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Mental Health Services
Oversight & Accountability Commission

# Meeting Materials Packet

## Commission Teleconference Meeting
## February 23, 2023
## 9:00 AM – 1:00 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

# COMMISSION MEETING NOTICE & AGENDA

FEBRUARY 23, 2023

**NOTICE IS HEREBY GIVEN** that the Commission will conduct a Regular Meeting on **February 23, 2023, at 9:00 a.m.** This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123 and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

**Date:** February 23, 2023

**Time:** 9:00 AM – 1:00 PM

**Location:** MHSOAC
1812 9th Street
Sacramento, California 95811

**COMMISSION MEMBERS:**
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
John Boyd, Psy.D.
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Steve Carnevale
Wendy Carrillo, *Assemblymember*
Rayshell Chambers
Shuo Chen
Dave Cortese, *Senator*
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
Alfred Rowlett
Khatera Tamplen

**EXECUTIVE DIRECTOR:**
Toby Ewing

**ZOOM ACCESS:**

**FOR COMPUTER/APP USE**
Link: https://mhsoac-ca-gov.zoom.us/j/87110700555
Meeting ID: 871 1070 0555

**FOR PHONE DIAL IN**
Dial-in Number: 1-408-638-0968
Meeting ID: 871 1070 0555

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the information contained after the Commission Meeting Agenda for a detailed explanation of how to participate in public comment and for additional meeting locations.

## Our Commitment to Excellence

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

- Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing.
- Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes.
- Catalyze improvement in state policy and community practice for continuous improvement and transformational change.

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## Commission Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. In addition, the Commission reserves the right to take action on any agenda item as it deems necessary based on discussion at the meeting. Items may be considered in any order at the discretion of the Chair. Unlisted items may not be considered.

**9:00 AM**

**1. Call to Order & Roll Call**

Chair Mara Madrigal-Weiss will convene the Commission meeting and a roll call of Commissioners will be taken.

**9:05 AM**

**2. Announcements & Updates** *Information*

Chair Mara Madrigal-Weiss, Commissioners and Staff will make announcements and the Commission will receive committee updates.

**9:35 AM**

**3. General Public Comment** *Information*

General Public Comment is reserved for items not listed on the. agenda. No discussion or action by the Commission will take place.

**10:05 AM**

**4. January 25 & 26, 2023 Meeting Minutes** *Action*

The Commission will consider approval of the minutes from the January 25 & 26, 2023 Commission Meeting.

- Public Comment
- Vote

**10:10 AM**

**5. Consent Calendar** *Action*

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

This Consent Calendar contains four Innovation Projects from San Mateo County, as identified in the chart below:

| Project Name | INN Funding Requested | Project Duration (years) |
|---|---|---|
| Adult Residential In-home Support Element (ARISE) | $1,235,000 | 4 |
| Mobile Behavioral Health for Farmworkers | $1,815,000 | 4 |
| Music Therapy for Asians and Asian Americans | $940,000 | 4 |
| Recovery Connection Drop-In Center | $2,840,000 | 5 |
| Total: | $6,830,000 | |

- Public Comment
- Vote

**10:20 AM**

**6. Mental Health in the Workplace** *Action*

The Commission will hear a presentation on the Workplace Mental Health project and consider adopting the Mental Health in the Workplace Report and Standards; *presented by Anna Naify, PsyD., Consulting Psychologist.*

- Public Comment
- Vote

**10:50 AM**

**7. Innovation Incubator Evaluation Report** *Information*

The Commission will receive the Innovation Incubator Evaluation Report prepared by Commission Staff; *presented by Melissa Martin-Mollard, Ph.D., Chief of the Research and Evaluation Division and Courtney Ackerman, M.A., Research Scientist.*

- Public Comment

**11:20 AM**

**8. Prevention and Early Intervention Report & Future Opportunities for Establishing PEI Priorities** *Action Information*

- The Commission will hear a presentation on the Prevention and Early Intervention Report, Well and Thriving, and will consider adopting the report; *presented by Kali Patterson, M.A., Research Scientist*, and,

- The Commission will discuss future opportunities for establishing PEI Priorities; *led by Chair Madrigal-Weiss.*

- Public Comment
- Vote

**1:00 PM**

**9. Adjournment**
Chair Mara Madrigal-Weiss will adjourn the Commission meeting.

| Our Commitment to Transparency | Our Commitment to Those with Disabilities |
|---|---|
| In accordance with 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) 500-0577 or by emailing mhsoac@mhsoac.ca.gov | 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) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible. |

**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.** The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fails, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

**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.

**Under newly signed AB 1261,** by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given additional time to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

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# AGENDA ITEM 4

**Action**

**February 23, 2023 Commission Meeting**

**Approve January 25 and 26, 2023 MHSOAC Teleconference Meeting Minutes**

**Summary:** The Mental Health Services Oversight and Accountability Commission will review the minutes from the January 25 and 26, 2023 Commission teleconference meeting. 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.

**Enclosures (2):** (1) January 25 and 26, 2023 Meeting Minutes; (2) January 25 and 26, 2023 Motions Summary

**Handouts:** None.

**Proposed Motion**: The Commission approves the January 25 and 26, 2023 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

# State of California

## MENTAL HEALTH SERVICES
## OVERSIGHT AND ACCOUNTABILITY COMMISSION

### Commission Meeting Minutes

**Date** January 25 & 26, 2023

**Time** Day 1: 2:00 p.m. – 5:00 p.m.
Day 2: 9:00 a.m. – 3:00 p.m.

**Location** Mission Inn Riverside
3649 Mission Inn Avenue
Riverside, California 92501

**Members Participating:**

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair*2
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Steve Carnevale
Rayshell Chambers
Shuo Chen*R
Itai Danovitch, M.D.
David Gordon*R2
Gladys Mitchell
Alfred Rowlett*1
Khatera Tamplen

*R Participated remotely.
*1 Day 1 only.
*2 Day 2 only.

**Members Absent:**

Mark Bontrager
John Boyd, Psy.D.
Assembly Member Wendy Carrillo
Senator Dave Cortese

**MHSOAC Meeting Staff Present:**

Toby Ewing, Ph.D., Executive Director
Geoff Margolis, Chief Counsel
Norma Pate, Deputy Director, Administration and Performance Management
Melissa Martin-Mollard, Ph.D., Director,

Research and Evaluation
Anna Naify, Psy.D., Consulting Psychologist
Tom Orrock, Chief, Community Engagement and Grants
Andrea Anderson, Chief of Communications
Sharmil Shah, Psy.D., Chief, Program Operations
Maureen Reilly, Assistant Chief Counsel
Kali Patterson, M.A., Research Scientist
Sara Yeffa, Communications and Public Engagement Officer
Amariani Martinez, Administrative Support
Cody Scott, Meeting Logistics Technician

## DAY 1: January 25, 2023

### 1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 2:07 p.m. and welcomed everyone.

Chair Madrigal-Weiss reviewed a slide about how today's agenda supports the Commission's Strategic Plan goals and objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Chair Madrigal-Weiss welcomed and introduced Matthew Chang, M.D., MMM, Director, Riverside University Health System (RUHS) Behavioral Health. She invited Dr. Chang to say a few words.

Dr. Chang provided a brief overview of the background, funding, and work of the RUHS Behavioral Health. He stated the RUHS Behavioral Health focuses on clinical and substance use services. He stated over 300 hospital beds were opened during the COVID-19 pandemic, which were filled within two weeks. He noted that this speaks to the unmet need in Riverside County. He stated the need to consider how to build the continuum of care downstream with limited funding to keep individuals out of hospitals and jails and off the street, such as by focusing on the social determinants of health in full-service partnerships, recovery villages, and mobile crisis response and management teams.

Chair Madrigal-Weiss and Commissioner Tamplen commended Dr. Chang and the RUHS Behavioral Health team for their work.

Commissioner Mitchell asked about the number of patients served.

Dr. Chang stated the hope is to build five recovery villages throughout Riverside County with between 400 and 500 beds each.

Amariani Martinez, Administrative Support, reviewed the meeting protocols.

Geoff Margolis, Chief Counsel, called the roll and confirmed the presence of a quorum.

**2: <u>Announcements and Committee Updates</u> (Information)**

Chair Madrigal-Weiss stated Commissioners Brown and Bunch are leading the Commission's work on firearm violence. She asked them to say a few words regarding the recent tragedies and the work of the Impacts of Firearm Violence Subcommittee.

Commissioner Bunch provided an overview of the Firearm Violence Project. She suggested hearing more from youth and communities of color about the impacts of shootings and mass violence.

Commissioner Brown stated these acts of violence bring together two challenging issues: the concern about persons who are suffering with a mental illness being stigmatized and unfairly branded as violent as a group, and the undeniable fact that many individuals who are involved in these terrible occurrences have been and do suffer from mental illness. It is important to consider what can be done as a community and as a nation to address these problems and to try to prevent them through the right type of early intervention and treatment to educate individuals that there are alternatives in many cases.

Commissioner Brown acknowledged the lives and service of slain Riverside Deputies Isaiah Cordero and Darnell Calhoun.

Chair Madrigal-Weiss extended the Commission's condolences to the families of the two officers and thanked them for their service.

Chair Madrigal-Weiss gave the announcements as follows:

**Announcements**

<u>Commission Meetings</u>

- The November 2022 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- The next Commission meeting will take place on February 23, 2023, in Sacramento as a hybrid meeting.

<u>Staff Changes</u>

- Trinnie Flaggs has been hired as a retired annuitant in the Human Resources area and will be performing classification and pay functions for the Commission.
- Antonio Andres, a student assistant at the Commission since December of 2021, has been hired permanently as an Associate Governmental Program Analyst (AGPA) in the Administrative Services area and will be providing Commission support, including meeting and IT support.
- Ashley Mills, who led the Commission's work on criminal justice and suicide prevention, and has supported the team working on Prevention and Early Intervention and firearms violence, has taken a leadership position at the California Department of

Public Health. Since Ms. Mills was not in attendance today, the Commission will thank Ms. Mills for her contributions at a future Commission meeting.

Workplace Mental Health Draft Report

- A draft of the Commission's report on Workplace Mental Health was distributed in December 2022. The Subcommittee met on January 12th, 2023, and voted to send the report to the full Commission for consideration of adoption. The Commission will review the report at the next meeting. Send questions and comments to staff.

Fellowship Announcement

- Applications for the Clinician Fellowship position can be sent to staff. More information is included in the job posting on the website.
- Staff is currently reviewing applications for the Peer Fellowship.

Delegated Authority

- The Commission approved an additional $1 million of Innovation spending authority for Sacramento County's Behavioral Health Crisis Collaborative Innovation Project, originally approved by the Commission on May 24, 2018.

Committee Appointments

- Priorities for the year will be discussed later today. In order to ensure that the work of the Committees is aligned with those priorities and fully supported with staff resources, Commissioner appointments to Committees will be announced at the next meeting.

**3: General Public Comment (Information)**

Richard Gallo, consumer and advocate and Volunteer State Ambassador, ACCESS California, a program of Cal Voices, stated staff has not responded to emails sent to the Commission. The speaker was unaware if staff have received the emails.

Chair Madrigal-Weiss stated Richard Gallo's emails are not being received. She provided the Commission's contact information for future emails.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke about recent mass shootings throughout the state, especially in the Asian Pacific Islander (API) community. She noted that most analyses state that API communities were already suffering from the trauma of increased violence and acts of hate in the wake of the COVID-19 pandemic.

Stacie Hiramoto stated the Commission was given the opportunity to directly address the mental health of youth from the API communities. In 2021, the Commission received approximately $5 million from the state budget for a special project. These funds were sponsored by the Asian Pacific Islander Legislative Caucus. She stated, according to their website, these funds were specifically earmarked for a special peer social network for API

youth to connect with and support each other through the use of social media. She stated the hope that the Commission will ensure that these funds are being used as they were intended by the Asian Pacific Islander Legislative Caucus and that youth from the API communities will be the focus of this campaign that was set to launch early this year.

### 4: November 17, 2022, Meeting Minutes (Action)

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the November 17, 2022, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

**Public Comment.** There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Danovitch made a motion, seconded by Commissioner Rowlett, that:

- *The Commission approves the November 17, 2022, teleconference Meeting Minutes as written.*

Motion passed, 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bunch, Carnevale, Chambers, Danovitch, Mitchell, Rowlett, and Tamplen, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Brown.

### 5: Consent Calendar (Action)

Chair Madrigal-Weiss stated Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura counties have requested to join the Semi-Statewide Electronic Enterprise Health Record Innovation Project. She stated the Commission will consider authorizing up to $30,003,104.67 in Mental Health Services Act (MHSA) Innovation funds over five years for their participation in the Semi-Statewide Enterprise Health Record Project.

Chair Madrigal-Weiss stated all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

**Public Comment.** There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the Consent Calendar. Commissioner Brown made a motion, seconded by Commissioner Carnevale, that:

- *The Commission approves the Consent Calendar as presented.*

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

The following Commissioners voted "Yes": Commissioners Brown, Bunch, Carnevale, Chambers, Chen, Danovitch, Mitchell, Rowlett, and Tamplen, and Chair Madrigal-Weiss.

**6: <u>Full-Service Partnership Report</u> (Action)**

Chair Madrigal-Weiss stated the Commission will receive a presentation and consider adoption of the Full-Service Partnership (FSP) Report as required under Welfare and Institutions Code section 5845.8 (Senate Bill (SB) 465). The draft report was included in the meeting materials. She asked staff to present this agenda item.

Melissa Martin-Mollard, Ph.D., Director, Research and Evaluation, provided an overview of background, history of FSPs and their critical role along the treatment continuum, key aspects, and recommended next steps of the FSP Report. She thanked Commissioner Rowlett for his assistance and guidance in developing this initial report.

Dr. Martin-Mollard stated, as part of the mandate of SB 465, the Commission conducted an initial review of data and information relating to FSPs. Three primary concerns were identified:

1. The state faces data quality challenges that impede its capacity to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization.
2. Despite regulatory requirements, county behavioral health departments do not appear to be allocating mandatory minimum funding levels to support FSP programs.
3. California has not established sufficient technical assistance and support to ensure that FSP programs are meeting the goals of reducing homelessness, hospitalizations, and justice involvement.

Dr. Martin-Mollard stated, despite the initial success of FSPs, significant numbers of Californians with mental health challenges lack stable housing, are involved in the criminal justice system, and are cycling through state and community hospitals. These realities raise the following questions that guided the initial inquiry for the report:

1. How effective are FSPs, as presently designed and operated, at reducing homelessness, incarceration, and hospitalization?

   Findings: There are gaps in reporting, missing data, and other issues. The data needs to be better. An analysis of FSP effectiveness relies on quality data.

2. What lessons can be learned from exemplary programs to improve the efficacy of the overall FSP initiative?

   Findings: There is an ongoing multi-county innovation project on FSPs looking at strategies to strengthen the design and delivery of FSP programs and capture the outcomes of these services. As part of this project, counties came up with a set of recommendations to improve current data-reporting systems, which the Commission supports.

3. Is California making adequate investments in FSPs, and, if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs and intended outcomes?

Findings: As part of its work under the terms of SB 465, the Commission will work with the Department of Health Care Services (DHCS) and county behavioral health leaders to clarify the fiscal requirements related to FSPs and strengthen utilization of existing resources to support improved FSP outcomes.

4. What strategies should the state explore or pursue to improve prevention and early intervention strategies to reduce reliance on FSP programs where possible?

   Findings: Research on early psychosis intervention indicates that there are clinically beneficial and cost-effective approaches to care delivery that can prevent the escalation of needs. The Governor and Legislature have supported several initiatives to increase upstream interventions that can lower demand for high-cost FSP services, particularly the expansion of access to early psychosis interventions.

Dr. Martin-Mollard stated the initial report lays out a process for developing a strategic data reporting and capacity building plan that will include the following:

- The formation of an advisory group.
- Identify opportunities for capacity building.
- Conduct a landscape analysis to better understand FSPs within the continuum of prevention, early intervention, and treatment.
- Data quality improvement efforts.
- Data linkage and population-based analyses.
- Provide recommendations for investment strategies for FSPs.

Dr. Martin-Mollard asked Commissioner Rowlett if he had anything to add.

Commissioner Rowlett acknowledged the work of staff on this report. He stated being a part of an FSP program should include data that provides an understanding of the unique trajectory of the client experience, which heretofore has been unable to consistently be obtained. The report highlights this.

Commissioner Rowlett stated the lack of data underscores and reinforces the notion that people do not have identities outside of specialty mental health services, when, in fact, they should. FSPs help individuals manage their Medi-Cal benefits such that they can flourish in communities outside of FSPs. This requires a greater emphasis on technology, which the report underscores.

Commissioner Rowlett suggested that at least 50 percent of the advisory group be made up of individuals who have utilized services either currently or in the past, individuals of color from a variety of different communities, and individuals in the community who are not associated with the provision of services.

