents.

San Francisco County met with various community members, leaders, consumers, residents, mental health professionals and peer-specialists representing the Black/African American Community in the Spring of 2020 to incorporate their input into this proposal. The input of the community representatives supported the needs voiced of providing traditional and non-traditional services to the Black/African American population in San Francisco County.

As part of the County's local community planning process, this project was posted for the 30-day public comment period from February 6 through March 9, 2020, and all comments were incorporated into the plan (see pg. 8 in the Innovation Plan).

San Francisco County also consulted with Solano County to gather lessons learned from their Health Disparities project. (Pages 8-9).

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on October 20, 2020. The final version of this project was again shared with stakeholders on February 10, 2021.

Comments received in response to Commission sharing the plan with stakeholder contractors and the listserv are listed below in its original format:

"It appears that the drafters have the best of intentions but lack knowledge of the subject. Sadly, a string of currently fashionable buzz-words and phrases does not produce a viable plan. San Francisco enjoys a wealth of talent and knowledge. The City needs to engage people with those qualities to rewrite its proposal and to staff the programs to be proposed."

"I just have a few questions. Maybe I missed those parts but will this be like a rapid response team for the African American community in SF? Or drop in center to better naviagte (sic) the mental health services offered around the city? Will they have clinical staff/peer support onsite? Will it serve all ages or just a specific age group? Like I said those questions might have been answered but I went directly to the objectives and budget and those questions came up. Overall from the first few pages I did read it looks like a program that should be there ongoing not just five years. Just my thoughts."

"For the past 16 years, TGIJP has been been centering Black trans lives with special emphasis on transgeneder (sic), gender variant, gnc, and intersex folx (sic) coming out of jails, prisons, and other locked facilities. There are three core pillars to our highly acclaimed re-entry program: 1) ***housing*** *(placement of our unhoused BIPOC trans / TGI clients into permanent sustainable housing) 2)* ***socio-economic support*** *- job training, leadership development, and job placement immediately upon release from the carceral system so that a person can get out of jail on a Friday and have job and paycheck to come to on a Monday, for instance. 3)* ***supportive services -*** *we have have a staff of case managers, navigators, and a soon-to-be-hired behavioral specialist / social worker. We noticed that our Black trans-led organization was not on the list of partners in the proposal but we would sure like to be as this is the work we've been doing for the past 15 years and the only Black trans-led organization with longevity."*

Learning Objectives and Evaluation:

The County will work with the SF-DPH Quality Management Team and a diverse group of consumers and other community members to develop and implement the evaluation plan utilizing the learning questions and outcome measures outlined below (p. 18 of the innovation plan).

The County identified five primary learning questions:

1.) What components of the culturally relevant program improves overall wellness for Black/African American clients?
2.) What engagement strategies work best to engage Black/African American individuals into mental/behavioral health services?
3.) What peer interventions are most helpful for Black/African American clients?
4.) What culturally congruent practices are reported to results in improvement in the mental health and wellness of Black/African American consumers?
5.) What activities lead to a positive experience for Black/African American Clients through the continuum of care?

The County identified the following projected outcomes:

- Increased feelings of self-worth
- Increased quality
- Increased community engagement
- Increased social connectedness
- Increase personal wellness
- Increased knowledge of behavioral health services
- Satisfaction with intervention strategies
- Satisfaction outreach/engagement strategy
- Reduction in mental health stigma

County may wish to provide more specificity on the estimated number of clients this project intends to serve, the evaluation method, how intended outcomes will be measured and what indicators will be used.

The Budget

The County is requesting authorization to spend up to $5,400,000 in MHSA Innovation funding for this project over a period of five years. **County is utilizing funds subject to reversion.**

BUDGET	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Peer Specialists	$250,000	$532,500	$532,500	$532,500	$532,500	$2,380,000
Behavioral Health Staff	$150,000	$372,500	$372,500	$372,500	$372,500	$1,640,000
Evaluation Budget	$50,000	$90,000	$90,000	$90,000	$90,000	$410,000
Cultural Liaisons (Cultural Interventions)	$130,000	$170,000	$170,000	$170,000	$170,000	$810,000
Operating Budget	$20,000	$35,000	$35,000	$35,000	$35,000	$160,000
Total Innovation Budget	**$600,000**	**$1,200,000**	**$1,200,000**	**$1,200,000**	**$1,200,000**	**$5,400,000**
Leveraged Funding	$62,313	$62,313	$62,313	$62,313,	$62,313	$311,565
Total Operational Budget	$662,313	$1,262,313	$1,262,313	$1,262,313	$1,262,313	$5,711,565

- Personnel costs total $4,830,000 (89%) to cover salaries and benefits for staff.
    - Staff includes: Peer Specialist, Peer Supervisor, Peer Administrative Staff and Cultural Liaisons and Consultants (drumming, art, interventions), Behavioral Health Clinical Staff, and Practice Improvements and Analytics Coordinator.
- The Evaluation costs total $410,000 (7%) and will be completed by SF DPH personnel and/or county contracted professional consultants.
- Operating Budget total of $160,000 (4%)
- Leveraged funding totals $311,565.

The total project budget is $5,711,565.

County may wish to address if they considered WET funding for any of the training components.

Additional Comments:

Commission staff indicates throughout this analysis and below several areas of concern which were communicated on November 19, 2020, The Commission may wish to seek further clarification on these additional points:

1. **Did the County consider requesting planning dollars to determine the best interventions to then return for spending authority on implementation?**
2. **How does the County specifically plan to sustain this project if successful?**
3. **How does the proposed timeline specifically take into consideration implementation, evaluation, and communication of results?**
4. **Will the county utilize learnings from the CRDP projects to inform and or strengthen the services proposed in this INN plan? If so, how?**
5. **County may wish to share how they plan to address the comments received by the stakeholders in this analysis?**

San Francisco - Innovations Learning Project Proposal

March 25, 2021

Culturally Congruent and Innovative Practices for Black/African American Communities

Problem we are trying to solve for San Francisco

Black/African Americans have the highest rate of hospitalization for depression in San Francisco. Also, our County Behavioral Health Services system shows a high penetration rate of Black/African Americans in our Child, Youth and Families System of Care. Black/African Americans have the highest penetration of any group for 5 or more visits.