Commissioner Rowlett stated the goal of the advisory group should include helping individuals who utilize specialty mental health services to flourish in the community that they want to live in. This means understanding how to use Medi-Cal more effectively and

efficiently, helping with the paperwork, ensuring that workforce challenges are addressed, and gathering data that informs services to consistently identify what works in large, small, urban, and rural counties. This would change the experience that individuals have with FSPs.

**Commissioner Comments & Questions**

Commissioner Danovitch stated one of the areas that the Commission has struggled with in the past in understanding how to evaluate the impact of FSPs is defining what an FSP is. He asked if there is a plan to characterize FSPs in order to correlate different models of FSP in different areas against different populations and outcomes.

Dr. Martin-Mollard stated characterizing FSPs and looking at different FSP models, their components, and how they operate differently is part of the landscape analysis.

Commissioner Danovitch stated FSPs are often discussed in terms of the individuals they serve. It is also important to think more broadly about whole communities for comparative analyses to better understand the concentration of FSPs in given areas.

Commissioner Bunch stated her assumption that the goal was for everyone to have a similar model of FSP.

Dr. Martin-Mollard stated identifying what works for different target populations and communities will be layered on top of the core components and best practices that should be embedded in every FSP program.

Commissioner Bunch stated there are not enough clinicians to provide services for the great number of individuals who need FSPs. She asked about ways to decrease waitlisting individuals.

Dr. Martin-Mollard stated one of the concerns about the Community Assistance, Recovery, and Empowerment (CARE) Act is that it is expected to increase demand for FSP services. She stated the need to not only focus on FSP programs but to situate them along the Prevention and Early Intervention continuum to hopefully reduce that funnel of need into FSP programs while also strengthening the capacity of those programs to serve individuals. The advisory group will provide guidance on many areas of concern, including workforce issues and the increased demand on FSPs.

Commissioner Tamplen encouraged increasing efforts in certified peer support specialist workforce development and involvement in FSPs.

**Public Comment**

Richard Gallo agreed that the FSP program is valuable but stated it needs to be measured to ensure that the funding is being spent well with a higher rate of success. The speaker also agreed that 50 percent of the advisory group should be made up of consumers and stated those consumers should be paid a stipend. The speaker stated the need for evaluation of all programs.

Stacie Hiramoto stated appreciation for the report but suggested that the next report be brought before the Client and Family Leadership Committee (CFLC) and the Cultural and

Linguistic Competence Committee (CLCC) and that these Committees be allowed to formally comment on the report prior to finalization. She suggested that the report focus more on the reduction of disparities and that that should be asked during the analyzation process. She noted that racial and ethnic communities are not benefiting as much as they could from FSP programs and are underrepresented in those programs as well.

Stacie Hiramoto spoke in support of consumers and family members being a part of the advisory committee but also suggested specifying members who represent racial, ethnic, and LGBTQ communities. It is important to include individuals on the advisory committee from communities that are not being served.

Steve Leoni, consumer and advocate, stated FSPs arise from a conflation between the passage of Assembly Bill (AB) 34 in 1999 and the passage of earlier legislation in 1989 that funded state projects. The Village was the most successful of the state projects. Mark Ragins, M.D., spent ten years using outcomes, data, and continuous quality improvement to refine The Village. At the time that AB 34 was passed, The Village had already gone through ten years of development. That should be noted in the history of FSPs.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, suggested creating an implementation team rather than an advisory committee. The speaker noted that it is difficult to know what the linkages are to the FSP programs, such as on page 32 of the report where the success rate is listed as 41 percent. The speaker agreed that the membership of the implementation/advisory team should include system users, support systems that support that group, and the right people in the FSP program who can motivate a difficult population and build trust.

Steve McNally stated the Open Data Portal helps California's data program but it is cumbersome. The speaker suggested creating a system in Excel until California's data problem can be figured out.

Damon Shuja Johnson, Executive Director, Black Men Speak, stated the importance of training practitioners, small community-based organizations, and peers. The peer movement should be run by peers. The individuals who really need this are not worried about data; they need the services.

**Commissioner Discussion**

Action: Chair Madrigal-Weiss asked for a motion to approve the Full-Service Partnership Report. Commissioner Rowlett made a motion, seconded by Commissioner Danovitch, that:

- *The Commission approves the Initial Report to the Legislature on Full-Service Partnerships as presented.*

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

The following Commissioners voted "Yes": Commissioners Brown, Bunch, Carnevale, Chambers, Chen, Danovitch, Mitchell, Rowlett, and Tamplen, and Chair Madrigal-Weiss.

**7: <u>Santa Barbara Innovation Project</u> (Action)**

Chair Madrigal-Weiss stated the Commission will consider approval of $7,552,606 in Innovation funding for Santa Barbara County's Housing Assistance Retention Team (HART) innovation project.

Commissioner Brown recused himself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Madrigal-Weiss asked the county representative to present this agenda item.

Natalia Rossi, J.D., MHSA Manager, Santa Barbara County Department of Behavioral Wellness, provided an overview, with a slide presentation, of the need, proposed project to address the need, community contribution, learning objectives, evaluation, and budget of the proposed HART Innovation Project. She stated the Homeless Information Management System will be implemented at all housing sites to measure data that is consistent with data being collected at other housing sites. These data measurements can then be shared county-wide and with other behavioral health departments across the state to help inform strategies to increase housing retention for individuals with mental illness.

**Public Comment**

Richard Gallo stated it is important to value peers and ensure that they are paid a living wage.

Vertilee Stone asked about the timeframe for the start of this program. The speaker asked a question about the Community Assistance, Recovery, and Empowerment (CARE) Court bill.

Chair Madrigal-Weiss asked Vertilee Stone to direct their questions to staff.

**Commissioner Discussion**

Commissioner Rowlett stated the proposed project is Santa Barbara County's first peer-driven onsite housing support program. He asked why it has taken so long to have a peer-led or peer-driven program in place.

Ms. Rossi stated the county does have peer-led programs but has limited housing support services. Peer support is offered and sometimes peers visit sites but the county does not have a peer-led team other than the peer-led outreach and engagement team. This project is specifically about a peer-led team for onsite housing support services. She noted that it was important for the county to pay beyond living wages for case management and peer support service positions.

<u>Action</u>: Chair Madrigal-Weiss asked for a motion to approve the Santa Barbara County Innovation Project. Commissioner Tamplen made a motion, seconded by Commissioner Bunch, that:

*The Commission approves Santa Barbara County's Innovation Project, as follows:*

*Name: Housing Assistance and Retention Team Program*

*Amount: Up to $7,552,606 in MHSA Innovation funds*

*Project Length: Four and a half (4.5) years*

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

The following Commissioners voted "Yes": Commissioners Bunch, Carnevale, Chambers, Chen, Danovitch, Mitchell, Rowlett, and Tamplen, and Chair Madrigal-Weiss.

Commissioner Brown rejoined the meeting.

**8: Alameda Innovation Projects (Action)**

Chair Madrigal-Weiss stated the Commission will consider approval of two Alameda County innovation projects: (1) $8,692,893 in Innovation funding for the Peer-Led Continuum for Forensics and Reentry Services and (2) $13,432,651 in Innovation funding for the Alternatives to Confinement Innovation project.

Commissioner Tamplen recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Madrigal-Weiss asked the county representative to present this agenda item.

Roberta Chambers, PsyD., Consultant, Indigo Project, provided an overview, with a slide presentation, of the need, proposed project to address the need, community contribution, learning objectives, evaluations, and budgets of the proposed Alternatives to Confinement and Peer-Led Continuum for Forensic and Reentry Services Innovation projects. She stated the county is proposing to test two different solutions to address the same problem – to address the over-incarceration of individuals with mental health issues and support them outside of a jail environment. One is a clinical model, while the other is entirely peer-led. These programs are part of a number of efforts by the county aimed to strengthen forensic and reentry mental health services for people with mental health needs.

**Commissioner Comments & Questions**

Commissioner Bunch asked if all services are voluntary.

Dr. Chambers stated all services are voluntary. The idea is to create choice in an environment where there is minimal choice.

Commissioner Mitchell asked where participants will be housed for the 30-day period.

Dr. Chambers stated TeleCare, one of the county contracted providers, received a Behavioral Health Community Infrastructure Program (BHCIP) grant that does all renovations on existing property they own for the crisis residential program. Although there are costs associated with developing those facilities, it is funded through the BHCIP program. An application will be submitted for the forensic peer respite.

Commissioner Mitchell asked about upstream training to engage families for either program.

Dr. Chambers stated individual and group coaching is available to family members for the Peer-Led-Continuum. These programs are not intended to be the entirety of what someone or

their families may need. There is a much larger reentry plan that provides a number of other services that help individuals in the longer term.

Commissioner Mitchell asked if there is an opportunity for the law enforcement contact to also have a shift in thinking in terms of the individuals they come in contact with. She asked where the referrals will come from.

Dr. Chambers stated referrals can be by self, family, law enforcement, or a provider. These programs will provide additional opportunity to help law enforcement specifically to make the decision to divert into a program instead of an arrest.

Commissioner Chambers asked who will lead this project. It is important that management and line staff are peers.

Dr. Chambers stated the entire reporting structure of the Peer-Led Continuum will be made up of individuals with lived experience.

Commissioner Brown asked about the referral process for the population that is already incarcerated and coming out and if the plan includes discharge planners or other individuals the county will interact with to bring individuals into this program.

Kate Jones, Director of Adult and Older Adult Services, Alameda County, stated a Push Report is sent to case management or a care coordination team in the community to inform them that an individual has gone into or been discharged from the local jail. The team engages that individual as quickly as possible. For an individual who is not connected to case management or a care coordination team, the staff at the jail will refer them to the Access Unit to get that person connected to one of the county teams. Ideally, if that person is on a longer stay, the team can outreach and engage with them to track the services and activities available to that person.

Commissioner Brown asked if there is a system in place that, when someone is being treated for mental illness in jail, allows them to have a warm handoff at discharge to treatment providers in the community so their care continues with limited interruption.

Ms. Jones stated individuals have a greater opportunity for warm handoffs to continue services when they receive services in the community from the team that is embedded in the jail. She stated it is more challenging when individuals are not already connected to a team. She stated Juan Taizan is currently working to create a discharge planning team. She asked him to say a few words.

Juan Taizan, Director, Forensic, Diversion, and Reentry Services, Alameda County Behavioral Health, stated his team is currently working on moving toward discharge planning occurring at intake. A level of care system has been designed where the team assesses every individual who is booking into the jail, providing them with a specific level of care and housing them appropriately in the jail according to that level of care, which drives their services while they are in the jail. The clinician meets with them and starts reentry and discharge planning for that individual during the more thorough intake process.

Mr. Taizan stated a discharge team has been built out who works with those clients prior to release to make any referrals that the clinician may have identified for that client, whether it be reconnecting to any service provider that they may have in the community or making new referrals to service providers in the community. Building out the discharge team is a learning process as clients are more connected to treatment in the community.

Mr. Taizan stated the goal that is being tracked and monitored now is for clients to have discharge plans in place, leave with those plans, and be connected to providers in the community.

Mr. Taizan stated clients who are not open to services with county behavioral health can still request a referral. The discharge team will meet with them, identify needs, and refer them to services in the community.

Mr. Taizan stated, as individuals are leaving, behavioral health has built up a Safe Landing Project at the jail that is staffed by a community mental health provider who has staff onsite who can assess clients, provide immediate needs, transport to services, and provide a more thorough assessment and engage that individual to connect them to services via the Access Center or other programs directly.

Commissioner Bunch stated her understanding that law enforcement has contact with someone on the street who appears to have a mental health issue but is not in crisis, so they drop them off at the Triage Center with the idea that the individual would stay there for services.

Dr. Chambers stated that is correct. It invites law enforcement to use another opportunity to not have to arrest individuals. The project creates a space with staff who are warm and welcoming and can help with next steps.

Commissioner Bunch asked about capacity.

Dr. Chambers stated the Triage Center is an outpatient environment that can serve 12 to 14 patients at a time, if needed.

Commissioner Mitchell asked about the expediency of this process and about individuals who are arrested but are discharged quickly.

Dr. Chambers stated the Triage Center is available 24/7. Safe Landing is also a resource as a place for discharged individuals to go. From there, they can go to peer respite or be assessed for crisis residential. She noted that there currently is no residential intervention available, whether peer or clinician led, for mental health patients who are also involved with the justice system. The proposed innovation project creates this new capacity for individuals to go to work on their mental health and justice issues at the same time.

**Public Comment**

Mark Karmatz asked for a presentation on this program in Los Angeles at a Community Leadership Meeting.

Chair Madrigal-Weiss stated presentations can be shared from recorded Commission meetings.

Stephanie Montgomery, Health Equity Division Director and Health Equity Officer, Alameda County Behavioral Health, spoke in support of the proposed innovation projects.

Rashawnda Lee-Hackett, Program Specialist, Office of Peer Support Services, Alameda County Behavioral Health, spoke in support of the proposed innovation projects.

Brian Bloom, Chair, Mental Health Advisory Board, Alameda County, stated the Mental Health Advisory Board wholeheartedly endorses and supports the proposed innovation projects. The speaker urged everyone not to forget that, as good as this program is and although it will help many people, there are so many people in jail who are too ill and suffer too severely to avail themselves of voluntary services. The speaker stated the need to think of other ways to help this population.

**Commissioner Discussion**

Action: Chair Madrigal-Weiss asked for a motion to approve the Alameda County Innovation Plans. Commissioner Mitchell made a motion, seconded by Chair Madrigal-Weiss, that:

*The Commission approves Innovation funding for each of the following Alameda County Innovation Plans, as follows:*

*1 Name: Alternatives to Confinement*

*Amount: Up to $13,432,651 in MHSA Innovation funds*

*Project Length: Five (5) years*

*2 Name: Peer-Led Continuum for Forensic and Reentry Services*

*Amount: Up to $8,692,893 in MHSA Innovation funds*

*Project Length: Five (5) years*

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

The following Commissioners voted "Yes": Commissioners Brown, Bunch, Carnevale, Chambers, Chen, Danovitch, Mitchell, and Rowlett, and Chair Madrigal-Weiss.

Commissioner Tamplen rejoined the meeting.

**9: The Governor's 2023-2024 Proposed Budget and the Commission's 2022-2023 Mid-Year Budget Report & Expenditure Authority (Action)**

Chair Madrigal-Weiss stated the Commission will be presented with the Governor's 2023-2024 Proposed Budget as it relates to mental health and a mid-year update of the Commission's 2022-2023 expenditures, and consider approving new expenditures. She asked staff to present this agenda item.

Norma Pate, Deputy Director, stated an overview of the Governor's proposed 2023-2024 Proposed Budget is in the meeting materials. More information on the Governor's budget will be forthcoming over the next few months.

Deputy Director Pate provided an overview of the Commission Budget 2022-23 Mid-Year Update. She noted that the Adjustments column indicates approximately $1 million in salary savings. She explained that several personnel positions were received but were difficult to fill. Recruitment strategies have been improved to hopefully reach the right candidates to fill these positions soon.

Deputy Director Pate asked the Commission to approve the following:

- Reallocate funds from salary savings to support communications, IT, and unanticipated costs associated with the Commission's new building and AV equipment needed to support hybrid meetings.
- $1.5 million from the Mental Health Student Services Act (MHSSA) Evaluation and Administrative Fund to be awarded to WestEd for initial evaluation work on the MHSSA grants. The funds will be used to develop an evaluation plan, continue community engagement around key metrics for school mental health, and conduct an analysis of current grantee findings and challenges.
- $300,000 from the Operations Fund for the Strategic Plan development.
- $110,000 from the Communications Fund for a Crossings TV contract.
- $670,000 new funding request for an older adult advocacy contract.

**Commissioner Comments & Questions**

Commissioners asked clarifying questions.

**Public Comment**

Stacie Hiramoto asked the Commission to clarify how it is going to spend the $42 million that is part of the Governor's Children and Youth Behavioral Health Initiative (CYBHI).

**Commissioner Discussion**

Action: Chair Madrigal-Weiss asked for a motion to approve the Fiscal Year 2022-23 Mid-year expenditure plan and associated contracts. Commissioner Danovitch made a motion, seconded by Commissioner Carnevale, that:

- *The Commission approves the Fiscal Year 2022-23 Mid-year expenditure plan and associated contracts.*

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

The following Commissioners voted "Yes": Commissioners Brown, Bunch, Carnevale, Chambers, Chen, Danovitch, Mitchell, Rowlett, and Tamplen, and Chair Madrigal-Weiss.

### 10: Recess

Chair Madrigal-Weiss recessed the meeting at 4:57 p.m. and invited everyone to join the Commission for Day 2 of the meeting tomorrow morning at 9:00 a.m.

## DAY 2: January 26, 2023

### 1: Call to Order and Introductory Comments

Chair Mara Madrigal-Weiss reconvened the Commission meeting at 9:12 a.m. at the Mission Inn Riverside, 3649 Mission Inn Avenue Riverside, CA 92501. She provided a brief overview of the January 26, 2023, meeting agenda and recapped the activities from the January 25, 2023, meeting.

### 2: The Commission's 2020-23 Strategic Plan (Information)

Chair Madrigal-Weiss stated the Commission will receive an overview of its 2020-2023 Strategic Plan including accomplishments, current projects, and opportunities for 2023. She asked staff to present this agenda item.

Toby Ewing, Executive Director, provided an overview, with a slide presentation, of the Commission's 2020-2023 strategic goals, initiative accomplishments and challenges, and how the initiatives align with strategic goals. The Commission's 2020-2023 strategic goals are as follows:

1. Advance a shared vision.
2. Advance data, analytics, and opportunities to improve results.
3. Catalyze improvement in policy and practice.

**Commissioner Comments & Questions**

Commissioner Danovitch stated the presentation slide distilling the initiatives with the strategic objectives is clear and helpful. It illustrates the incredibly exciting opportunities and challenges across the Commission's 13 initiatives. He noted that the initiatives are broad, which can undermine effectiveness. He stated clear focus needs to be included in the discussion, understanding that focus involves giving up some things for the higher-level purpose and goal of being more impactful and effective in selected spaces.

Commissioner Carnevale asked if the alcove Youth Drop-In Centers will be expanded from physical locations to a digital footprint and if it promotes peer work.

Executive Director Ewing stated each center has a youth board. The centers begin as a physical location but the strong advisory board decision-making role of youth suggests that they will quickly move to add a digital capacity.

Tom Orrock, Chief, Community Engagement and Grants, added that the first person a young person meets is a peer.

Vice Chair Alvarez stated her question applies to all 13 Commission initiatives. She asked about transformational change and how the Commission's advocacy contracts inform these initiatives.

Executive Director Ewing stated it is unique to each initiative. The advocacy contracts were in place and focused prior to launching the initiatives and do not yet connect. Part of the opportunity is to make those connections happen.

Chair Madrigal-Weiss referred to the Early Psychosis Intervention Plus Initiative and stated it is critically important that a person who experiences their first episode get care within the first 18 months.

Executive Director Ewing stated there was a national study that found that when this package of coordinated specialty care services, which is much like wraparound services that are tailored to the need, is available within the first 18 months, individuals have a much higher likelihood to maintain family connections over the course of their lifetime, meet personal goals for school, work, and family, have stable housing, etc. The alternative is generally a slow decline in all those life outcomes.

Executive Director Ewing stated one of the things the Commission wants to understand is how individuals progress from first episode psychosis into or not into FSPs and into being unhoused, criminal justice involvement, and hospitalization. This cannot be done currently because the data systems are not there but are being worked on. The hypothesis is, if a better job can be done intervening within the first 18 months of some of the most devastating diagnoses, the need for FSPs and costly impacts such as relying on hospitals can be reduced. This can be connected back to the alcove Youth Drop-In Centers as well because so much of that is about creating trust with young people so that, when they have that first experience, they do not hide it but they feel comfortable talking to a trusted friend.

Vice Chair Alvarez stated the mental health system is one piece of a much larger system of care that has connection and opportunities to leverage other efforts. She acknowledged the work of Attorney General Bonta, who has set up a new office around gun violence prevention aligned with the efforts of the Commission's Impacts of Firearm Violence Initiative.

Vice Chair Alvarez stated one of the flexibilities granted the Commission through the Mental Health Wellness Act was that the funds could go to counties and other entities.

Executive Director Ewing agreed and stated prior to that the funding could only go to counties for personnel and matching funds could not be used. The Mental Health Wellness Act is now much broader. The DHCS is focusing these funds on what is reimbursable while the Commission's Innovation Incubator focuses on what is effective. The discussion needs to be about incorporating both strategies.

Commissioner Danovitch stated the Commission's portfolio and set of achievements are impressive and reflects on Commission staff, Commissioners, and everyone involved in the

process. This distillation clearly and coherently describes the work of the Commission. He asked about the dissemination plan to share these accomplishments to help recognize the achievements of the Commission, counties, and community and maintain the momentum.

Executive Director Ewing stated staff continues to refine and improve the presentation of the Commission's work and the communication materials but there is still work to be done, particularly the connection between the investment that is made and the impacts in the community. Establishing this framework will assist staff in regularly providing progress reports to the Commission showing the initiative, goal, work done, and impacts achieved.

Chair Madrigal-Weiss thanked staff for summarizing the Commission's portfolio and providing the Commission's organizational chart to help Commissioners better understand staff and the work being done as they begin to update the strategic plan.

Presentation, continued

Executive Director Ewing continued the slide presentation and discussed focusing upstream and key initiatives and opportunities across the lifespan that are funded by the Commission. He noted that early childhood and older adult work have not been included in this chart because they are not yet live. He stated this chart was meant to help track where the Commission is and is not investing and how the initiatives overlap and connect.

Mr. Orrock stated, relating to the Prevention and Early Intervention and Early Psychosis Intervention Program, the United States has an 18-month average before the first episode of psychosis is spotted. Other countries are at approximately 2 months, which is ideal. California has approximately 30 coordinated specialty care clinics programs whereas, according to the math, it needs 337. The reason California takes 18 months is because it does not have the centers of integrative care in place to get to that 2-month point.

Executive Director Ewing stated the United Kingdom has a goal that their community will have access to coordinated specialty care or a comparable evidence-based program within two weeks of the first onset of psychosis. California does not even have a goal.

Chair Madrigal-Weiss asked if those coordinated specialty care clinics are only covered by public insurance.

Executive Director Ewing stated public insurance coverage is at approximately 80 percent of the service mix. The balance is typically covered by the MHSA. Commercial insurance pays 40 percent. He stated there is no financial mechanism to grow that service because of the mismatch between the need and the payment structure.

Commissioner Brown stated there are many examples in the state that show the lack of resources, particularly in certain areas. He gave the example that his county of 450,000 people has one center with 16 beds, when there should be 15 beds per 100,000 people according to recommended averages. He asked if there are other metrics in terms of what is being spent per capita in other countries and with other approaches with the various types of psychoses.

Executive Director Ewing stated this is not an area the Commission has invested in. He asked for guidance from Commissioners on what the Commission should be investing in this year. He drew everyone's attention to the Focusing Upstream presentation slide to consider what more can be done upstream to lower the need for bedspace.

Commissioner Brown stated it is all about balance. California is still at a stage where there are far too many individuals in jail who should be in psychiatric hospitals. It is a lack of resources that drives that because there are no other alternatives.

Commissioner Carnevale stated the need to get to and attack the root causes – what causes these conditions and what causes systems to fail. Attacking the root causes will be more likely to succeed in moving the needle in the long run.

Commissioner Mitchell agreed with thinking about policies and overarching causes but stated families also need to be considered. Even before 0-5, families need to be educated to better understand how to start the process.

Highlight on Three Initiatives

Executive Director Ewing asked Commissioners Gordon, Danovitch, and Tamplen to highlight three initiatives from their perspective.

- School Mental Health

Mr. Orrock gave the presentation for Commission Gordon, who was available on Zoom to answer questions. Mr. Orrock provided an overview of the timeline, progress, and next steps of the School Mental Health Initiative. He noted that the $270 million investment in school mental health supports a range of strategies with flexibility in how partnerships can use these funds. As a result, funds are being used to educate staff, bring clinicians on campus, and develop partnerships. Because of this diversity, the Commission is supporting site visits and learning collaboratives across a range of school mental health strategies.

Vice Chair Alvarez asked for more detail on the learning collaborative.

Mr. Orrock stated the DHCS has joined the learning collaborative meetings on a couple of occasions to highlight their infrastructure program and the Student Behavioral Health Incentive Program (SBHIP).

Executive Director Ewing stated the need to recognize the breadth of work that is happening is beyond the expertise of Commission staff. The Commission is playing a facilitation role to connect individuals who are working on school finance reform with individuals who can benefit from that so they can learn together. Part of this push has been to consider how to think about mental health through an all-comer lens and, because of that, through an all-payer lens and how to facilitate the conversations between local partners and the state on not just financing decisions but programming decisions, the role of screening, etc.

Vice Chair Alvarez stated the Commission's Organization Chart showed that the Deputy Director of Legislative and External Affairs is pending. This person will be the liaison between the Commission and other agencies to ensure consistent information sharing and

communication that is not just about the public but includes agency partners. Being person-centered will only happen when having these conversations together across agencies. It is important to build the Commission's capacity to do that.

Chair Madrigal-Weiss stated appreciation for how innovative this project was in the flexible use of its funds. No other funding source allowed the local education agency (LEA) to shape what was best for their school community.

Mr. Orrock stated everyone will benefit from grantees who identify partnership, training, and connection of systems as their top priorities. Much can be learned from that.

- Innovation and the Innovation Incubator

Commissioner Danovitch and Sharmil Shaw, Psy.D., Chief, Program Operations, provided an overview of the timeline, projects, key components of the Innovation Action Plan, and approved Innovation funds for the Innovation and Innovation Incubator Initiative.

Commissioner Danovitch thanked staff for their work on this project. He provided an overview of the definition of innovation, why it is included, and the role of the Commission in the innovation process that shapes initiatives, ensures that there is learning from them, and ensures that that learning is disseminated.

Commissioner Danovitch stated one of the things that is challenging about innovation is that to innovate one must be willing to fail. County systems are built to reliably succeed and not to fail, which creates a conflict between the current system and what the system needs to do in order to adapt. Doing the same things over and over does not lead to transformation.

Commissioner Danovitch stated some of the problems that caused the Commission to develop the Incubator in the first place were that the proposals presented to the Commission for approval were not innovative or transformative. They were incremental, not sustaining, and not generalizable. Also, the process developing an innovative plan and getting it approved was time-consuming, cumbersome, unpredictable, and frustrating for all. At the same time, the Commission was evolving in their expectations of innovations from approving projects and disseminating funds to overseeing outcomes. This was the impetus for developing the Innovation Incubator.

Commissioner Danovitch stated the Incubator supports technical assistance and continuous quality improvement. One of the qualities of the Commission's initiatives is they involve blending of funds, which is unique. They also involve more multi-county collaboratives than were seen in the past and a systems analysis project done by Social Finance. He recommended that Commissioners review the report put out by Social Finance. The report was produced through exactly the set of processes the Commission aspires to with all its work. The report generated the Innovation Action Plan, which includes a detailed work plan that informs next steps.

Commission Danovitch stated the need to become better at evaluating Innovative plans, including the structures, processes, and outcomes. An important priority for the Commission is to consider how to talk about and benefit from the learnings of the Innovation plans and

also to incentivize and reinforce continued learning. He encouraged talking about priorities for use of Innovation funds and ways to lever up the work done, such as how to leverage public and private partnerships to take advantage of the resources and potential in California and the alignment of interest that currently exists.

Vice Chair Alvarez asked how the Innovation Incubator helps make clear what innovation proposals should look like to help Commissioners determine what should be funded with Innovation funding versus what counties can be challenged with to implement their other funding streams differently.

Commissioner Danovitch stated innovative proposals have an elusive quality where it is difficult to define what innovative is, but you know it when you see it. Part of it is the identification of the problem and review of existing solutions, which identify a gap and develop a targeted solution to address that gap. Ideally, it is a solution that has generalizability to others. It is a function of a process. That is the reason for the technical assistance and incubation approach. A process was developed to ensure there were stages to go through so the solutions that were being entertained had qualities of having gone through that.

Commissioner Carnevale stated innovation does not typically occur inside a company. It is difficult to see what needs innovating from the inside. That is why public/private partnerships are important. Often, ideas need to come from outside the system for more innovative solutions.

- Youth and Peer Empowerment

Commissioner Tamplen provided an overview of the peer and youth projects, Youth Innovation Project Planning Committee (YIPPC), Sally Zinman Consumer and Rusty Selix Clinician Fellows, Peer Certification Guide, and the Consumer and Family Leadership Committee (CFLC). She stated the YIPPC is be developing a Youth Engagement Toolkit for review in early 2023. She noted that the work on the Peer Certification Guide started before the California Mental Health Services Authority (CalMHSA) was identified as a certifying body. The CFLC discusses information provided from CalMHSA as information becomes available to ensure that peer support specialists and family peer support specialists across the state know about opportunities available to them.

Commissioner Tamplen stated the Resource Guide will also include a history of the peer support specialist movement in California and will add peer art from successful participants of the programs. The Resource Guide is accessible on the website and will continually be updated by the CFLC as information is received by the state.

Vice Chair Alvarez stated there is attention and opportunity around peer support for young people and how young people can be paid for the incredible supports and services that they provide fellow young people. She stated the hope that the Resource Guide will be helpful in promoting that model across more high schools statewide. It is important to consider how this work over the next few years contributes to an advocacy strategy for sustainability.

Commissioner Carnevale applauded the work of the CFLC on this important initiative.

Commissioner Mitchell stated even saving one youth from addiction, the courts, homelessness, unemployment, etc., and preventing some negative outcome touches many systems on a macro level due to this innovative initiative.

Anna Naify, Psy.D., Consulting Psychologist, stated the Anti-Bullying Social Media Peer-to-Peer Support Network, led by Commissioner Chen, is another innovative way to support peer-to-peer support and create a safe space. A soft launch is anticipated soon for a social media space. An advisory committee, a majority of which are youth, has informed that project as well. This is another pathway for peer support and youth empowerment.

**Public Comment**

Steve McNally stated, when we do not talk to each other, we cannot collaborate, and we cannot collaborate unless we all feel safe. The speaker suggested tightening down the Commission with its influence, the Planning Commission that has seven agencies that provide information, and the 900+ local boards, which include 59 electeds. As the money comes down, there may be money that cannot be implemented because of restrictions and confusion. Medical is incredibly accountable and law enforcement is somewhat accountable, but behavioral health is not so accountable. Hospitals could do crisis stabilization units. The speaker stated their county has great public/private partnerships.

Steve McNally suggested that every county needs to have an entity that allows money to flow through. Changing the culture will depend upon how much more money is allocated because no one really wants to work together. The speaker stated the need to identify the champions across the state and start linking them together.

Richard Gallo stated concern with school well centers and the special education student population. The speaker spoke against school districts handing out to school wellness centers to do their job for them when they were planning to spend for them to assess and provide services for that student with mental illness.

Richard Gallo stated the data documentation reporting demographics need to be included in all programs and services across the board. That is the only way to measure who is being served throughout the communities.

Richard Gallo stated the CARE Act is not intended to be utilized with MHSA funding. This needs to be reviewed carefully.

Richard Gallo stated it is a shame to wait until peer certification happens for peer programs to happen. It should not be that way. The peer movement should have happened all along utilizing MHSA funding.

Richard Gallo stated there are counties that do not like the requirement to include a community planning process because they do not want public participation regarding the needs of the mental health community and would rather continue planning the way they

always have. It is important for the Commission to measure and monitor the county community planning process.

Poshi Walker, LGBTQ Program Director, Cal Voices, stated the hope that the Commission will continue to do hybrid meetings. Although there are many benefits to meeting in person, one of the few benefits of the COVID-19 pandemic was that so many individuals who could not be involved ordinarily could participate in virtual meetings.

Poshi Walker stated many individuals have mentioned mental health stigma. In the role as cultural broker for the #Out4Mental Health project, which is one of the Commission's community advocacy projects, one of the things that has come to light is that there is mental health stigma that is cultural and societal and is real and needs to be dealt with. There is a difference between mental health stigma and fear. Listening Sessions conducted by Cal Voices have shown that, while they have specifically been with LGBTQ individuals, there is real fear that, if they engage in mental health services, they will be involved in mandated reporting or they will be 5150ed. Research has begun to show that, for example, African Americans are overrepresented in the number of 5150s in at least the counties that were researched. Also, individuals who are immigrants have a terrible fear that either they or their child will say something that could create an immigration problem for them. These fears are justified.

Poshi Walker stated confronting institutional racism and implicit bias is a much heavier lift than just putting up billboards saying there is no shame in getting mental health services. The speaker wanted to bring this to the Commission's attention in the hope that, as the Commission looks at mental health stigma, it will keep these fears in mind. There is an opportunity to explore how to reduce the use of mandated reporting, 5150s, or reporting around immigration status when someone is seeking out mental health services so that those fears can be addressed and no longer occur.

Stacie Hiramoto thanked Richard Gallo and Poshi Walker for their comments. She stated, although she makes many suggestions in public comment, she believes the Commission and staff do very good work. She echoed Poshi Walker's comments about continuing the hybrid meeting format and complimented the camera team and technical operations for their work in these meetings.

Chair Madrigal-Weiss agreed and stated the in-person participants also appreciated the good work of the team.

### 3: <u>Working Lunch</u>

Chair Madrigal-Weiss invited meeting participants to take a short break, pick up their lunches on the patio, and return for a working lunch. She summarized the discussion from the first part of today's meeting and provided an overview of opportunities going forward. She recognized staff for their hard work and the additional demands placed upon them by the Legislature, the Governor, and Commissioners.