Overall, our mental/behavioral health system statistics continue to show that Black/African Americans in San Francisco are receiving services at a disproportionate rate compared to the Black/African American population in San Francisco. **As of November 2020, Black/African Americans account for about 20% of the population served across San Francisco's behavioral health system while Black/African Americans make up only 6% of the city's population.**

What is not working and how this INN project will address the problem

After years of trying to better engage with Black/African American San Francisco residents, we realized our engagement and intervention strategies were not working.

We identified the need to evaluate robust outreach efforts to determine how to best engage this community and the need to evaluate culturally-adaptive interventions. We identified the need to innovate.

<u>Innovative Component</u>

This project is unique to San Francisco since **we will test and utilize innovative and culturally congruent interventions that have not previously been offered to San Francisco's Black/African American communities.** This project will include four (4) primary learning goals.

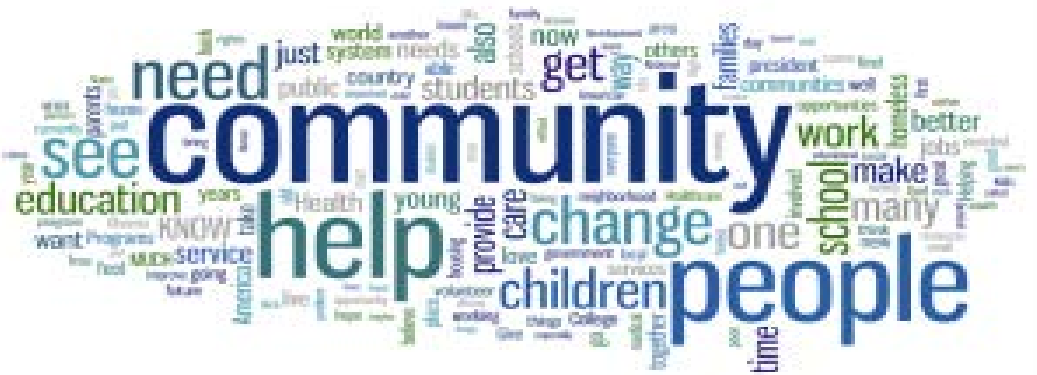
1. Implement and evaluate **new outreach and engagement practices for Black/African American clients** including those who are currently underserved by the County mental health plan.
2. Implement and evaluate **culturally adaptive interventions and practices** that increase consumer satisfaction, efficacy and retention.
3. Implement and evaluate the efficacy of using **peers with lived experience** who represent the Black/African American communities and have specialized expertise working with this population.
4. Develop a **wellness-oriented manualized curriculum that emphasizes elements of the Sankofa framework.**

How the San Francisco community contributed to the creation of this project

The San Francisco Mental Health Services Act (SF-MHSA) team hosted nineteen (19) community engagement meetings to better understand the needs of the community. Community stakeholders requested the following:

- Community healing practices and non-traditional methods of interventions and engagement should be offered to the Black/African American community.
- We need better ways to incorporate a person's cultural values into the services being provided.
- The County should integrate art, socialization, life-skills and family-based groups when working with this population.
- We need to explore alternate ways of engaging with Black/African American community members.
- Maybe engage this community by using Black/African American peers to go out to community spaces and local places including churches, barbershops and other places where this community may congregate.

The community is advocating for this project along with invested stakeholders working with the San Francisco Racial Equity Ordinance - No 188-19.



What we are hoping to learn and how we will measure it

Culturally Adaptative Interventions and Practices

This project will implement and evaluate the following culturally congruent interventions/practices:

- Better **link consumers with someone who is representative of intersecting identities** such as race, gender, sexual identity and age.
- Implement **African Centered story-telling, expressive arts, community rituals and/or spirituality practices** based on the interest of the participants.
- Hold **trauma-informed community healing circles** at community programs, churches, faith-based programs, barbershops or other community settings.

Key Learning Questions

1. What components of the culturally relevant program improves overall wellness for Black/African American clients?
2. What engagement strategies work best to engage Black/African American individuals into mental/behavioral health services?
3. What peer interventions are most helpful for Black/African American clients?
4. What culturally congruent practices are reported to result in improvement in the mental health and wellness of Black/African American consumers?
5. What activities lead to a positive experience for Black/African American clients throughout the continuum of care?

Data collection may include, but not limited to:

- Consumer application, acceptance and enrollment logs
- Attendance logs
- Self-confidence measures
- Measures of social and community connectedness
- Consumer feedback tools
- Consumer mental health recovery scale
- PDSA (Plan-Do-Study-Act)
- Client interviews and focus groups

Description of the Budget

San Francisco County is requesting $600,000 in Innovation funding for the first year, and $1,200,000 annually for the four subsequent years, for a total INN budget of $5,400,000 over five (5) years.

BUDGET	Year One	Year Two	Year Three	Year Four	Year Five	Total
Peer Specialist Budget	$ 250,000	$ 532,500	$ 532,500	$ 532,500	$ 532,500	$ 2,380,000
Behavioral Health Staff (to support peers)	$ 150,000	$ 372,500	$ 372,500	$ 372,500	$ 372,500	$ 1,640,000
Evaluation Budget	$ 50,000	$ 90,000	$ 90,000	$ 90,000	$ 90,000	$ 410,000
Cultural Liaisons (cultural interventions)	$ 130,000	$ 170,000	$ 170,000	$ 170,000	$ 170,000	$ 810,000
Operating Budget (Client engagement)	$ 20,000	$ 35,000	$ 35,000	$ 35,000	$ 35,000	$ 160,000
TOTAL INNOVATION BUDGET	**$ 600,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 5,400,000**
Leveraged Funding	$ 62,313	$ 62,313	$ 62,313	$ 62,313	$ 62,313	$ 311,565
TOTAL OPERATIONAL BUDGET	**$ 662,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 5,711,565**

Questions?