Chair Madrigal-Weiss displayed a chart, included in the meeting materials, identifying the tentative schedule for 2023 Commission meetings and a potential list of initiatives identified as priorities for this year. She noted that the Commission typically does not meet in June and December. She stated examples of priority focus areas are Prevention and Early Intervention, FSPs, MHSSA, Innovation, youth engagement, firearm violence, mental health in the workplace, API Plus, peers, criminal justice, a youth summit, an innovation summit, or other priorities.

Chair Madrigal-Weiss stated the next agenda item focuses on how to set these priorities.

**4: <u>The Commission's 2023 Priorities</u> (Information)**

Chair Madrigal-Weiss stated the Commission will discuss options and priorities for the final year of the 2020-2023 Strategic Plan. She asked a series of questions to facilitate the discussion, as follows:

1. What are existing or planned activities for 2023?
2. What issues do you want to see the Commission address?
3. How can the Commission effectively build on its existing progress?
4. What factors of metrics should the Commission apply towards prioritization?
5. Are there any accomplishments or lessons learned that could impact prioritization?
6. Are there priorities of the Governor or Legislature that we should consider?

Commissioner Madrigal-Weiss noted that there are other important questions to ask as well as those listed. She stated the need for the Commission to engage in a thoughtful exercise about the Commission's priorities and the difficult resource choices needed to be made in order to be effective this year and that have the best chances of making transformational change in the mental health system. She asked staff to present this agenda item.

Executive Director Ewing reviewed a chart, included in the meeting materials, on allocating Commission resources to remind Commissioners about opportunities for involvement, including Commission meetings, Subcommittees, Committees, site visits, and community engagement events. He encouraged Commissioners to attend more site visits as they are highly-effective ways of engaging with community members.

Executive Director Ewing reviewed upcoming meeting agendas and opportunities and stated the goal of having a three-month rolling calendar of Commission meetings planned to help alert partners and speakers. He asked for guidance on how to begin to populate the balance of the Commission's calendar in ways that are responsive to Commission priorities and Commissioner needs, while recognizing the tension between time commitment and impacts.

**Commissioner Comments & Questions**

Commissioner Bunch suggested collaborating with the Attorney General Bonta's Office on the impacts of firearm violence prior to putting it on the agenda for the February meeting.

Executive Director Ewing stated, with a project like that, the Commission does at least two public hearings on the topic. The first public hearing is typically about identifying problems by level-setting with a presentation on the landscape, defining the issue, data findings, and what is known and not known about the issue. The next public hearing is typically about identifying solutions.

Executive Director Ewing stated the impacts of firearm violence topic is not driven by a statutory mandate or a budget direction but is self-directed by the Commission. Commissioners can decide on the amount of time to spend on that topic.

Commissioner Danovitch stated, in thinking about how to calendar the year, he encouraged harkening back to the strategic plan. This is the final year of the strategic plan. He suggested thinking about the goals, objectives, and measurable initiatives and whether they continue to be the right ones. He stated the need to use the tool of the meetings to advance those objectives. He suggested (1) using the strategic plan to make decisions around how to manage time over the year and (2) dedicating time during the year for strategic planning discussions to take stock of where the work has come from and where it needs to go, in order to make adjustments.

Executive Director Ewing stated a couple of meetings were dedicated to the strategic planning process for the 2020-23 Strategic Plan. He noted that strategic planning meetings do not have to be held during Commission meetings but that the resulting strategic plan will be less reflective of those Commissioners who do not participate. He asked Dr. Shah to review upcoming Innovation Plans for approval.

Dr. Shah stated there are 16 Innovation Plans currently in the queue. Four of them are able to be reviewed under delegated authority. Twelve Innovation Plans will require being calendared between now and May. She noted that four Innovation Plans will be presented at the February meeting for Commission approval.

Commissioner Danovitch stated how the Commission reviews and approves Innovation Plans is not prescribed. He suggested, if the strategic objectives require more time, the Commission could review 12 plans in a single session with a more succinct review process, such as on a Consent Calendar.

Executive Director Ewing stated the importance of the restrictions of the Commission's calendar not being the cause of county funding being reverted. He stated county plans typically do not mature at the same time. He noted that, although the agenda allows 30 minutes per plan, it sometimes takes longer. For example, it took two hours yesterday to approve two innovation plans.

Commissioner Mitchell suggested focusing upstream to help build the Commission's calendar and work plan priorities.

Executive Director Ewing stated Commission meetings must prioritize mandated work. The Commission's portfolio can focus upstream.

Commissioner Carnevale stated the Commission's objective is to serve all people in California but it cannot do everything. Every project is interesting and helps people, but the Commission must pick the highest priorities to agendize. The challenge is the lack of data to help quantify impacts, which makes prioritizing difficult. Much of the Commission meeting agenda is spent in project review, but it is unclear whether the projects being reviewed are high-priority projects.

Commissioner Carnevale stated he liked Commissioner Mitchell's idea of looking through a Prevention and Early Intervention lens, which is an indirect way of thinking that getting involved earlier in the cycle will have greater impacts. Commissioner time is consumed by the projects without thinking much about the strategy. He suggested finding a way to spend more time on the right priorities. He stated he liked the idea of tying back the Commission's strategy to ensure that everything the Commission does is in the right strategic order. He stated it feels like Commissioners do not control their time but are instead controlled by the projects put in front of them. Boards usually spend more time on strategy in order to get to the maximum impact with the people served. He asked how Commissioners can better support staff.

Mr. Orrock stated it would be helpful to hear about how to have a better coordinated system of care in California and how current projects can better fit together.

Deputy Director Pate stated it would be helpful internally to have a strategy for items that come before the Commission so staff can better understand what is being expected of them. Staff can then prepare better and will have more time to think through and create meaningful materials to bring forward to the Commission. An agreed-upon plan of what will come to the Commission for the next year will help staff internally to work together as a team.

Commissioner Carnevale stated staff may better understand the needs of communities in California. He asked staff to provide guidance on Commission priorities, based on what people need.

Deputy Director Pate suggested that staff continue the process it took to prepare the information presented today and bring a proposed plan for approval at the next Commission meeting.

Chair Madrigal-Weiss stated Commissioners can make educated guesses based on limited information, but it is difficult to prioritize due to the lack of data. She suggested color-coding the Commission's mandated work to be completed at each meeting. She agreed with putting Innovation plans on the Consent Calendar. There are other things Commissioners can be doing that would be more effective.

Vice Chair Alvarez suggested that the staff report on project work being done includes how the project meets each goal. She noted that very little has been done on Goal 2, advance data, analytics, and opportunities to improve results. Goal 2 is where the Commission can be held accountable to providing the public with the information it needs. Data is already here. Commissioners are looking to staff to inform how to access it, whether through rulemaking, notices of information, etc. Commissioners can then provide guidance on the best of those

recommended strategies to reach the goal. It will feel more substantive to say at the end of the year that the Commission initiated these specific processes.

Executive Director Ewing stated staff has worked diligently on Goal 2 but that does not mean the work was successful. He stated there were two things staff hoped to get done in today's meeting in addition to what was done already today: (1) this conversation and give staff guidance in terms of the calendar and strategic opportunities, and (2) have a conversation about expectations for the strategic planning process. These are related in the sense that there are things that can happen this year but that are not related to the strategic planning process – and there are priorities that can be included in the strategic planning process for the next four years.

Executive Director Ewing stated, hearing what Commissioner Mitchell said about work upstream and what Vice Chair Alvarez and Commissioners Carnevale and Danovitch said about focusing on initiatives that are already adopted, it feels that there are four priorities that can be highlighted. This does not mean that the other work does not get done, but means that the other work is not the focus of the Commissioners' most valuable time during Commission meetings. It can still happen in Committee work, staff work, or community engagement.

1. FSPs – the Commission is directed by law to produce a report in a couple of years. Although FSPs are not the most upstream, they are the most important node before someone is hospitalized, homeless, or incarcerated. Staff is to put together a work plan for Commissioners to review that prioritizes some of the FSP work between now and the November meeting.
2. The strategic planning process for the future – this will require possibly two Commission meetings to engage on the strategic plan.
3. The metrics – Staff has worked hard on metrics but has had many roadblocks. The data the Commission is trying to use is not the Commission's data. It is time for staff to engage Commissioners and to bring decision-makers in to ask questions about why this is so difficult and to learn about the data that is gathered from individuals. That data then needs to be tracked to the provider, from the provider to the county, from the county to the state, and from the state to the Commission to identify gaps. Staff has heard suggestions about developing independent sources of data such as a survey. A survey may be affordable through MHSSA funding.
4. Firearm violence –move this issue to a future agenda to develop a more robust engagement with the attorney general's office.

Executive Director Ewing stated prioritizing these four things for the remainder of the year, in addition to the other work required such as the Mental Health Wellness Act funding, allocating resources, and reviewing innovation plans, would mean other things either would not get done or would have to be done outside of Commission meetings.

Commissioner Danovitch stated another way to keep track of the work while prioritizing Commissioner time is with a scorecard, where at a high level Commissioners can see all the different initiatives and what is green, yellow, and red. He stated it is enlightening hearing that staff has done a lot of work on Goal 2 behind the scenes but has hit roadblocks because Commissioners assumed that no work was being done on Goal 2. He suggested having a meeting around that work. Learning what has been tried and not worked would be important because that is where Commissioners can give guidance on how to think differently and what is important enough to pursue.

Commissioner Carnevale suggested not stopping here but continuing this coordinated effort by discussing how to begin quantifying some of this and how to create a dashboard/scorecard for every Commission meeting rather than every six months to show some level of progress toward the strategic goals. This will result in Commissioners being able to stay focused on certain things and yet feeling they can see the whole picture.

Deputy Director Pate agreed and stated staff has discussed this internally. A dashboard/scorecard will help Commissioners see the work that staff is doing. Commissioners can then help staff better prioritize the work and present the work at Commission meetings in a meaningful way.

Commissioner Brown stated the importance of making a distinction between long-range strategic planning and shorter-term planning. He agreed with the suggested four priorities and added, rather than having strategic planning itself as a priority, combining it with a high-level evaluation of existing projects and direction to confirm the Commission is on the right track with the goals and objectives.

Commissioner Brown stated the need to be cognizant of the fact that strategic plans are great but they are living documents that have to be flexible. Commissioners need to be willing to change or even abandon them depending on what happens in the economy or other issues that impact society in general. He suggested a check-in at least twice a year on the status of the work on the short-term and an annual check-in towards the end of the year on long-range adjustments based on what has happened during the year.

Commissioner Brown stated the need to also be cognizant about major issues within the state that involve mental health, such as incompetent to stand trial (IST), which has become a big issue and will be a contentious issue with the new Department of State Hospitals' plan on how to lower the number of ISTs. He suggested planning a site visit to the Department of State Hospitals.

Commissioner Brown suggested blocking out 30 minutes at every Commission meeting for an information presentation on a major issue in the field the Commission needs to be aware and on top of.

Executive Director Ewing summarized the take-aways from this discussion. Staff is to provide an annual check-in, a biannual report, and a monthly scorecard. The focus will be on FSPs with the connection to the state hospital system and the IST data with a site visit, the strategic plan, the metrics issue, which is in the current strategic plan and cuts across

everything the Commission does, the firearm violence issue, and a 30-minute hot-topic presentation. He stated he would be hesitant to introduce new issues during the hot-topic presentation but would rather it be a hot topic on one of the initiatives the Commission is already working on.

Vice Chair Alvarez stated Commissioners approve county plans but they do not really know what is happening in counties. She suggested that counties provide regular updates where Commissioners can ask questions.

Chair Madrigal-Weiss asked if it is the Commission's place to ask that of counties and, if so, at what point the Commission would get that information, if it should become part of the Commission's ten meetings per year, and how the Commission can ask that question of counties equitably.

Commissioner Mitchell agreed and asked if this is an accountability question.

Commissioner Bunch asked how the Commission can monitor everything counties do when it does not audit counties.

Executive Director Ewing stated these questions should be reviewed in depth as part of the strategic planning process. He stated staff have approximately 50 to 60 Innovation plans in the queue with two Commission staff to process them. There is no requirement or staffing to monitor beyond the mandate of reviewing and approving Innovation plans. The purpose of the Innovation Incubator is to summarize the counties' use of MHSA funding without looking over their shoulders.

Dr. Shah stated counties are required to submit seven reports to the DHCS and the Commission. In terms of oversight and accountability, there are some differences – the DHCS has a role and the Commission has somewhat of a role. The regulations indicate what the counties are to provide in their reports. Whether that information is helpful to the Commission in telling the MHSA story is an important question and something that needs to be discussed.

Executive Director Ewing stated the opportunity is there but there is a lot of work to do. What complicates this is that the DHCS is the auditor. They do a review of each county every three years but it is typically a compliance audit, not an effectiveness audit.

Vice Chair Alvarez asked for a tutorial on the role and opportunities of Committees and how they can be more effective.

Executive Director Ewing stated Committees are advisory to the Commission. The Commission's Rules of Procedure stipulate that the Commission can delegate its decision-making authority to Committees but this normally should not occur.

Commissioner Carnevale stated more is learned about topics in Committees, more input can be given, and it is an opportunity to dig deeper on topics with staff who are experts in those areas. Committees are useful for both Committee Members and staff.

Commissioner Danovitch stated the Commissioner who chairs the Committee has a broad discretion and range to organize that Committee in a way to do work that ultimately has to pass through the Commission as the approval body. There is an opportunity during the strategic planning process to facilitate discussion around how Committees are run and whether there are opportunities to learn from each other to maximize effectiveness together with staff.

**Public Comment**

Steve McNally suggested looking outside ourselves. The reason for peers was to get an unlicensed workforce raised quickly. The speaker stated, if Boards are given work to do, some of them will give it back. Four counties will give 45 percent of California in the Los Angeles Area.

Steve McNally stated Commissioners have influence. When influence meets knowledge, it becomes a change agent. Many people with influence do not have the knowledge or the time to get the knowledge. There are a couple of things: First 5 early childhood programs in San Bernardino. The speaker suggested the topic of how to leverage First 5 setting up MHSA for later. Leveraging the money is one idea.

Steve McNally stated another question is how far Commissioners are willing to go – whether Commissioners are willing to open up their influence to give other people the work, or whether they are willing to carry the message to the people who appointed them. There is going to be level-setting for CARE Court, for example. Los Angeles just came in, so there will be some money coming to Los Angeles from somewhere. The speaker stated they did not know if everyone understands what CARE Court is going to be when it is implemented and who it will affect. There is going to be a lot of disconnect with the people who did support it.

Steve McNally stated clarity on roles is important. There are more entities besides the Commission but everyone comes to the Commission because the Commission is the influence. Whoever represents 500 or more employers, what do those people want? The speaker stated they can pull a list of those employers in the county. There is not that many of them; it is a manageable number that can be done using spreadsheets and talking to people. The speaker suggested building in time for people to talk.

Steve McNally stated meetings often do not provide enough time for meeting participants to know each other. The speaker got a better understanding about how wacky government finance is when talking to people and how difficult it is to get things done. Governor Newsom made a big proposal for open data and it is just a big clunky piece of data. If the Commission or other group would figure out how to make county reports out of it, no one is completely right – it is more or less following the data as it goes up and then intercepting it because there are too many blockers who do not want to share it.

Richard Gallo stated counties do not know what they are doing until they get the proper training and support. MHSA Coordinators do not know how things are supposed to work unless they are properly trained. A county director cannot be relied on when some county directors want to do things the old way with a community planning process.

Richard Gallo stated they reviewed Monterey evaluations on the Action Plan. Every provider was left blank with no follow-up action plan. They needed to have one there for individuals to include their services to meet the needs of the mental health community.

Steve Leoni stated they were encouraged by everything they heard today from staff and Commissioners. For priorities for the coming year, the speaker suggested educating the Legislature, even before putting together all the data. All the values and the effectiveness of FSPs and other programs within the MHSA are being ignored or are unknown to many legislators. Also, there is a new crop of legislatures every year who do not know anything about mental health issues.

Steve Leoni suggested, while working to improve the data, paying attention to the substrate of the Internet Protocol (IP) underneath it. A lot of it is antiquated and does not work well together. Although there are Innovation projects working on this issue, it needs something more comprehensive. Modern computer systems and processes can have great productivity gains where more data can be collected more firmly with less effort from everyone. This can potentially revolutionize everything.

Stacie Hiramoto thanked Commissioner Alvarez for raising the issue of Committees, Subcommittees, and their roles. Interested parties in the behavioral health community would have a lot to say about this topic but it has never been discussed in an organized, open, and transparent meeting. She asked that the Commission put out written information on how the decision is made to form a Subcommittee versus a Committee. Subcommittees are not in the Commission's Rules of Procedure. Rules on Subcommittees are not as supportive, empowering, or collaborative in terms of interested parties.

Stacie Hiramoto stated the Rules of Procedure require all Committees to have two consumers, two family members, and two members from the community who are knowledgeable and experienced in reducing disparities. These positions are omitted from Subcommittee membership with major affect on the results of the work of that Subcommittee. Also, a Subcommittee does not require recording in writing what took place during the meeting. This is a disadvantage to the public.

Poshi Walker stated appreciation for the discussion on the role of the CLCC and the CFLC and questions about delegation. Speaking as a person with institutional knowledge in having served on these Committees in the past, Poshi Walker stated delegating the authority to make an absolute decision is very different than consulting with a Committee and requesting their guidance and having that guidance presented and discussed at Commission meetings prior to the Commissioners voting on an issue. Poshi Walker stated one of the frustrations of Committee Members in the past was that the Committees were not asked for guidance and continues not to be asked for advice or consultation on things such as legislation, Prevention and Early Intervention, or other issues that affect members of the populations represented by the CLCC and the CFLC. The speaker suggested that the Commission discuss how to use what could be a very rich resource.

Poshi Walker stated the Committees used to educate the Commissioners on different populations but this no longer happens. Committees used to also help with outreach for what has now turned into listening sessions. Another thing that should be discussed by the Commission is who becomes a member of these Committees and how that is decided.

Poshi Walked reminded the Commission that, just because someone is a member of a population does not mean that they can speak for the population or that they are a subject matter expert in that population. Tokenism has too often been seen or multiple boxes were checked but the person did not have expertise in all those boxes.

Poshi Walked asked the Commission to consider that who is chosen to serve on Committees is important. While local voices are important, it is much more important to include individuals who understand the work of the Commission, the statewide macro goals and not just their own little county, and who have expertise in what is needed with the MHSA. The speaker again emphasized that Committees can be rich resources for the Commission.

**5: Break**

Due to time constraints, no break was taken.

**6: The Commission's 2024-2027 Strategic Plan (Action)**

Chair Madrigal-Weiss stated the Commission will discuss development of a 2024-2027 Strategic Plan and consider authorizing funding to retain a strategic planning consultant. She asked staff to present this agenda item.

Executive Director Ewing asked for feedback and guidance around the strategic planning process and to identify a Commissioner who will take the lead of that process. He also asked for funding to bring in a third-party consultant who can support the process. A third-party consultant is important because (1) they do this full-time and are experts and (2) through the process, unfiltered feedback about what is and is not working is requested from communities the Commission serves. This is often easier to share with a person outside the Commission. He noted that the funding for the strategic planning was included and approved in yesterday's budget discussion, so there is no need to vote separately on this issue today.

**Commissioner Comments & Questions**

Commissioner Bunch asked staff to prepare a work plan prior to soliciting Commissioner feedback.

Chair Madrigal-Weiss asked Commissioner Carnevale to take the lead in working with staff and retaining a strategic planning consultant.

Commissioner Carnevale accepted the position.

**Public Comment.** There was no public comment.

**7: Adjournment**

Chair Madrigal-Weiss stated the next Commission meeting will take place on February 23, 2023. There being no further business, the meeting was adjourned at 2:52 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

**Motions Summary**
**Commission Meeting**
**January 25, 2023**

**Motion #:** 1

**Date:** January 25, 2023

**Proposed Motion:**
The Commission approves the November 17, 2022, teleconference Meeting Minutes as written.

**Commissioner making motion:** Commissioner Danovitch

**Commissioner seconding motion:** Commissioner Rowlett

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☐ | ☐ | ☐ | ☒ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☐ | ☐ | ☒ | ☐ | ☐ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☐ | ☐ | ☐ | ☐ | ☒ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☐ | ☐ | ☐ | ☒ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☐ | ☐ | ☐ | ☒ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**January 25, 2023**

**Motion #:** 2

**Date:** January 25, 2023

**Proposed Motion:**
The Commission approves the Consent Calendar as presented.

**Commissioner making motion:** Commissioner Brown

**Commissioner seconding motion:** Commissioner Carnevale

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

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 17. Commissioner Bontrager | ☐ | ☐ | ☐ | ☒ | ☐ |
| 18. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 19. Commissioner Brown | ☒ | ☐ | ☐ | ☐ | ☐ |
| 20. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 21. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 22. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 23. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 24. Commissioner Chen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 25. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 26. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 27. Commissioner Gordon | ☐ | ☐ | ☐ | ☒ | ☐ |
| 28. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 29. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 30. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 31. Vice-Chair Alvarez | ☐ | ☐ | ☐ | ☒ | ☐ |
| 32. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**January 25, 2023**

**Motion #:** 3

**Date:** January 25, 2023

**Proposed Motion:**
The Commission approves the Initial Report to the Legislature on Full Service Partnerships.

**Commissioner making motion:** Commissioner Rowlett

**Commissioner seconding motion:** Commissioner Danovitch

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

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☐ | ☐ | ☐ | ☒ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☒ | ☐ | ☐ | ☐ | ☐ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☐ | ☐ | ☐ | ☒ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☐ | ☐ | ☐ | ☒ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**January 25, 2023**

**Motion #:** 4

**Date:** January 25, 2023

**Proposed Motion:**
The Commission approves Santa Barbara County's Innovation Project, as follows:

| | |
|---|---|
| Name: | Housing Assistance and Retention Team Program |
| Amount: | Up to $7,552,606 in MHSA Innovation funds |
| Project Length: | Four and a half (4.5) years |

**Commissioner making motion:** Commissioner Tamplen

**Commissioner seconding motion:** Commissioner Bunch

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

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. **Commissioner Bontrager** | ☐ | ☐ | ☐ | ☒ | ☐ |
| 2. **Commissioner Boyd** | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. **Commissioner Brown** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. **Commissioner Bunch** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. **Commissioner Carnevale** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. **Commissioner Carrillo** | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. **Commissioner Chambers** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. **Commissioner Chen** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 9. **Commissioner Cortese** | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. **Commissioner Danovitch** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. **Commissioner Gordon** | ☐ | ☐ | ☐ | ☒ | ☐ |
| 12. **Commissioner Mitchell** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. **Commissioner Rowlett** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. **Commissioner Tamplen** | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. **Vice-Chair Alvarez** | ☐ | ☐ | ☐ | ☒ | ☐ |
| 16. **Chair Madrigal-Weiss** | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**January 25, 2023**

**Motion #:** 5

**Date:** January 25, 2023

**Proposed Motion:**
The Commission approves Alameda County's Innovation Projects, as follows:

1. Name: Alternatives to Confinement
   Amount: Up to $13,432,651 in MHSA Innovation funds
   Project Length: Five (5) years

2. Name: Peer-Led Continuum for Forensic and Reentry Services
   Amount: Up to $8,692,893 in MHSA Innovation funds
   Project Length: Five (5) years

**Commissioner making motion:** Commissioner Mitchell

**Commissioner seconding motion:** Chair Madrigal-Weiss

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

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☐ | ☐ | ☐ | ☒ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☒ | ☐ | ☐ | ☐ | ☐ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☐ | ☐ | ☐ | ☒ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☐ | ☐ | ☐ | ☒ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**January 25, 2023**

**Motion #:** 6

**Date:** January 25, 2023

**Proposed Motion:**
The Commission approves the Fiscal Year 2022-23 Mid-year expenditure plan and associated contracts.

**Commissioner making motion:** Commissioner Danovitch

**Commissioner seconding motion:** Commissioner Carnevale

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

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☐ | ☐ | ☐ | ☒ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☒ | ☐ | ☐ | ☐ | ☐ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☐ | ☐ | ☐ | ☒ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☐ | ☐ | ☐ | ☒ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

# AGENDA ITEM 5

**Action**

**February 23, 2023 Commission Meeting**

**Consent Calendar**

**Summary:** The Mental Health Services Oversight and Accountability Commission will consider approval of the Consent Calendar which contains four Innovation Funding Requests.

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar Items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held over for consideration at a future meeting at the discretion of the Chair.

**San Mateo County requests that the Commission authorize up to $6,830,000 In Mental Health Services Act Innovation funds for the following four projects:**

| Project Name | Total INN Funding Requested | Duration of INN Project (years) |
|---|---|---|
| Adult Residential In-home Support Element (ARISE) | $1,235,000 | 4 |
| Mobile Behavioral Health for Farmworkers | $1,815,000 | 4 |
| Music Therapy for Asians and Asian Americans | $940,000 | 4 |
| Recovery Connection Drop-In Center | $2,840,000 | 5 |
| **Total:** | **$6,830,000** | |

**Adult Residential In-home Support Element (ARISE):**

The County is proposing to increase housing retention by creating a model for residential in-home support services specifically designed for clients living with serious mental health challenges and/or substance use disorder (SUD) who are unlikely to be approved for state In Home Supportive Services (IHSS), or who would be underserved by IHSS, and who, without additional support, are at risk of losing their housing due to challenges with managing their housing environment.

ARISE will adapt the IHSS structure into a new model with increased worker pay ($30/hour), guaranteed hours, and specialized training. The current structure of IHSS requires clients to find, interview and hire workers. **A key difference in the ARISE model is the addition of a**

**support team to train workers and coordinate services with each client. A peer worker and occupational therapist will work with clients to match qualified workers to the client based on needs, culture, language, and personality, and ensure the work that is done is appropriate, adequate, and tailored to the needs of the client.** The County hopes that lessons learned from this project will inform changes to the state IHSS program so that it can better serve individuals with behavioral health conditions.

**Mobile Behavioral Health for Farmworkers:**

The County is proposing to bring behavioral health and physical health services **directly** to farmworkers and their families, including children, through an outreach team and a mobile health bus that will be equipped to provide clinical, medical, and prenatal care. These services will also be provided to 23 farms along the Northern Coast of San Mateo County and all services will be provided in Spanish with the goal of supporting the farmworker community to engage in behavioral health services, supports, and resources.

The components of this project will utilize the following approaches and services:

- **Behavioral health outreach and education in farmworker communities**
- **Cultural arts and community connection**
- **Assessment and early intervention**
- **In-person and tele-behavioral health treatment**
- **Recovery support for people recovering from behavioral health challenges**
- **Linkage to community resources**

To address fears of discrimination and deportation, **a client's immigration status will not be asked, nor will Medi-Cal be required to receive services.** Additionally, confidentiality will be maintained, and the exterior of the bus will not identify services being offered.

**Music Therapy for Asians and Asian Americans:**

The County is proposing to bring music therapy ("a form of treatment that uses music within the therapeutic relationship to help accomplish the patient's individualized goals"), as a treatment modality to Asians and Asian Americans in order to reduce stigma, increase literacy surrounding behavioral health, and promote referrals and linkages to behavioral health services. The County is hoping to learn if the use of music therapy is an effective outreach and engagement strategy for this target population.

Working with peers and consultation with behavioral health therapists, music therapists will work with the Asian and Asian American community to build social and emotional skills through the creation and playing of music, including utilizing instruments from Asian countries. Additionally, the County hopes the program components will allow for connectedness and cultural community-building.

The project will utilize the following therapeutic components:

- Music therapy group classes
- Music-based support groups
- Intergenerational events and performances

Staff for this project will consist of trained music therapists, peer workers, and a behavioral health clinician. All staff will identify as Asian and Asian American and will have experience working with this community.

**Recovery Connection Drop-In Center:**

To address the need for more services that are recovery oriented with a more approachable access point for individuals experiencing substance use and/or co-occurring substance use and mental health challenges, the County proposes to test the use of a peer support model centered around the evidence-based, Wellness Recovery Action Plan (WRAP) programming by opening a culturally responsive Recovery Connection Center.

The Recovery Connection Center will:

- use a peer support model that welcomes individuals in with an informational meeting with a peer coach and continues with voluntary peer-led services including 1:1 mentoring and support.
- center around evidence-based, WRAP programming with groups organized based on specific circumstances of participants.
- serve as a training center and provide ongoing WRAP training to peers, clinicians, and paraprofessionals to increase the number of certified WRAP providers and expand referral pathways to expand capacity countywide.
- provide linkages to more intensive behavioral health services as needed through developed partnerships and county programs.
- provide health and mental wellness classes.
- provide job readiness support and employment referral services including volunteer opportunities.
- be open 10am-7pm, Monday-Friday with the option to extend hours based on need.

**The Community Program Planning Process:**

In preparation for the County's MHSA three-year community planning process, a needs assessment was done to help identify community needs and priorities. All of these projects meet the identified priorities. The Needs assessment, stakeholder workgroup events and respective demographic participant information are included in the appendices of all the projects.

San Mateo engaged with the community, service providers, and individuals with lived experiences to gather ideas for innovation projects between February and July 2022. A workgroup consisting of County staff, individuals with lived experience, nonprofit providers and the County's MHSA Steering Committee reviewed, scored, and provided comments and suggestions informing the continued development of all four projects.

**Enclosures (6):** (1) Commission Community Engagement Process; (2) Adult Residential In-home Support Element (ARISE) Staff Analysis; (3) Mobile Behavioral Health for Farmworkers Staff Analysis; (4) Music Therapy for Asians and Asian Americans Staff Analysis; (5) Recovery Connection Drop-In Center Staff Analysis; (6) Letters of Support

**Additional Materials (4):** Links to the four final Innovation project plans available on the Commission website at the following URLs:

**Adult Residential In-home Support Element (ARISE)**
https://mhsoac.ca.gov/wp-content/uploads/San-Mateo_INN-Plan_ARISE.pdf
**Mobile Behavioral Health for Farmworkers**
https://mhsoac.ca.gov/wp-content/uploads/San-Mateo_INN-Project_Mobile-BH-for-Farmworkers.pdf
**Music Therapy for Asians and Asian Americans**
https://mhsoac.ca.gov/wp-content/uploads/San-Mateo_INN-Project_Music-Therapy.pdf
**Recovery Connection Drop-In Center**
https://mhsoac.ca.gov/wp-content/uploads/San-Mateo_INN-Project_Recovery-Connection.pdf

**Proposed Motion:** That the Commission approves funding for the four San Mateo County Innovation Plans for a total of up to $6,830,000 as described herein.

Mental Health Services
Oversight & Accountability Commission

**Commission Process for Community Engagement on Innovation Plans**

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

## Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  **iii. Commission staff will then share the link for innovation projects with the following recipients:**
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  **i. When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:**
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  ii. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

Mental Health Services
Oversight & Accountability Commission

# STAFF ANALYSIS – SAN MATEO COUNTY

| | |
|---|---|
| **Innovation (INN) Project Name:** | **Adult Residential In-home Support Element (ARISE)** |
| **Total INN Funding Requested:** | **$1,235,000** |
| **Duration of INN Project:** | **4 Years** |
| **MHSOAC consideration of INN Project:** | **February 23, 2023** |

**Review History:**

| | |
|---|---|
| Approved by the County Board of Supervisors: | Scheduled for February 14, 2023 |
| Mental Health Board Hearing: | December 7, 2022 |
| Public Comment Period: | November 2, 2022-December 7, 2022 |
| County submitted INN Project: | December 21, 2022 |
| Date Project Shared with Stakeholders: | November 15, 2022 & January 23, 2023 |

**Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):**

**The primary purpose of this project is to** *increase access to mental health services, including but not limited to, services provided through permanent supportive housing.*

**This Proposed Project meets INN criteria** *by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

**Project Introduction:**

The County is proposing to increase housing retention by creating a model for residential in-home support services specifically designed for clients living with serious mental health challenges and/or substance use disorder (SUD) who are unlikely to be approved for state In Home Supportive Services (IHSS), or who would be underserved by IHSS, and who, without additional support, are at risk of losing their housing due to challenges with managing their housing environment.

**What is the Problem:**

San Mateo County Mental Health Association (MHA) is a County Behavioral Health partner that provides various services to over 500 clients annually. MHA assists individuals living with serious mental health challenges and/or SUD to develop and improve daily living skills, including home maintenance. MHA reports that some

individuals experience significant deficits in their executive functioning, which has resulted in situations where a client is asked to leave or evicted because of their inability to maintain their housing in a safe and habitable way.

Further complicating the risk, clients who lost their housing during the Pandemic, resulted in the inability of MHA occupational therapists to meet clients in person, see the condition of their living environments and provide support. In addition, the eviction moratorium prevented landlords from evicting tenants even when the conditions of their homes became uninhabitable. As a result, MHA is seeing a backlog of clients who are at risk of losing their housing due to habitability concerns.

The California IHSS program provides in-home assistance to eligible aged, blind, and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. **The current IHSS system was not designed for clients with behavioral health challenges, but it does serve a small subset of clients with behavioral health needs. However, MHA reports that many clients who need in-home assistance to retain housing are currently not eligible for IHSS and if they are eligible, need more tailored support than IHSS provides.**

**How this Innovation project addresses this problem:**

The proposed project develops an alternative to the existing IHSS system, creating an in-home support model designed for adults with behavioral health needs with the key learning goal to determine if the model improves client outcomes. If successful, the project design could transform the in-home support services model in other counties and beyond.

A small test of the proposed project model was completed using a grant in the amount of $50,000. MHA identified 18 clients from their caseload who were struggling with home maintenance and provided in-home supports. All but one of these clients maintained their housing during the grant period (and program staff were successful in delaying that client's eviction).

Based on the need for successful housing retention strategies, the County proposes to use Innovation funds to test a full implementation of the proposed project model and complete an evaluation to determine if the model is truly successful at supporting clients to improve outcomes and retain housing.