Jessica Brown, MPH

Director of MHSA

Behavioral Health Services

San Francisco Department of Public Health

(415) 255-3963

Jessica.N.Brown@sfdph.org

PROPOSED MOTION

The Commission approves San Francisco's Innovation Plan as follows:

Name:	Culturally Congruent and Innovative Practices for Black/African American Communities
Amount:	Up to $5,400,000 in MHSA INN funds
Project Length:	Five (5) Years

AGENDA ITEM 4

Action

March 25, 2021 Commission Meeting

Legislative Priorities

Summary: The Commission will consider legislative and budget priorities related to Commission initiatives, including Assembly Bill 638 (Quirk-Silva) and Senate Bill 749 (Glazer) for the current legislative session.

Background:

Assembly Bill 638 (Quirk-Silva)

Currently, the Mental Health Services Act (MHSA), requires counties to establish a program designed to prevent mental illnesses from becoming severe and disabling and authorizes counties to use funds designated for prevention and early intervention to broaden the provision of those community-based mental health services by adding prevention and early intervention services or activities. AB 648 would amend the MHSA to allow counties to include prevention, and early intervention strategies that address mental health needs, substance use or abuse needs, or needs relating to cooccurring mental health and substance use services.

Recent change in state law by Senate Bill 1004 (Chapter 843, Statutes of 2018) directs the Commission to establish priorities and a statewide strategy for prevention and early intervention services. The goal of this effort is to create a more focused approach to delivering effective prevention and early intervention services and increasing coordination and collaboration across communities and mental healthcare systems.

According to the Centers for Disease Control and Prevention, as of June 2020, 13% of Americans reported starting or increasing substance use as a way of coping with stress or emotions related to COVID-19. Overdoses have also spiked since the onset of the pandemic. The trend has continued throughout 2020, according to the American Medical Association, which reported in December that more than 40 U.S. states have seen increases in opioid-related mortality along with ongoing concerns for those with substance use disorders.

SB 638 will strengthen the work of the Commission's Prevention and Early Intervention Project and provide clarity in the law that will allow counties to allocate funds from the Prevention and Early Intervention component to address mental health, substance abuse or cooccurring needs. It is difficult to determine if someone in crisis has a mental health or substance abuse disorder, treatment should be focused on helping the individual's wellness and not determine what came first the mental health need or the substance abuse.

Enclosed for your review is information regarding Assemblymember Quirk-Silva's plan to improve access to care for individuals with mental health, substance abuse disorders or cooccurring disorders.

Senate Bill 749 (Glazer)

Currently, the MHSA requires counties to develop and approve locally MHSA Three-Year Program and Expenditure Plans (3YPs) and Annual Updates to those plans. These plans are intended to be integrated, comprehensive plans for identifying local behavioral health needs and priorities and for using MHSA funds to leverage other funding streams to best meet those needs and priorities.

To support the planning process, counties are further required to submit annually to DHCS and the Commission a report of actual expenditures on programs and activities authorized in the 3YPs and Annual Updates. These annual Revenue and Expenditure Reports (RERs) are intended to (1) identify annual MHSA distributions to counties; (2) quantify the amount of non-MHSA funding associated with MHSA funds; (3) identify unexpended MHSA funds held by counties; (4) determine amounts of MHSA funds to be reverted back to the State; and (5) support the evaluation of county programs and services funded or co-funded by MHSA revenue.

Under existing reporting requirements, counties report non-MHSA funds, such as Medi-Cal and Realignment funds, spent in co-funded MHSA programs and services. But no comprehensive reporting is available to track and analyze overall public-sector mental health or behavioral health spending in context with the MHSA.

Further, no statewide, comprehensive tracking program has been created to match actual program and service expenditures reported in the RERs back to their authorizing 3YPs or Annual Updates. Such a tracking system is necessary in order to evaluate patterns in MHSA program expenditures and outcomes, including analyzing the overall impact of the MHSA in meeting needs and priorities, including through leveraging non-MHSA funding sources.

SB 749, introduced by Senators Glazer and Eggman with co-authors Nielsen, Rubio, and Wiener, would direct the Commission to extend its existing fiscal oversight work to develop and implement the data infrastructure necessary to track and analyze spending patterns in MHSA program and services more fully.

Enclosed for your review is information regarding Senator Glazer's plan to develop and implement a comprehensive tracking program to support statewide learning about county spending on and outcomes from mental and behavioral health programs and services.

Presenter: Norma Pate, Deputy Director

Enclosures (2): (1) Assembly Bill 638 (Quirk-Silva) & Fact Sheet; and (2) Senate Bill 749 (Glazer) & Fact Sheet.

Handout (1): MHSOAC Legislative Tracking Chart

AMENDED IN ASSEMBLY MARCH 11, 2021

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 638

Introduced by Assembly Member Quirk-Silva

February 12, 2021

An act to amend Section ~~5343~~ *5840* of the Welfare and Institutions Code, relating to mental ~~health.~~ *health, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 638, as amended, Quirk-Silva. ~~Mental health and substance use disorders.~~ *Mental Health Services Act: early intervention and prevention programs.*

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs and requires counties to spend those funds on mental health services, as specified. The MHSA requires counties to establish a program designed to prevent mental illnesses from becoming severe and disabling and authorizes counties to use funds designated for prevention and early intervention to broaden the provision of those community-based mental health services by adding prevention and early intervention services or activities.

Existing law authorizes the MHSA to be amended by a ⅔ vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA.

This bill would amend the MHSA by including in the prevention and early intervention services authorized to be provided, prevention and

early intervention strategies that address mental health needs, substance use or abuse needs, or needs relating to cooccurring mental health and substance use services. By authorizing a new use for continuously appropriated funds, this bill would make an appropriation. The bill would state the finding and declaration of the Legislature that this change is consistent with, and furthers the intent of, the MHSA.

~~Existing law provides for the temporary involuntary commitment for evaluation and treatment of a person who is gravely disabled, as defined, as a danger to themselves or others, either as a result of a mental health disorder, or as a result of the use of controlled substances.~~

~~This bill would make technical, nonsubstantive changes to those provisions.~~

Vote: ~~majority~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 5840 of the Welfare and Institutions Code is amended to read:

5840. (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components

similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these ~~services.~~ *services, including prevention and early intervention strategies that address mental health needs, substance use or abuse needs, or needs relating to cooccurring mental health and substance use services.*

(f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

SEC. 2. The Legislature finds and declares that this act is consistent with, and furthers the intent of, the Mental Health Services Act within the meaning of Section 18 of that act.

~~SECTION 1. Section 5343 of the Welfare and Institutions Code is amended to read:~~

~~5343. Notwithstanding any other law, if a person is a danger to others or to themselves, or gravely disabled, as a result of the use of controlled substances, the person shall be subject, insofar as possible, to the provisions of Articles 1 (commencing with Section 5150), 2 (commencing with Section 5200), 4 (commencing with Section 5250), 5 (commencing with Section 5275), and 7 (commencing with Section 5325) of this chapter, except that custody, evaluation and treatment, or any procedure pursuant to~~

~~those provisions shall only be related to, and concerned with, the problem of the person's use of controlled substances.~~

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ASSEMBLYWOMAN QUIRK-SILVA, 65TH DISTRICT

AB 638 (QUIRK-SILVA): MENTAL HEALTH SERVICES ACT: EARLY INTERVENTION AND PREVENTION PROGRAMS MISUSE DISORDERS

SUMMARY

AB 638 authorizes prevention and early intervention strategies that address mental health needs, substance misuse or substance use disorders, or needs relating to co-occurring mental health and substance use services under the Mental Health Services Act.

BACKGROUND

Thirty years ago, the State of California in an effort to move away from institutionalization began closing state hospitals for people with severe mental illness. It did so without providing adequate funding for mental health services in the community and many people were caught in the revolving door of homelessness, jails, and using hospital Emergency Rooms.

To address this issue, Proposition 63, known as the Mental Health Services Act (MHSA), was approved by voters in 2003. It places a 1% tax on personal income above $1 million. Proposition 63 emphasizes transformation of the mental health system while improving the quality of life for Californians living with mental illness.

Mental health disorders are among the most common health conditions faced by Californians. Nearly 1 in 6 California adults experience a mental illness of some kind, and 1 in 24 have a serious mental illness that makes it difficult to carry out major life activities. Additionally, 1 in 13 children have an emotional disturbance that limits participation in daily activities. Left untreated, these illnesses impact quality of life and survival.

Unfortunately, the COVID-19 pandemic has affected children and adults in unprecedented ways. Anxiety, depression, isolation, and feelings of despair as well as suicide attempts have increased dramatically among adults, school-aged children and young adults. Many who had underlining or diagnosed mental health and substance use disorders are now dealing with an increased need for services and treatment.

Drug-related overdose fatalities have risen 50% since 2017 and is one of the top-ten leading causes of death in our State. Overdose related deaths are rising higher in California than in the United States and vary significantly across counties and demographic groups.

In the 12-months between June 2019 and June 2020 there were at least 7,254 overdose deaths which equals approximately 17 overdose fatalities per 100,000 state residents. Accidental drug overdoses kill twice as many people as car accidents.

Last year, Assembly Bill 2265 which clarified counties can treat patients with mental health and co-occurring substance use disorders under MHSA was signed into law. This was an important first step to remove programmatic barriers in serving these individuals with mental health and co-occurring substance use disorders, but the reality of the COVID-19 pandemic has amplified the need to do more.

SOLUTION

AB 638 builds upon last year's strides in addressing the complex needs and services of those with co-occurring issues by expanding the Mental Health Services Act to include prevention and early intervention services to be provided under the Act.

CONTACT

Michelle Teran
Office of Assemblywoman Quirk-Silva
(916) 319-2065
michelle.teran@asm.ca.gov

SENATE BILL No. 749

Introduced by Senators Glazer and Eggman
(Coauthors: Senators Nielsen, Rubio, and Wiener)

February 19, 2021

An act to add Section 5845.7 to the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 749, as introduced, Glazer. Mental health program oversight: county reporting.

Existing law provides for various mental and behavioral health programs that are administered by the counties. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission to oversee the provisions of the MHSA and review the county plans for MHSA spending. Existing law requires the State Department of Health Care Services, in consultation with the commission and other entities, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, which identifies and evaluates county mental health programs funded by the MHSA.

This bill would require the commission, in consultation with state and local mental health authorities, to create a comprehensive tracking program for county spending on mental and behavioral health programs and services, as specified, including funding sources, funding utilization, and outcome data at the program, service, and statewide levels. The bill would require the counties to report specified data for the preceding fiscal year to the commission on or before July 31 of each year. The bill would also require the commission to report the results of the county

reporting to the Governor's office and the Legislature on or before September 1 of each year, and to publish that information on its internet website in a location accessible to the public. By requiring additional reporting from the counties, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5845.7 is added to the Welfare and Institutions Code, to read:

5845.7. (a) The commission, in consultation with state and local mental health authorities, shall create a comprehensive tracking program for county spending on mental and behavioral health programs and services, including funding sources, funding utilization, and outcome data at the program, service, and statewide levels.