ARISE will adapt the IHSS structure into a new model with increased worker pay ($30/hour), guaranteed hours, and specialized training. The current structure of IHSS requires clients to find, interview and hire workers. **A key difference in the ARISE model is the addition of a support team to train workers and coordinate services with each client. A peer worker and occupational therapist will work with clients to match qualified workers to the client based on needs, culture, language, and personality, and ensure the work that is done is appropriate, adequate, and tailored to the needs of the client.** The County hopes that lessons learned from this project will inform changes to the state IHSS program so that it can better serve individuals with behavioral health conditions.

The project also seeks to understand client engagement in County behavioral health services. MHA estimates that a sizeable proportion of clients have not been engaged in services for the past couple of years. The project offers an opportunity to explore whether participating in a program such as ARISE supports engagement or re-engagement in services.

In addition, ARISE aims to increase the quantity and quality of qualified IHSS in-home support workers who are interested in working with clients living with behavioral health challenges and/or SUD.

Commission staff shared Ventura County's Managing Assets for Security and Health (MASH) Senior Supports for Housing Stability project with San Mateo to encourage cross-county learning. The MASH project was approved in June 2022 and adapts the Home Share Model to increase housing retention for seniors by offering in-house support through the renting of an available room in exchange for household chores, cooking, running errands, etc. While the MASH approach is significantly different than ARISE, there may be shared challenges in the matching of clients with identified supports.

## The Community Program Planning Process(see pages 12-14 of original plan)

Local Level

In preparation for the County's MHSA three-year community planning process, a needs assessment was done to help identify community needs and priorities. One identified priority included the need to strengthen the housing continuum and provide integrated treatment and recovery supports for individuals living with mental health and substance use challenges. This project meets that identified priority. *Note: the prioritized needs assessment, stakeholder workgroup events and respective demographic participant information has been included as part of Appendix 2.*

San Mateo engaged with the community, service providers, and individuals with lived experiences to gather ideas for innovation projects between February and July 2022. A total of 19 project ideas were received and screened for regulatory compliance. A workgroup consisting of County staff, individuals with lived experience, nonprofit providers and the County's MHSA Steering Committee reviewed, scored, and provided comments and suggestions informing the continued development of this project.

In addition, a small advisory group of clients, family members and community leaders including representatives from IHSS, Aging and Adult Services and/or other partner agencies will be established early in the project and will inform all aspects of the ARISE program.

San Mateo County's community planning process included the following:

- 30-day public comment period: November 2, 2022-December 7, 2022
- Local Mental Health Board Hearing: December 7, 2022
- Board of Supervisor Approval: Scheduled for February 14, 2023

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 21, 2022.

Commission Level

This project was initially shared with Community Partners on November 15, 2022, and the final version was again shared on January 23, 2023. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

No comments were received by the Commission in response to the sharing of this project.

**Learning Objectives and Evaluation (see pages 9-12 of original plan):**

The project will serve up to 35 adults annually, who live with serious mental health challenges and/or SUD, live independently and are at risk of losing housing.

An independent evaluation consultant will be contracted and monitored by County staff to finalize the design of the evaluation and formally evaluate the innovation project. The project's learning goals include:

1. Do clients receiving in-home supports tailored for individuals with behavioral health needs maintain their housing?

2. To what extent does the ARISE program support clients' health, wellbeing, and recovery?

3. To what extent does the ARISE program improve capacity for in-home supports to serve individuals with complex behavioral health challenges and how might these outcomes inform changes to the state IHSS program?

The County hopes to identify the impact of this project by the following measures:

- Number of clients enrolled and served for at least one month with less than 5% failing a housing inspection and less than 10% receiving complaints or lease violations, no evictions, and client self-reports of program effectiveness in maintaining their living environment.
- Percent of clients engaged in behavioral health services at baseline and follow-up, satisfaction of clients with the program, and self-reported health and wellness outcomes.
- Number of available IHSS workers in the county at baseline and follow-up who are willing to provide in home support for individuals with behavioral health challenges, and the overall satisfaction of in-home support workers.

Quantitative and Qualitative data collected for this project may include:

- Program and administrative data.
- ARISE client and staff interviews and/or focus groups.

## The Budget (see pages 18-20 of plan)

| 4 Year Budget | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | TOTAL |
|---|---|---|---|---|---|---|
| Direct Costs | | $330,000 | $330,000 | $330,000 | | $ 990,000 |
| Administration | $10,000 | $ 40,000 | $ 35,000 | $ 35,000 | $25,000 | $ 145,000 |
| Evaluation | $ - | $ 35,000 | $ 30,000 | $ 30,000 | $ 5,000 | $ 100,000 |
| | | | | | | $ - |
| | | | | | | $ - |
| Total | $10,000 | $405,000 | $395,000 | $395,000 | $30,000 | $1,235,000 |

| Funding Source | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | TOTAL |
|---|---|---|---|---|---|---|
| Innovation Funds | $10,000 | $405,000 | $395,000 | $395,000 | $30,000 | $1,235,000 |

San Mateo County is seeking authorization to use up to **$1,235,000** in innovation funding over a four-year period.

- Direct costs total **$990,000** (80% of the total project) and include all contractor expenses for service delivery (salaries and benefits, supplies, rent, translation, subcontracts).
- Indirect costs consist of:
  - Independent evaluation contract costs total **$100,000** (8% of total project) to cover costs associated with developing the evaluation plan, supporting data collection, analysis and preparing reports.
  - Administration costs total **$145,000** (12% of the total project) to cover costs for county oversight of the project including procurement, contract monitoring, and fiscal tracking.

## Sustainability

Contracted service providers for this program will be required to develop a sustainability plan in collaboration with the advisory group with the goal of leveraging diversified funding. If the evaluation indicates that the proposed project is successful, the County will also consider continued use of MHSA funds.

*The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the County must receive and inform the MHSOAC of approval from the San Mateo County Board of Supervisors before any Innovation Funds can be spent.*

Mental Health Services
Oversight & Accountability Commission

# STAFF ANALYSIS – SAN MATEO COUNTY

| | |
|---|---|
| **Innovation (INN) Project Name:** | **Mobile Behavioral Health for Farmworkers** |
| **Total INN Funding Requested:** | **$1,815,000** |
| **Duration of INN Project:** | **4 Years** |
| **MHSOAC consideration of INN Project:** | **February 23, 2023** |

**Review History:**

| | |
|---|---|
| Approved by the County Board of Supervisors: | Scheduled for February 14, 2023 |
| Mental Health Board Hearing: | December 7, 2022 |
| Public Comment Period: | November 2, 2022-December 7, 2022 |
| County submitted INN Project: | December 21, 2022 |
| Date Project Shared with Stakeholders: | November 15, 2022 and January 23, 2023 |

**Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):**

**The primary purpose of this project is to** *increase access to mental health services to underserved groups.*

**This Proposed Project meets INN criteria** *by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

**Project Introduction:**

The County is proposing to bring behavioral health and physical health services to farmworkers and their families, including children, through an outreach team and a mobile health bus that will be equipped to provide clinical, medical, and prenatal care. These services will also be provided in Spanish with the goal of supporting the farmworker community to engage in behavioral health services, supports, and resources.

**What is the Problem:**

San Mateo has identified approximately 80 farms located along the County's coastline. Based on a 2019 completed needs assessment, San Mateo estimates there are 1,300-1,600

farmworkers that work on these farms. Additionally, farmworkers employed in the County also have families and children – estimated to be 1,700-2,000. The County provides data to support that approximately 30-50% of this population (farmworkers and their families) were seen at County Clinics, but the majority of those seen were children and young adults. The County has concluded that farmworkers and adults within the families are not being connected to needed behavioral and physical health care.

Low penetration rates may be attributed to the fact that most farmworkers and their families are immigrants and may be undocumented, resulting in fear of seeking services along with past and ongoing trauma that may include housing and economic instability, risk of exploitation, lack of job protection, trauma related to immigration and migration to the United States, isolation, and discrimination. A County administered survey provided to 13 farmworkers revealed all participants reported mental health symptoms including anxiety, stress, and concerns of discrimination and feeling unsafe and overworked in the workplace.

The County is proposing to bring services **directly** to farmworkers and their families to provide needed services for this underserved and unserved population.

**How this Innovation project addresses this problem:**

The community-based organization who brought this idea forward to the County during the community planning process, Ayudando Latinos a Sonar (ALAS), proposes to utilize their existing mobile bus to allow for provision of services to be brought directly to 23 farms along the Northern Coast of San Mateo County to provide behavioral health and physical health services to farmworkers and their families.

This project will utilize a Farmworker Outreach team consisting of the following staff:

- Two full-time Clinicians (MFT or MSW)
- Social Worker
- Two part-time MFT trainees (onboarded from the Psychology program at the University of San Francisco)
- Clinical Supervisor
- Farmworker Program Director
- One part-time non-clinical staff

The components of this project will utilize the following approaches and services (see pgs 5-7):

- **Behavioral health outreach and education in farmworker communities** – the Farmworker outreach team will visit farms Monday-Friday during accessible times to offer food, conduct assessments and determine if families may need assistance.
- **Cultural arts and community connection** – cultural activities will be created to allow farmworkers and their families to tell their story with the hopes of creating a stronger attachment and acceptance within their community.

- **Assessment and early intervention** – the clinical staff on the bus will conduct age-appropriate assessments and screenings for early intervention of behavioral health challenges.
- **In-person and tele-behavioral health treatment** – Clinical staff will be Latinx and Spanish speaking, offering both in-person and tele-health services (approx-12 sessions) for individuals of all ages, including individual and group counseling.
- **Recovery support for people who are recovering from behavioral health challenges** – this project will provide services and to promote recovery, will work in partnership with NAMI and the Latino Collaborative to support those recovering from substance use and addiction.
- **Linkage to community resources** – the mobile team will work with farmworkers and their families if education and personal growth goals are desired. Community partners for this effort may include the County libraries, College of San Mateo, University of San Francisco, Stanford University, and the Mexican Consulate.

It is important to note that to address fears of discrimination and stress surrounding deportation, **a client's immigration status will not be asked, nor will Medi-Cal be required to receive services. Additionally, confidentiality will be maintained, and the exterior of the bus will not identify services being offered.**

In conducting research for this project, the County states that although mobile health care is not new, it typically does not provide behavioral health services that are culturally responsive and utilize cultural arts. Ventura County's innovation project was researched by San Mateo and the County concluded that Ventura's project does serve farmworkers but focuses on those who are homeless and living with a mental health challenge. The provision of service for Ventura is crisis response and provides short-term mental health interventions. Other research revealed that Oregon has community health centers that serve migrant farmworkers, La Clinica; however, the health centers do not provide behavioral health services.

This project aims to provide cultural arts and clinical behavioral health services delivered directly onsite to farmworkers and their families to test and pilot best practices for the provision of mobile behavioral health services for this population.

**The Community Program Planning Process (pgs 15-18 and Appendices 2-4):**

Local Level

In preparation for the County's MHSA three-year community planning process, a needs assessment was done to help identify community needs and priorities. One of the priorities identified included increasing culturally focused community engagement opportunities to create culturally and trauma-informed services. This project meets that identified priority. *Note: the prioritized needs assessment, stakeholder workgroup events and respective demographic participant information has been included as part of Appendix 2.*

San Mateo engaged with the community, service providers, and individuals with lived experiences to gather ideas for innovation projects between February and July 2022. A total of 19 project ideas were received and screened for regulatory compliance. A workgroup consisting of County staff, individuals with lived experience, nonprofit providers and the County's MHSA Steering Committee reviewed, scored, and provided comments and suggestions informing the continued development of this project.

San Mateo will create and utilize an advisory group of farmworker clients, family members and community leaders at the beginning of this project that will inform activities, outreach and engagement strategies, and the overall evaluation and dissemination of this project.

San Mateo County's community planning process included the following:

- 30-day public comment period: November 2, 2022-December 7, 2022
- Local Mental Health Board Hearing: December 7, 2022
- Board of Supervisor Approval: Scheduled for February 14, 2023

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 21, 2022.

Commission Level

This project was initially shared with Community Partners on November 15, 2022, and the final version was again shared on January 23, 2023. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

No comments were received by the Commission in response to the sharing of this project.

**Learning Objectives and Evaluation (pgs 13-15):**

The County indicates this project is anticipated to serve at least 150 low-income Latinx farmworkers and their families annually with this project, equating to approximately 10% of the 1,500 registered farmworkers along the Northern Coast region of the County.

The County has set forth specific learning questions for this project and will hire an external contractor to complete the evaluation. The learning questions will assist the County in determining if this project will inform best practices on how to provide behavioral health services to farmworkers by bringing services directly to them.

The learning questions for this project are as follows:

1. To what extent does a culturally responsive, mobile behavioral health resource expand access to and utilization of behavioral health services in the Latinx farmworker community?

2. How does an integrated approach using cultural arts and formal clinical services support behavioral health service adoption and outcomes among the Latinx farmworker community?
3. What are the needs and best practices to support farmworker behavioral health?

The County hopes to identify the impact of this project by the following measures:

- Number of families and farmworkers served by mobile bus
- Number of families and farmworkers linked to behavioral health services
- Decreased stigma surrounding behavioral health
- Number and percentage of clients that engage in, participate in, and are satisfied with, the cultural art activities proposed in this project
- Identification of the most highly rated components of this project
- Client and staff feedback relative to this project

Quantitative and Qualitative data collected for this project may include:

- Baseline data including initial intake forms
- Utilization data
- Verbal interviews and/or surveys with farmworkers and their families
- Interval assessments and intake performed by clinicians
- Program staff interviews or focus groups

## The Budget:

| 4 Year Budget (5 FYs) | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | TOTAL |
|---|---|---|---|---|---|---|
| Direct Costs | | $ 485,000.00 | $ 485,000.00 | $ 485,000.00 | $ - | $ 1,455,000.00 |
| Indirect Costs | $ 10,000.00 | $ 115,000.00 | $ 100,000.00 | $ 100,000.00 | $ 35,000.00 | $ 360,000.00 |
| | | | | | | $ - |
| | | | | | | $ - |
| **Total** | **$ 10,000.00** | **$ 600,000.00** | **$ 585,000.00** | **$ 585,000.00** | **$ 35,000.00** | **$ 1,815,000.00** |

| Funding Source | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | TOTAL |
|---|---|---|---|---|---|---|
| Innovation Funds | $ 10,000.00 | $ 600,000.00 | $ 585,000.00 | $ 585,000.00 | $ 35,000.00 | $ 1,815,000.00 |
| | | | | | | |
| | | | | | | |
| **Total** | **$ 10,000.00** | **$ 600,000.00** | **$ 585,000.00** | **$ 585,000.00** | **$ 35,000.00** | **$ 1,815,000.00** |

San Mateo County is seeking authorization to use up to **$1,815,000** in innovation funding over a four-year period.

- Operating costs consist of:
    - Direct Costs total **$1,455,000** (80% of total project) to cover costs associated with contractor service provision, including: salaries and benefits, rent, utilities, transportation and mileage, program supplies, translation services and outreach subcontractors. The mobile bus that will be utilized for this project has already been purchased by ALAS, the Community Based Organization that brought this idea forward to the County and community for consideration.

Repairs and maintenance for the bus are funded by outside sources and will not utilize MHSA innovation funding.

- Indirect Costs total **$360,000** (20% of the total project) and will cover the evaluation of this project ($145,000 or 8% of total project) as well as County administrative costs ($215,000 or 12% of total project for contractor monitoring, fiscal tracking, oversight of project).

*The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; **however**, if Innovation Project is approved, the County must receive and inform the MHSOAC of approval from the San Mateo County Board of Supervisors before any Innovation Funds can be spent.*

Mental Health Services
Oversight & Accountability Commission

# STAFF ANALYSIS – SAN MATEO COUNTY

| | |
|---|---|
| **Innovation (INN) Project Name:** | **Music Therapy for Asians and Asian Americans** |
| **Total INN Funding Requested:** | **$940,000** |
| **Duration of INN Project:** | **4 Years** |
| **MHSOAC consideration of INN Project:** | **February 23, 2023** |

**Review History:**

| | |
|---|---|
| Approved by the County Board of Supervisors: | February 14, 2023 |
| Mental Health Board Hearing: | December 7, 2022 |
| Public Comment Period: | November 2, 2022-December 7, 2022 |
| County submitted INN Project: | December 21, 2022 |
| Date Project Shared with Stakeholders: | November 15, 2022 and January 23, 2023 |

**Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):**

**The primary purpose of this project is to** *increase access to mental health services to underserved groups.*

**This Proposed Project meets INN criteria** *by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

**Project Introduction:**

The County is proposing to bring music therapy ("a form of treatment that uses music within the therapeutic relationship to help accomplish the patient's individualized goals"), as a treatment modality to Asians and Asian Americans to reduce stigma, increase literacy surrounding behavioral health, and promote referrals and linkages to behavioral health services. The County is hoping to learn if the use of music therapy is an effective outreach and engagement strategy for this target population.