(b) As part of the program required in subdivision (a), the commission shall do all of the following:

(1) Explore available data and information when developing the reporting framework, and obtain relevant data and information from other state entities.

(2) Develop categories of mental health programs and services tailored to inform assessments of spending patterns. These programs and services may include, but are not limited to, the following:

(A) Emergency services.

(B) Inpatient care.

(C) Intensive outpatient services.

(D) Basic social supports.

(E) General outpatient services.

(F) Community wellness supports.

(G) Outreach and education.

(3) Develop statewide measurements of mental health and report publicly about those measurements annually so that stakeholders and policymakers can assess the progress the state is making in addressing mental health needs.

(c) On or before July 31 of each year, each county shall report to the commission, in a manner to be determined by the commission, all of the following for the preceding fiscal year:

(1) The expenditures in each of the major categories established in paragraph (2) of subdivision (b).

(2) Unspent funding that was dedicated to mental and behavioral health programs and services, from all major sources.

(3) Program- and service-level outcomes that enable stakeholders to determine whether the county's use of funds benefits individuals living with mental illnesses. These outcomes may include, but not be limited to, all of the following:

(A) For emergency services: the response time of first responders, emergency room wait time and length of stay, and the frequency and timeliness of linkage to subsequent services.

(B) For inpatient care; the availability of beds and the timeliness of placement by facility type, medication compliance, and the frequency and timeliness of linkage to subsequent services.

(C) For intensive outpatient services: the population served and the population with unmet needs, medication compliance, and the incidences of hospitalization, incarceration, and other negative outcomes.

(D) For basic support services: the population served and the population with unmet needs, the average length of stay for housing and shelter, and the frequency and timeliness of linkage to concurrent or subsequent services.

(E) For general outpatient services: the population served and the population with unmet needs, the frequency and timeliness of linkage to concurrent or subsequent services, medication compliance when applicable, and incidences of hospitalization, incarceration, and other negative outcomes.

(F) For community wellness supports: the population served and the population with unmet needs, the frequency and timeliness of linkage to concurrent or subsequent services, and client-reported wellness and satisfaction with programs and supports.

(G) For outreach and education: the population served or affected by outreach and education efforts, the impact of those efforts on individuals' engagement with treatment, and community awareness of, and attitude toward, available services.

(d) (1) On or before September 1 of each year, the commission shall report to the Governor's office and the Legislature the results of the county reporting required by this section. The report shall also be posted on the commission's internet website in an area accessible to the public.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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Senator Steven M. Glazer, 7th Senate District

SB 749 – Mental Health Program Oversight

Summary

This bill would provide greater oversight of mental health services spending by requiring the Mental Health Services Oversight and Accountability Commission (MHSOAC) to track the spending of mental health services funds and the outcomes for people dealing with mental illness achieved by that spending

Issue

According to a state audit released last summer, Californians have little ability to discern how well the billions of dollars we invest in mental health services are working for those in need. Despite the wide variety of services counties can provide, the State's current public reporting for mental health funds relies on disjointed and incomplete tools—a result of multiple funding sources with different requirements and levels of transparency.

Existing Law

Current law requires the Mental Health Services Oversight and Accountability Commission to oversee the Mental Health Services Act (MHSA) reporting. Other funds counties use for mental health services including Medi-Cal and realignment, have their own reporting requirements to different agencies. For example, funding through Medi-Cal is reported through the Department of Health Care Services with information regarding types of services and some outcomes but this does not provide a broader understanding of county mental health systems.

The state auditor identified the MHSA reporting framework as being the most comprehensive public reporting requirements of the different mental health funding sources. Yet despite the comprehensive reporting MHSA reporting also includes broad categories that do not convey specific information about how counties spend their funds.

Proposal

This bill creates a state framework for collecting information regarding mental health funding through the Mental Health Services Oversight and Accountability Commission. MHSOAC would be required to collaborate with state and local mental health authorities to create a comprehensive tracking program for county spending on mental health programs and the outcomes from that spending.

This bill would require counties to report specified data to the previous fiscal year to the commission by July 31 of each year.

MHSOAC would then be responsible for tracking county funding sources, funding utilization and outcome data at the program, service and statewide levels. MHSOAC would develop categories of mental health programs and services including emergency services, inpatient services, etc., to inform assessments of spending and outcome patterns.

Contact

Policy: Caila Pedroncelli, Legislative Aide
(916) 651-4007 or caila.pedroncelli@sen.ca.gov

Press: Steve Harmon, Communications Director
Steven.Harmon@sen.ca.gov

MISCELLANEOUS ENCLOSURES

March 25, 2021 Commission Meeting

Enclosures (6):

(1) Capitol Collaborative on Race & Equity (CCORE) Information Sheet
(2) Motion Summaries from the February 17 and February 25, 2021 Commission Meeting Teleconference
(3) Evaluation Dashboard;
(4) Innovation Dashboard;
(5) Calendar of Tentative Agenda Items;
(6) Department of Health Care Services Revenue and Expenditure Reports Status Update

Capitol Collaborative on Race & Equity (CCORE)



PUBLIC HEALTH INSTITUTE
CALIFORNIA STRATEGIC GROWTH COUNCIL
CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE

Information Sheet

What is the Capitol Collaborative on Race & Equity (CCORE)?

CCORE (formerly the GARE Capitol Cohort) is a community of California State government entities working together since 2018, to learn about, plan for, and implement activities that embed racial equity approaches into institutional culture, policies, and practices. CCORE implements a commitment by the Health in All Policies Task Force to increase the capacity of State government to advance health and racial equity. The California Strategic Growth Council (SGC) and the California Department of Public Health (CDPH) convene the HiAP Task Force. In addition to the community of practice, CCORE offers two capacity building components: 1) a training program for State government entities, and 2) a staff team that provides technical assistance and support to the CCORE community.