**What is the Problem:**

**San Mateo County states there is a low rate of utilization of behavioral health services for Asian and Asian Americans in the County.** Demographically, Asians/Asian Americans make up approximately 32% of the population within the county; however, less than 3% of adults

and less than 2% of youth accessed behavioral health services during Fiscal Year 2019/2020. Many in this target population will only seek behavioral health services when they are in a crisis.

Low penetration rates may be attributed to the fact that Asians and Asian Americans have a higher stigma surrounding behavioral health and the County presents data that suicide rates among this population increased from 15% in 2019 to 25% in 2020. **Lack of culturally responsive behavioral health services may also be a contributing factor in the underutilization of services for this population in San Mateo County, as well as the shame that this target population may feel when other people find out about a loved one's mental health challenge, cycling back to the stigma.**

The County has concluded that Asians/Asian Americans – children, young adults, adults, and older adults - are not accessing or engaging in needed behavioral health services.

The County is proposing to test the efficacy of utilizing music therapy for this target population to provide needed services for this underserved, and unserved population.

**How this Innovation project addresses this problem (pgs 4-7):**

Working with peers and in consultation with behavioral health therapists, music therapists will work with the Asian and Asian American community to build social and emotional skills through the creation and playing of music, including utilizing instruments from Asian countries. Additionally, the County hopes the program components will allow for connectedness and cultural community-building.

The County states all staff in this project will identify as Asian/Asian American and will have experience working with this community. Projected staff are as follows:

- Trained music therapists – will facilitate music therapy group classes and the intergenerational events and performances
- Peer workers – these employees will have graduated from music therapy class and will support the music therapists
- Behavioral Health Clinician – this position will assist in designing and shaping the music therapy groups and will also be available for program participants if a behavioral health issue arises.

Once a client is enrolled to participate in the program, they will meet with a music therapist for an intake session to identify the client's musical preferences, any musical skills and abilities, any issues with sensory processing and identification of any trauma or triggers. The client will then be given the option to participate in the music therapy group class, the support group or both.

The project will utilize the following therapeutic components:

- **Music therapy group classes** – participants will work with the music therapist to work towards client-directed goals that may include creating a performance or music video

and will receive education on mental health literacy and discuss music among various cultures.

- **Music-based support groups** – the support groups will focus primarily on building empathy and connectedness and will focus on issues that participants would like to discuss openly amongst each other. The music therapist will work with individuals to teach how music can be used to work through feelings of anxiety, grief, and depression.
- **Intergenerational events and performances** – participants may elect to hold semi-annual performances where they share what they have learned during these classes with the hopes this will bring together all age groups to celebrate learning and promote empathy and connectedness within the community.

The County will rely on participant referrals being received from community-based and faith-based organizations, hospitals and medical staff who serve this population as well as word of mouth; services will be provided in places this community already gathers. (i.e. Asian/Asian American community centers, faith based organizations, libraries, parks, etc).

**The Community Program Planning Process (pgs 14-16 and Appendices 2-4):**

Local Level

In preparation for the County's MHSA three-year community planning process, a needs assessment was done to help identify community needs and priorities. One of the priorities identified included increasing culturally focused community engagement opportunities to create culturally and trauma-informed services. This project meets that identified priority. *Note: the prioritized needs assessment, stakeholder workgroup events and respective demographic participant information has been included as part of Appendix 2.*

San Mateo engaged with the community, service providers, and individuals with lived experiences to gather ideas for innovation projects between February and July 2022. A total of 19 project ideas were received and screened for regulatory compliance. A workgroup consisting of County staff, individuals with lived experience, nonprofit providers and the County's MHSA Steering Committee reviewed, scored and provided comments and suggestions informing the continued development of this project.

San Mateo will create and utilize an advisory group of Asian and Asian American clients, family members and community leaders at the beginning of this project that will inform activities, outreach and engagement strategies, and the overall evaluation and dissemination of this project.

San Mateo County's community planning process included the following:

- 30-day public comment period: November 2, 2022-December 7, 2022
- Local Mental Health Board Hearing: December 7, 2022
- Board of Supervisor Approval: Scheduled for February 14, 2023

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 21, 2022.

Commission Level

This project was initially shared with Community Partners on November 15, 2022 and the final version was again shared on January 23, 2023. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

There were three comments received and summarized below in support of this project:

- *This letter is in support of the Music Therapy for Asians/Asian Americans MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services. I am a licensed marriage and family therapist working in the county of San Mateo, I believe in the importance of therapy as part of good health and wellbeing in our community. Many Asian Americans still have a stigma towards psychotherapy and this is a major reason why they refrain from seeking counseling/mental health support even when they are in crisis. I am hopeful that once this project is offered to the community, it will enable Asian Americans to experience the mental health benefits that music allows. Music therapy is a mental health intervention that can be easily utilized across many Asian cultures, can decrease anxiety, pain, depression and promote better mood and emotional wellbeing. Thank you for supporting the Asian American Community!*

- *Please find my letter of support attached for the Music Therapy for Asians/Asian Americans MHSA Innovation Project. I truly believe in the holistic benefits of this project to provide culturally responsive mental health services for Asian/Asian American local communities. Thank you so much for your time and consideration.*

- *This letter is to support the Music Therapy for Asians/Asian Americans MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services. I'm excited for this music project and hope that this service will be made available to our communities very soon. I am currently involved with the Filipino Mental Health Initiative of San Mateo County as a community and advisory member. Music is central to our family identity and ingrained in our Filipino culture. Music brings people from all backgrounds together and creates communities that can have a common appreciation of our shared love of the lyrics, melodies, vocals, and arrangements. Music helps all of us express our emotions in safe spaces and memorializes collective moments in our lives. We need more culturally relevant services which break down stigma with mental health and other barriers to care inherent in conventional treatments. That's why this innovation project to provide music therapy to the Asian community is so important at this time. Music not only enriches our lives, music saves lives.*

**Learning Objectives and Evaluation (pgs 11-13):**

The County indicates this project is anticipated to serve at least 250 unduplicated Asian and Asian American county residents annually with this project.

The County has set forth specific learning questions for this project and will hire an external contractor to complete the evaluation. The learning questions will assist the County in determining if the use of music therapy is effective for outreach and engagement, reducing stigma and increasing behavioral health literacy for the Asian and Asian American communities.

The learning questions for this project are as follows:

1. To what extent does music therapy promote behavioral health literacy and reduce behavioral health stigma among Asian/Asian Americans?
2. To what extent does music therapy increase linkages to behavioral health services for Asian/Asian Americans?
3. To what extent is music therapy effective in promoting protective factors among Asian/Asian Americans?

The County hopes to identify the impact of this project by the following measures:

- Percentage of participants with an increase in knowledge of behavioral health
- Percentage of participants with an increase in knowledge in how and where to seek support
- Percentage of participants with a reduction in stigmatizing views of behavioral health
- Number of links and referrals made to behavioral health services and supports
- Number of self-reported participants who reach out for behavioral health services and supports
- Percent of participants who feel more connected to others in their community
- Percent of participants who feel they can face challenges in their life
- Percent of participants who look at themselves more positively

Quantitative and Qualitative data collected for this project may include:

- Retrospective surveys provided at end of group therapy and support groups utilizing specific scales (behavioral health literacy and stigma scales, community cohesion and resilience scales)
- Interviews and/or focus groups with participants of program and staff
- Program administrative records

## The Budget (pgs 19-22):

| 4 Year Budget (5 FYs) | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | TOTAL |
|---|---|---|---|---|---|---|
| Direct Costs | $ - | $ 255,000.00 | $ 250,000.00 | $ 250,000.00 | $ - | $ 755,000.00 |
| Indirect Costs | $ 5,000.00 | $ 65,000.00 | $ 50,000.00 | $ 50,000.00 | $ 15,000.00 | $ 185,000.00 |
| | | | | | | $ - |
| | | | | | | $ - |
| **Total** | **$ 5,000.00** | **$ 320,000.00** | **$ 300,000.00** | **$ 300,000.00** | **$ 15,000.00** | **$ 940,000.00** |

| Funding Source | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | TOTAL |
|---|---|---|---|---|---|---|
| Innovation Funds | $ 5,000.00 | $ 320,000.00 | $ 300,000.00 | $ 300,000.00 | $ 15,000.00 | $ 940,000.00 |
| | | | | | | |
| | | | | | | |
| **Total** | **$ 5,000.00** | **$ 320,000.00** | **$ 300,000.00** | **$ 300,000.00** | **$ 15,000.00** | **$ 940,000.00** |

San Mateo County is seeking authorization to use up to **$940,000** in innovation funding over a four-year period.

- Operating costs consist of:
  - Direct Costs total **$755,000** (80% of total project) to cover costs associated with contractor service provision, including: salaries and benefits, rent, utilities, transportation and mileage, program supplies, translation services and outreach subcontractors.
  - Indirect Costs total **$185,000** (20% of the total project) and will cover the evaluation of this project ($75,000 or 8% of total project) as well as County administrative costs ($110,000 or 12% of total project for contractor monitoring, fiscal tracking, oversight of project).

*The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; **however**, if Innovation Project is approved, the County must receive and inform the MHSOAC of approval from the San Mateo County Board of Supervisors before any Innovation Funds can be spent.*

**Resources:**

Definition of Music Therapy: Music Therapy | Psychology Today

Mental Health Services
Oversight & Accountability Commission

# STAFF ANALYSIS – SAN MATEO COUNTY

| | |
|---|---|
| **Innovation (INN) Project Name:** | **Recovery Connection Drop-In Center** |
| **Total INN Funding Requested:** | **$2,840,000** |
| **Duration of INN Project:** | **5 Years** |
| **MHSOAC consideration of INN Project:** | **February 23, 2023** |

**Review History:**

| | |
|---|---|
| Approved by the County Board of Supervisors: | Scheduled for February 14, 2023 |
| Mental Health Board Hearing: | December 7, 2022 |
| Public Comment Period: | November 2, 2022-December 7, 2022 |
| County submitted INN Project: | December 21, 2022 |
| Date Project Shared with Stakeholders: | November 15, 2022 & January 23, 2023 |

**Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):**

**The primary purpose of this project is to** *increase access to mental health services to underserved groups.*

**This Proposed Project meets INN criteria** *by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

**Project Introduction:**

The County is proposing to test the use of a peer support model by opening a culturally responsive, one stop center called Recovery Connection with a goal of increasing services that are recovery oriented through an approachable access point for individuals experiencing substance use and/or co-occurring substance use and mental health challenges.

**What is the Problem:**

San Mateo County reports an increase in substance use and/or co-occurring substance use and mental health challenges during the pandemic as evidenced by a 430% increase in overdose-related referrals to the County's Medication Assisted Treatment outreach/response team and a 21% increase in treatment of Opioid Use Disorder in the San Mateo Medical Center's Emergency Department since March 2020.

In addition, the County's 2019 Community Health Needs Assessment found that 47% of adults reported that they would not know how to access treatment for a substance use related issue. Asian American adults reported even higher numbers (64%). This data indicates that before the pandemic, a significant number of individuals in the county did not know how to access the services that were needed, which is now higher as a result of the pandemic.

**Through the community planning process, the need to reach individuals experiencing substance use challenges to support their recovery and reduce the exacerbation or development of mental health challenges was reinforced.** The current practice in the county requires individuals to sign up for formal treatment or recovery services, that are largely abstinence-based and do not meet individuals where they are at. In addition, the support offered is more intermittent than needed with more services offered during times of crisis and because recovery is not linear, many people experience struggles and relapse and again find themselves in need of more support.

**How this Innovation project addresses this problem:**

To address the need for more services that are recovery oriented with a more approachable access point for individuals experiencing substance use and/or co-occurring substance use and mental health challenges, the County proposes to test the use of a peer support model centered around the evidence-based, Wellness Recovery Action Plan (WRAP) programming by opening a culturally responsive Recovery Connection Center.

The peer support model was chosen for the proposed project as Substance Abuse and Mental Health Services Administration promotes the peer model as an effective approach and, Voices of Recovery San Mateo County, a San Mateo County peer-led recovery organization, has anecdotally seen the success of a peer support and peer-led WRAP model.

Further, the County identified other successful projects utilizing the Recovery Community Center (RCC)/Recovery Cafe model, including participant survey data from Seattle, Washington's 2019-20 Annual Report indicating that: 93% said that Recovery Café helped maintain their recovery; 87% said that Recovery Café helped reduce drug relapse; 78% said that Recovery Café helped stabilize their mental health; and 74% said that Recovery Café increased their sense of hope. While these examples are close to what San Mateo community members are requesting, they are not centered around WRAP and often have membership requirements such as sobriety or a minimum amount of engagement, which is an identified barrier in the current services offered by the County. **San Mateo County is adapting the Recovery Community Center (RCC)/Recovery Cafe model to meet the needs in San Mateo through this project.**

The Recovery Connection Center is designed for individuals with substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement.

The Recovery Connection Center will (see pages 5-7 of plan):

- use a peer support model that welcomes individuals in with an informational meeting with a peer coach and continues with voluntary peer-led services including 1:1 mentoring and support.
- center around evidence-based, WRAP programming with groups organized based on specific circumstances of participants.
- serve as a training center and provide ongoing WRAP training to peers, clinicians, and paraprofessionals to increase the number of certified WRAP providers and expand referral pathways to expand capacity countywide.
- provide linkages to more intensive behavioral health services as needed through developed partnerships and county programs.
- provide health and mental wellness classes.
- provide job readiness support and employment referral services including volunteer opportunities.
- be open 10am-7pm, Monday-Friday with the option to extend hours based on need.

## The Community Program Planning Process(see pages 16-17 of original plan)

Local Level

In preparation for the County's MHSA three-year community planning process, a needs assessment was done to help identify community needs and priorities. One identified priority included the need for integrated treatment and recovery supports for individuals living with mental health and substance use challenges. This project meets that identified priority. *Note: the prioritized needs assessment, stakeholder workgroup events and respective demographic participant information has been included as part of Appendix 2.*

San Mateo engaged with the community, service providers, and individuals with lived experiences to gather ideas for innovation projects between February and July 2022. A total of 19 project ideas were received and screened for regulatory compliance. A workgroup consisting of County staff, individuals with lived experience, nonprofit providers and the County's MHSA Steering Committee reviewed, scored, and provided comments and suggestions informing the continued development of this project.

In addition, a small advisory group of clients, family members and community leaders including representatives from partner agencies will be established early in the project and will inform all aspects of this project.

San Mateo County's community planning process included the following:

- 30-day public comment period: November 2, 2022-December 7, 2022
- Local Mental Health Board Hearing: December 7, 2022
- Board of Supervisor Approval: Scheduled for February 14, 2023

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 21, 2022.

Commission Level

This project was initially shared with Community Partners on November 15, 2022, and the final version was again shared on January 23, 2023. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

One letter in support of the project was received by the Commission in response to the sharing of this project. The letter is provided as an enclosure.

**Learning Objectives and Evaluation (see pages 12-15 of original plan):**

The project will serve an estimated 940 – 1100 participants each year through the weekly WRAP and health and wellness groups.

An independent evaluation consultant will be contracted and monitored by County staff to finalize the design of the evaluation and formally evaluate the innovation project. The project's learning goals include:

1. Does a drop-in recovery center increase access to recovery services and mental health services and supports for individuals who were not previously engaged in services?
2. What changes do individuals who participate in WRAP and other drop-in recovery center services experience in their long-term recovery, including recovery time, number of relapses, mental wellness indicators and economic mobility?
3. Does training peer workers, clinicians, and paraprofessionals in WRAP increase capacity in San Mateo County to use WRAP with individuals with substance use and mental health challenges?

The County hopes to identify the impact of this project by the following measures:

- Number and percent of participants who were not previously connected to substance use treatment or services.
- Number of participants who report they would be unlikely to have accessed services outside of the drop-in center.
- Proportion of participants from underserved populations compared to county reported penetration rates
- Participant reported length of time in recovery compared to previous lengths of time in recovery.
- Participant reported reduction of substance use compared to previous use.
- Participant reported changes in housing status, employment, income, family relationships and reducing involvement in the criminal justice system.
- Participant report quality of life changes.
- Number of trainings and number of people trained in WRAP.

Quantitative and Qualitative data collected for this project may include:

- Program and administrative data.
- Participant intake forms, surveys, and focus groups.
- Staff interviews and/or focus groups.

## The Budget (see pages 21-25 of plan)

| 5 Year Budget | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | FY 27/28 | TOTAL |
|---|---|---|---|---|---|---|---|
| Direct Costs | | $500,000 | $575,000 | $590,000 | $610,000 | | $2,275,000 |
| Administration | $10,000 | $ 75,000 | $ 75,000 | $ 75,000 | $ 75,000 | $30,000 | $ 340,000 |
| Evaluation | $ - | $ 40,000 | $ 55,000 | $ 55,000 | $ 55,000 | $20,000 | $ 225,000 |
| | | | | | | | |
| Total | $10,000 | $615,000 | $705,000 | $720,000 | $740,000 | $50,000 | $2,840,000 |
| | | | | | | | |
| **Funding Source** | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 | FY 26/27 | FY 27/28 | **TOTAL** |
| Innovation Funds | $10,000 | $615,000 | $705,000 | $720,000 | $740,000 | $50,000 | $2,840,000 |

San Mateo County is seeking authorization to use up to **$2,840,000** in innovation funding over a five-year period.