Who convenes CCORE?

The Public Health Institute (PHI) works in collaboration with a number of State, philanthropic, and training partners to offer CCORE. PHI is a non-profit, non-governmental organization, with significant capacity and expertise convening and training governmental partners to advance equity and facilitates cross-sectoral initiatives. PHI is grateful to the many supporting organizations including: Race Forward, SGC, The California Endowment, The California Wellness Foundation, and CDPH, which provides leadership and staffing support throughout the initiative.

What are CCORE's anticipated outcomes?

1. State government entities establish Racial Equity Action Plans and organizational leadership structures to implement their plans.
2. State government increases transparency around racial equity commitments and progress.
3. State government pursues proposals for resources to advance racial equity.
4. State employees and leaders grow in their personal and interpersonal learnings about racial equity, strengthening their capacity and the implementation efficacy of institutional-level change strategies.
5. Executives across the State enterprise are informed about progress and cultivate a policy environment receptive to action for racial equity.

To learn more about CCORE, email CCORE@phi.org

Capitol Collaborative on Race & Equity (CCORE)

What are CCORE's key features?

KEY FEATURE #1: Training cohorts provide CCORE participants with foundational and technical lessons and experiential learning.

The curriculum is grounded in a goal-oriented change management framework that guides individual and organizational change. This developmental approach builds on previous learnings and revisits foundational content to support retention.

- CCORE Learning Cohort (August 2020 through October 2021) is designed for State entities that have not previously participated in CCORE, and do not yet have Racial Equity Action Plans. Training includes racial equity concepts, history, language, practices, policies, and tools, including the use of Racial Equity Tools and development of customized Racial Equity Action Plans.
- CCORE Advanced Implementation Cohort (2020 through 2021) is designed for State entities that participated in the 2018 and 2019 pilot initiative. Training modules include an expanded framework for addressing institutional & structural racism, and understanding individual power and privilege to catalyze organizational change. Participants will build technical skills for leveraging State processes to advance Racial Equity Action Plan implementation.

KEY FEATURE #2: CCORE entities receive support to make lasting systems change, tailored to their unique needs and opportunities.

Participating organizations receive:

- Coaching and technical assistance, using Health in All Policies methods, to implement racial equity policy and programmatic commitments.
- Peer mentorship from government innovators and movement builders across the nation.
- Transformational and adaptive leadership skills support a policy environment receptive to innovative racial equity policy and practice.

KEY FEATURE #3: Cross-agency networking and enterprise-wide executive engagement amplify racial equity progress to the highest levels of State government.

Participating organizations benefit from:

- Amplification of messages and strategies through executive briefings (i.e., Cabinet members) and reports, convenings, and other mechanisms.
- A State government network that collectively elevates racial equity values, collaborates on strategy, models leadership for racial equity, and supports transformational governance.



PUBLIC HEALTH INSTITUTE
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CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 17, 2021

Motion #: 1

Date: February 17, 2021

Time: 11:06 AM

Motion:

The MHSOAC supports and/or cosponsors Senate Bill 14, Senate Bill 224, and Assembly Bill 573 depending on the authors' needs and staff capacity.

Commissioner making motion:

Commissioner seconding motion:

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Berrick	☒	☐	☐
3. Commissioner Boyd	☐	☐	☐
4. Commissioner Brown	☒	☐	☐
5. Commissioner Bunch	☒	☐	☐
6. Commissioner Carrillo	☐	☐	☐
7. Commissioner Danovitch	☒	☐	☐
8. Commissioner Gordon	☒	☐	☐
9. Commissioner Mitchell	☒	☐	☐
10. Commissioner Tamplen	☒	☐	☐
11. Commissioner Wooton	☒	☐	☐
12. Vice Chair Madrigal-Weiss	☐	☐	☐
13. Chair Ashbeck	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 17, 2021

Motion #: 2

Date: February 17, 2021

Time: 12:21 PM

Motion:

The Commission approves the proposed amendments to the Rules of Procedure except the increase in the delegated authority for contracts in Rule 2.4 and the changes to the committee membership composition in Rule 6.1.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Danovitch

Motion carried 90 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Berrick	☒	☐	☐
3. Commissioner Boyd	☐	☐	☐
4. Commissioner Brown	☒	☐	☐
5. Commissioner Bunch	☒	☐	☐
6. Commissioner Carrillo	☐	☐	☐
7. Commissioner Danovitch	☒	☐	☐
8. Commissioner Gordon	☒	☐	☐
9. Commissioner Mitchell	☒	☐	☐
10. Commissioner Tamplen	☒	☐	☐
11. Commissioner Wooton	☐	☐	☒
12. Vice Chair Madrigal-Weiss	☐	☐	☐
13. Chair Ashbeck	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 25, 2021

Motion #: 1

Date: February 25, 2021

Time: 9:29 AM

Motion:

The Commission approves the January 28, 2020 meeting minutes.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Danovitch

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Berrick	☒	☐	☐
3. Commissioner Boyd	☒	☐	☐
4. Commissioner Brown	☒	☐	☐
5. Commissioner Bunch	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐
7. Commissioner Danovitch	☒	☐	☐
8. Commissioner Gordon	☒	☐	☐
9. Commissioner Mitchell	☐	☐	☐
10. Commissioner Tamplen	☒	☐	☐
11. Commissioner Wooton	☒	☐	☐
12. Vice Chair Madrigal-Weiss	☒	☐	☐
13. Chair Ashbeck	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 25, 2021

Motion #: 2

Date: February 25, 2021

Time: 12:47 PM

Motion:

The Commission approves Santa Clara County's Innovation plan, as follows:

Name: Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities

Amount: Up to $1,753,140 in MHSA Innovation funds

Project Length: Three (3) Years

Commissioner making motion: Commissioner Alvarez

Commissioner seconding motion: Vice Chair Madrigal-Weiss

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Berrick	☒	☐	☐
3. Commissioner Boyd	☐	☐	☐
4. Commissioner Brown	☒	☐	☐
5. Commissioner Bunch	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐
7. Commissioner Danovitch	☒	☐	☐
8. Commissioner Gordon	☐	☐	☐
9. Commissioner Mitchell	☒	☐	☐
10. Commissioner Tamplen	☒	☐	☐
11. Commissioner Wooton	☒	☐	☐
12. Vice Chair Madrigal-Weiss	☒	☐	☐
13. Chair Ashbeck	☒	☐	☐

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the February Commission Meeting

Contract Number	Amount
17MHSOAC073	$33,254.54
17MHSOAC074	$33,254.54
18MHSOAC040	$0
Total	**$66,509.08**

Contracts with Deliverable Changes

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai Le Masson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,558,604.54**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No **No**
Data Collection and Management Report	Complete	6/15/20	No

MHSOAC Evaluation Dashboard March 2021
(Updated March 12th, 2021)

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21-3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21-6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	Not Started	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Not Started	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

MHSOAC
Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai Le Masson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: **$1,558,604.54**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No **No**
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21-6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	Not Started	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Not Started	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (18MHSOAC040)

MHSOAC Staff: Dawnte Early

Active Dates: 07/01/19 - 06/30/21

Total Contract Amount: **$1,257,008**

Total Spent: $880,756

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Report	Complete	09/30/19	No
Quarterly Progress Report	Complete	12/31/19	No
Quarterly Progress Report	Complete	03/31/2020	No
Quarterly Progress Report	Complete	06/30/2020	No
Quarterly Progress Report	Complete	09/30/2020	No
Quarterly Progress Report	Complete	12/31/2020	No
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
MARCH 2021

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	7	11	**18**
Participating Counties (unduplicated)	3	7	**10**
Dollars Requested	$9,056,107	$$35,127,922	**$44,184,029**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2015-2016	N/A	23	$52,534,133	15 (25%)
FY 2016-2017	33	30	$68,634,435	18 (31%)
FY 2017-2018	34	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2020-2021	6	5	$6,319,364	3

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	San Francisco	Wellness in The Streets Extension	$262,500	5 Years	1/8/2021	Pending
Under Review	Fresno	Suicide Prevention Follow-Up Program	$1,300,000	3 Years	3/1/2021	Pending
Under Review	Fresno	CRDP Evolutions Project	$1,800,000	3 Years	3/5/2021	Pending
Under Review	Humboldt	Resident Engagement & Support Team (REST)	$1,612,342	5 Years	12/17/2020	Pending
Under Review	Madera	Project DAD (Dads, Anxiety & Depression)	$930,401.56	5 Years	3/3/2020	Pending
Under Review	San Luis Obispo	BH Education & Engagement Team (BHEET)	$610,253	4 Years	6/4/2020	Pending
Under Review	San Luis Obispo	SoulWomb Project	$576,180	4 Years	6/4/2020	Pending
Under Review	Santa Clara	Independent Living Empowerment Project	$990,000	3 Years	6/29/2020	Pending
Under Review	Santa Clara	Community Mobile Response Program (Phase I-Planning Funding)	$24,816,245	5 Years	11/20/2020	Pending
Under Review	Shasta	Hope Park	$1,750,000	5 Years	2/17/2021	Pending
Under Review	TBD	Multi-County Psychiatric Advance Directive Project	TBD	4 Years	3/9/2021	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	San Francisco	Culturally Congruent Practices for Black African Americans	$5,400,000	5 Years	11/20/2020	2/11/2021

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	San Francisco	Technology Assisted Mental Health Solutions (Help@Hand)	$340,950	5 Years	1/5/2021	1/5/2021
Under Final Review	Colusa	Social Determinants of Rural Mental Health	$495,568	3 Years	12/10/2020	12/10/2020
Under Final Review	Sonoma	New Parent TLC	$394,586	3 Years	10/6/2020	2/3/2021
Under Final Review	Sonoma	Instructions Not Needed	$689,861	3 Years	10/6/2020	2/3/2021
Under Final Review	Sonoma	Nuestra Cultura Cura Social INN Lab (aka On the Move)	$736,584	3 Years	10/6/2020	2/3/2021
Under Final Review	Sonoma	Collaborative Care Enhanced Recovery Project (CCERP)	$998,558	3 Years	7/2/2020	2/3/2021

APPROVED PROJECTS (FY 20-21)			
County	Project Name	Funding Amount	Approval Date
San Mateo	Cultural Arts and Wellness Social Enterprise Café for Filipino/a/x Youth	$2,625,000	8/27/2020
Modoc	INN and Improvement through Data (IITD)-Extension	$91,224	10/12/2020
San Mateo	Co-location of Prevention Early Intervention Services in Low Income Housing	$925,000	11/16/2020
San Mateo	PIONEERS (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve)	$925,000	12/9/2020
Santa Clara	Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities	$1,753,140	2/25/2021

Calendar of Tentative Commission Meeting Agenda Items

Proposed 3/15/2021

Agenda items and meeting locations are subject to change

April 22, 2021: Sacramento, CA (Teleconference)

Award Early Psychosis Intervention Plus (EPI Plus) Phase 2 Grants
The Commission will consider awarding EPI Plus grants to the highest scoring applications received in response to the Request for Applications for the Early Psychosis Intervention Plus Phase 2 grants.

Innovation Plan Approvals
The Commission will consider approval of $1,300,000 in Innovation funding for Fresno County's Suicide Prevention Follow-Up Program innovation project and $1,800,000 for their CA Reducing Disparities Project Evolutions innovation project.

Public Hearing on Prevention and Early Intervention
The Commission will hold a hearing to explore key concepts and opportunities for prevention and early intervention across the lifespan and place-based approaches to prevention and early intervention to meet people where they learn, work, connect with social networks and cultural practices, and receive care and support.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

May 27, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Public Hearing and Update on the Mental Health in the Workplace Project
The Commission will hear an update on the Commission's Mental Health in the Workplace project and a panel presentation on the challenges and opportunities related to workplace mental health.

Governor's May 2021 Budget Revise Briefing and the Commission's 2021-22 Budget
The Commission will be presented with an overview of the Governor's May Budget Revise for Fiscal Year 2021-22. The Commission will consider approval of its final Fiscal Year 2020-21 Operations Budget and its proposed Fiscal Year 2021-22 Operations Budget.

Outline for Triage Request for Applications
The Commission will be presented with an outline for the next round of Triage grants.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

June 24, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval-
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Allcove-Youth Drop In Center Update

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

July 22, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

OAC Budget Overview
The Commission will consider approval of its Fiscal Year 2020-21 Operations Budget and will hear an update on expenditures.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

August 26, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Mental Health Student Service Act Update
The Commission will be presented with an update on the implementation of the Mental Health Student Service Act.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

September 23, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Prevention and Early Intervention Report Presentation
The Commission will consider the final report of the PEI project subcommittee for adoption.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

October 28, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Workplace Mental Health Report Presentation
The Commission will consider the final report of the WPMH project subcommittee for adoption.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

November 18, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

INN Subcommittee Year End Report Out
The Commission will be presented with an update on the activities of the Innovation Subcommittee.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

DHCS Status Chart of County RERs Received
March 25, 2021 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated March 9, 2021. This Status Report covers the FY 2016-17 through FY 2019-20 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review. FY 2017-18 RER data has not yet been incorporated into the Fiscal Reporting Tool due to format changes.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at https://mhsoac.ca.gov/resources/documents-and-reports/documents?field_county_value=All&field_component_target_id=46&year=all

On October 1, 2019, DHCS published a report detailing MHSA funds subject to reversion as of July 1, 2018, covering allocation year FY 2015-16 for large counties and 2008-09 for WET and CFTN funds, updating a July 1, 2018 report detailing funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). Both reports can be accessed at the following webpage:

https://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx

DCHS MHSA Annual Revenue and Expenditure Report Status Update

FY 2005-06 through FY 2018-19, all Counties are current

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Alameda	1/29/2021	2/1/2021	2/8/2021
Alpine			
Amador	1/15/2021	1/15/2021	2/2/2021
Berkeley City	1/13/2021	1/13/2021	1/13/2021
Butte			
Calaveras	1/31/2021	2/1/2021	2/9/2021
Colusa			
Contra Costa	1/30/2021	2/1/2021	2/22/2021
Del Norte	2/1/2021	2/2/2021	2/17/2021
El Dorado	1/29/2021	1/29/2021	2/4/2021
Fresno	12/29/2020	12/29/2021	1/26/2021
Glenn	2/19/2021	2/24/2021	
Humboldt			
Imperial	2/1/2021	2/1/2021	2/12/2021
Inyo			
Kern	2/2/2021	2/2/2021	2/8/2021
Kings	1/4/2021	1/4/2021	
Lake	2/9/2021	2/9/2021	2/17/2021
Lassen	1/25/2021	1/25/2021	1/28/2021
Los Angeles			
Madera			
Marin	2/2/2021	2/2/2021	2/17/2021

DHCS Status Chart of County RERs Received
March 25, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Mariposa	1/29/2021	1/29/2021	
Mendocino	12/30/2020	1/4/2021	1/20/2021
Merced	1/11/2021	1/12/2021	1/15/2021
Modoc			
Mono	1/29/2021	1/29/2021	2/16/2021
Monterey	2/24/2021	3/1/2021	
Napa	12/23/2020	12/24/2020	12/28/2020
Nevada	1/29/2021	2/16/2021	2/18/2021
Orange	12/31/2020	1/20/2021	2/9/2021
Placer	2/3/2021	2/22/2021	2/23/2021
Plumas	2/25/2021	2/25/2021	
Riverside	2/1/2021	2/2/2021	
Sacramento	1/29/2021	2/1/2021	2/16/2021
San Benito			
San Bernardino	3/3/2021	3/4/2021	
San Diego	1/30/2021	2/1/2021	2/4/2021
San Francisco	1/29/2021	2/2/2021	
San Joaquin	2/1/2021	2/2/2021	2/11/2021
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021
San Mateo	1/29/2021	2/1/2021	2/16/2021
Santa Barbara	12/29/2020	12/30/2020	1/5/2021
Santa Clara	1/28/2021	2/11/2021	3/3/2021
Santa Cruz			
Shasta	1/14/2021	1/15/2021	1/19/2021
Sierra	12/31/2020	2/22/2021	
Siskiyou	2/16/2021	2/17/2021	

DHCS Status Chart of County RERs Received
March 25, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Solano	2/1/2021	2/1/2021	2/25/2021
Sonoma	1/29/2021	2/2/2021	
Stanislaus	12/31/2020	1/5/2021	1/5/2021
Sutter-Yuba	1/30/2021	2/1/2021	
Tehama			
Tri-City	1/27/2021	1/28/2021	
Trinity	2/1/2021	2/2/2021	2/17/2021
Tulare	1/26/2021	1/27/2021	2/10/2021
Tuolumne			
Ventura	1/29/2021	2/2/2021	2/16/2021
Yolo	1/28/2021	2/2/2021	2/2/2021
Total	47	47	34