- Direct costs total **$2,275,000** (80% of the total project) and include all contractor expenses for service delivery (salaries and benefits, supplies, rent, translation, subcontracts). Contacted personnel will include:
  - 1 FTE Program manager
  - 4 FTE Peer Staff
  - 4 FTE Outreach staff who will focus on hard to reach and underrepresented populations
  - 1 FTE Administrative staff
- Indirect costs consist of:
  - Independent evaluation contract costs total **$225,000** (8% of total project) to cover costs associated with developing the evaluation plan, supporting data collection, analysis and preparing reports.
  - Administration costs total **$340,000** (12% of the total project) to cover costs for county oversight of the project including procurement, contract monitoring, and fiscal tracking.

The County anticipates that the contractor will be able to bill Medi-Cal for peer support services by year two of the project.

## Sustainability

Contracted service providers for this program will be required to develop a sustainability plan in collaboration with an advisory group with the goal of leveraging diversified funding. If the evaluation indicates that the proposed project is successful, the County will also consider continued use of MHSA funds.

*The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the County must receive and inform the MHSOAC of approval from the San Mateo County Board of Supervisors before any Innovation Funds can be spent.*

**11/14/22**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **ARISE Program** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Elizabeth Jessen, and I am a Harm Reduction Specialist at MidPen Housing. I work with Case Manager Bob Hutchinson at MidPen's Mosaic Gardens Property in Redwood City. Since this program has been utilized by the residents in the community, I have seen a great improvement. One of the resident's here at Mosaic Gardens quality of life has been greatly improved. Before the ARISE program, the resident was at risk with losing their housing due to the condition their apartment was in. There was clutter and trash throughout the unit and due to their health, the resident was incapable of cleaning it themselves. The worker who came into the resident's life as part of this program has turned their unit into a safe and comfortable home for the resident. The resident is no longer at risk for receiving lease violations that could have led to them losing their housing. This program could assist clients in maintaining their housing, as well as improving their quality of life. I personally feel that if this program was spread throughout its intended community, it would make a huge positive impact. This program alleviates the stresses of potentially losing housing while improving quality of life at the same time. The combination of these factors has the potential to greatly improve one's mental health.

Sincerely,

Elizabeth Jessen

Harm Reduction Specialist MidPen Housing

# HOUSING AUTHORITY OF THE COUNTY OF SAN MATEO

264 Harbor Blvd, Bldg A, Belmont, CA 94002-4017 ♦ Tel: (650) 802-3300 ♦ Fax: (650) 802-3372

Re: ARISE Program

Greetings-

My name is Emilyn Callado and I have been with the Housing Authority of the County of San Mateo (HACSM) for almost seven years. All of my roles have had something to do with our homeless and disabled populations. The following three programs are currently under my supervision:

1. ***Permanent Supportive Housing (PSH)*** – provide long-term housing subsidy for chronically homeless individuals and households who are also certified to have a disability (which may include severe mental illness, drug/alcohol abuse, HIV/AIDS, chronic illness and physical disabilities);

2. ***Emergency Housing Voucher (EHV)*** – as a response to folks getting displaced and/or resources being discontinued due to COVID, 222 emergency vouchers were issued to help homeless individuals and families pay their rent for a long-term period;

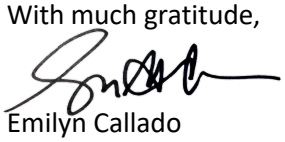
3. ***Mainstream*** – housing subsidy program, referrals must go through the San Mateo County hospital system. There is a disability requirement and preference for those who are homeless or at-risk of homelessness.

HACSM relies on the support and partnership of other SMC agencies, which includes the Mental Health Association. Our common goal is to not only house folks, but to equip them with the tools and services necessary to maintain their housing. If this means staying connected to them for several months or years after they are housed, then MHA has been able to do that with a huge portion of our clients. This has been anything from scheduling their utility bill payments, walking with them to the rental office drop box, or obtaining a cell phone.

As you can see from the descriptions of the listed programs above, we work with very specialized populations. Most of these individuals have built up walls which makes it tough for them to trust anyone. Couple that with other county resources (like IHSS, Social Security, etc.) that have strict requirements/guidelines, our clients may have trouble navigating through SMC systems and/or securing income, food, and healthcare. Our clients often lack support systems, too; they may not have friends or family who can help them, they don't know who to turn to, or they don't want to "bother" anyone.

Programs like "ARISE" are the perfect response to address the needs of our community. Clients may not even know what's out there or what their options are. ARISE staff would work closely with clients, really invest in who they are as a person so that they would be able to address their specific needs, and be able to advocate on their behalf. Housing intervention/voucher programs are only successful if people stay housed. Thank you for bringing ARISE into our SMC community. If this program stays around (or expands!), I can only see it as a benefit which will prevent our previously homeless community from returning to homelessness.

With much gratitude,



Emilyn Callado
Housing Programs Supervisor
Housing Authority of the County of San Mateo
264 Harbor Blvd, Bldg A
Belmont, CA 94002
650-508-6765
ecallado@smchousing.org

SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH & RECOVERY SERVICES**

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smchealth.org

December 21, 2022

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **ARISE** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Lisa Mancini and I am the Interim Director of San Mateo County Behavioral Health and Recovery Services.

In my 30+ years of working with older adults and people with disabilities, our current system of service for individuals living with serious mental illness (SMI) and/or substance use disorders (SUD) has struggled to provide comprehensive long- term support to allow these individuals to remain living in the community. The largest home and community-based service, In-Home Supportive Services (IHSS) requires the recipient to direct and manage their caregiver. However, clients with SMI and/or SUD, are oftentimes unable to consistently assume this role and are then at risk of losing their housing due to challenges in safely managing activities of daily living, and instrumental activities of daily living, as well as home maintenance.

The proposed project creates an exciting new model for residential in-home services designed to support clients with SMI and/or SUD who are at risk of losing their housing. This alternative to the current IHSS system that takes into consideration behavioral health needs, fills a long-standing gap in our current service delivery system. This project aligns with our goals of respecting every individual by creating supports to allow clients with SMI and/or SUD to remain living in the community. By providing in-home support and housing security for clients with SMI and/or SUD, we will understand if the ARISE program participants engagement/re-engagement with BHRS services improves. Our ultimate goal is to support the establishment of a stable home environment so that mental health and substance abuse challenges can be addressed.

Thank you for supporting this proposed project and for your commitment to improving the continuum of care for clients with SMI and/or SUD.

Sincerely,

Lisa Mancini
Interim Director

COUNTY OF SAN MATEO CALIFORNIA

**11/15/2022**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **Arise Program** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

Hello, My Name is Mona Millan, I am an Assistant Community Manager at Mosaic Garden Apartments a MidPen Housing Property.

Property Management works closely with Case Manager Bob Hutchinson by communicating daily about residents' concerns and needs to support our Residents in Maintaining their Housing we brainstorm and come up with a plan to be the best support we can be.
One of our Residents suffers with health and mobility, she was at risk of losing her housing due to unit not meeting sanitary & living standards, she became worried of her unit not passing inspection and of losing housing, it can really affect one's mental health.

The Arise Program has played a major role in supporting our community we have seen the major positive impact in our resident, When her Arise Helper Started working with her, we began seeing so much improvement all the way around for instance her unit is in much better condition her self-esteem has significantly improved, and she is not at risk any more of loosing her housing and for that we have to Thank the Arise Program Thank so much for stepping in and improving a healthy lifestyle for our residents.

I can see how such a Great Program can truly change the lives of residents.

Very Respectfully,

Mona Millan

Assistant Community Manager – Midpen Housing

**11/9/2022**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the Adult Residential In-Home Support Element (A.R.I.S.E.) Program MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Nika Rosen. I am a care manager with the Bridges to Wellness program with San Mateo County.

I referred one of my clients to the ARISE program this year and was very pleased with the services and support they offered my client. This particular client was in urgent need of in-home support and due to the shortage of IHSS workers in her area, she was going without this much needed support. MHA informed me about their pilot program, ARISE, and we were able to get this client enrolled quickly.

The Program Manager I worked with, Adrian Loarca, was wonderful! He made the process so smooth and easy. We were able to get this client support quickly which really helped to improve her quality of life. This particular client can be challenging but Adrian remained very patient and creative in the way we support this client to ensure they were happy. It was a great collaborative effort between my program (Bridges to Wellness) and ARISE to meet this client's needs.

I believe this program is very beneficial for the clients I work with and I hope ARISE will be approved to continue providing services.

Sincerely,

**Nika Rosen, MSW**
**She/Her/Hers**
Care Navigator II
Public Health, Policy & Planning
Bridges to Wellness-Whole Person Care
SAN MATEO COUNTY HEALTH
PUBLIC HEALTH, POLICY & PLANNING
T: 650-454-0339 cell
F: 650-573-1023 fax

ASIAN AMERICAN WOMEN ARTISTS ASSOCIATION

**January 31, 2023**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

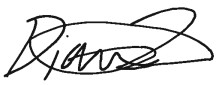
This letter is to support the **Music Therapy for Asians/Asian Americans** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services. My name is Diana and I am the Managing Director of the Asian American Women Artists Association (AAWAA). This project comes at a time when anti-Asian hate, violence and discrimination has reached the forefront of our consciousness. With my experience working in the arts, I know that music and art therapy can create multiple avenues to cultivate healing, resilience and empathy among our communities.

Having grown up in San Mateo and benefited from San Mateo County Behavioral Health resources myself, I am aware of the need for more opportunities to support the mental, emotional and spiritual growth of Asian and Asian American identified people on a visceral level. As a daughter of working class, immigrant parents, I know I am not alone in growing up with pressures to assimilate and adapt to American values, language and culture, all while learning to balance and appreciate that of my own family. I, however, would not be the person and leader I am today without the support of therapy and the artistic community that I and so many feel nourished and empowered in.

Embedding this program into the San Mateo County Behavioral Health system has the potential to change the cultural stigma around how our communities access and engage with mental health services. Many in our communities arrive here seeking resources and opportunities, but are also wary of interacting with systems that do not speak their language. Knowing that this program will offer interpretation in spaces where our communities already gather, I am confident that these music therapy classes will break down barriers. I also see this program growing beyond this initial proposal to not only reach San Mateo's intergenerational Asian and Asian American population, but also put the agency in the hands of the community to build their own spaces of creativity, care and expression.

It's with my sincere hope that this proposal be accepted as a Mental Health Services Act Innovation project. I look forward to hearing updates about this program as it is a much needed resource that can reach so many in our Asian and Asian American communities.

With Gratitude,



Diana Li

Managing Director
Asian American Women Artists Association
www.aawaa.net

January 27, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

As a poet and arts practitioner, I recognize and support the benefits of music therapy as an evidence-based intervention. I have organized and curated community events that offered a safe space for mental wellness through the arts, including music. As a Filipino immigrant and daughter of immigrants, I connect with this project on a more personal level, having seen first-hand the stigma surrounding mental health in my own family. Music therapy classes, support groups and performances can offer an opportunity for our Asian-American community to heal from historical and intergenerational trauma, and reimagine a life where our community can freely express and fully embrace ourselves.

Having partnered with the San Mateo County Behavioral Health and Recovery Services on some of my projects in the past, I can attest to how crucial their services are, and how they work to the highest standards with the utmost compassion and integrity. I am honored to write this letter of support for this project proposal, and hope San Mateo County is granted this opportunity to bring this innovative and culturally responsive program to our community members.

All my best,

Aileen Cassinetto
Poet Laureate Fellow, Academy of American Poets
Commissioner, San Mateo County Commission on the Status of Women
C 650.787.7423 / acassine@gmail.com
www.aileencassinetto.com

BAY AREA MUSIC THERAPY®

February 1, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am Ian F. Wilkerson, MT-BC, CEO and Founder of Bay Area Music Therapy (BAMT). BAMT is an organization dedicated to providing people with the highest quality integrative music therapy services. Our well-trained music therapists and adjunct providers can address the emotional, physical, psychological, and social needs of our community.

I am very excited and impressed by this wellness service being proposed for the Asian and Asian-American community. Music is a universal language where we can relate to one another and is a great tool for preventive care and mind-body connection. We appreciate how this proposal is offered to a range of ages, including children, youth, adults, and seniors. We see great potential for this wellness service to provide a unique space for the Asian-American community for self-expression, creativity, and self-empowerment – foundation of our work as therapists.

We highly recommend this innovative music therapy service be piloted for the Asian-American community in San Mateo County. This program has the power to advance physical, mental and social wellbeing of the Asian-American community and can inspire other communities to take on a similar approach.

Musically,

Ian F. Wilkerson, MT-BC
CEO & Founder
Bay Area Music Therapy
1007 W College Avenue #176, Santa Rosa, CA 95401
Board-Certified Music Therapist & Breathwork Coach
Tel: (707) 595-0995

CommunityConnections
Psychological Associates, Inc.

January 31, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

I am writing this letter in support of the **Music Therapy for Asians/Asian Americans** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am a licensed clinical psychologist whose expertise lie in the areas of Asian American mental health, diversity and culture, community mental health, and suicide prevention. I am a Director at Community Connections Psychological Associates, and a Professor of Psychology at Palo Alto University where I direct the Diversity and Community Mental Health (DCMH) emphasis. For the past 25 years, a major part of my work has focused on decreasing mental health and suicide disparities for Asian American communities – the exact problems addressed by the current Innovation proposal (i.e., low service use by San Mateo's Asian / Asian American community members, and concerning rises in suicide rates). My professional mission to decrease Asian American mental health/suicide disparities has been actualized through the development of a Mental Health Disparities course that I have taught to Ph.D. students for almost 15 years, editorship of two American Psychological Association journal special issues focused on Asian American suicide and mental health disparities, authorship of 52 publications, and community and advocacy through engaged professional research, collaborative projects, and volunteerism. As such, I feel well qualified to speak to the merits of the proposed MHSA Innovation project.

Through my work, I am familiar with the need to address service disparities amongst Asian Americans who have among the lowest rates of mental health care utilization (controlled for mental health needs) of any ethnic group in the United States for the past 24+ years. Despite decades of concerted efforts (i.e., via language-specific services, cultural training, etc.) to reduce these disparities, the problem of service underutilization remains. It has become clear that true innovation is needed to meet the behavioral health needs of this vulnerable population.

The proposed Innovation project leverages two critical innovation concepts that have been discussed in the mental health field as key solutions to eliminating such disparities: 1) partnership between behavioral health and community leaders to bring behavioral health to culturally- and community-approved sources of engagement (i.e., via the Innovation project's use of music therapy/classes in community spaces); and 2) mitigation of stigma through culturally-accepted modalities (i.e., via Asian cultures' appreciation of music). Whereas these innovation concepts have historically lacked actualization in the community, the current "Music Therapy for Asian

Americans" Innovation project utilizes each of these key concepts with promising potential to make much needed impact on the mental health needs of San Mateo's Asian American communities. The project is well-designed and prepared to make a meaningful impact in San Mateo County, and is consistent with MHSA principles.

In conclusion, the proposed "Music Therapy for Asians/Asian Americans" Innovation project is exceedingly well-poised to address the dire need for culturally congruent and community collaborative outreach/service options for underserved Asian/Asian American communities in San Mateo county. I support its request for funding, and believe it has the potential to address the concerning mental health service and suicide prevention needs of the Asian American population that comprises nearly 1/3 of San Mateo County.

Sincerely,

Joyce Chu, Ph.D.

Clinical Psychologist, PSY 23059
Director, Community Connections Psychological Associates
Professor, Palo Alto University
joycepchu@gmail.com
(650) 814-8376
Pronouns: She/Her/Hers

January 30, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **Music Therapy for Asians/Asian Americans** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

As chair and vice-chair of the San Mateo County Behavioral Health Commission, we are honored to support the Music Therapy for Asians/Asian Americans MHSA Innovation Project.

The proposed project will provide music therapy for Asian/Asian Americans as a culturally responsive approach to reducing stigma, increasing health literacy, promoting linkage to behavioral health services, and building protective factors for behavioral health. Music therapy provides an avenue for expression in a population where there is often discomfort in talking directly about behavioral health.

Asian Americans experience systemic and cultural stressors that negatively impact their mental health, but they often do not seek behavioral health services. In our county alone, Asian and Asian Americans make up 31.8% percent of our population.

This program fills a gap in our county to provide culturally sensitive services to a vulnerable population.

Sincerely,

Chris Rasmussen, San Mateo County Behavioral Health Commission Chair
Sheila Brar, San Mateo County Behavioral Health Commission Vice-Chair

izzi
early education

February 3, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am Angel Barrios, the Executive/Program Director for Izzi Early Education, a non-profit organization We are the federal grantee for Head Start and Early Head Start serving children ages 0 -5 years old through our infant/toddler and preschool programs.

Izzi is excited to see this proposed project will provide music therapy for Asian/Asian Americans as a culturally responsive approach. The proposed project is innovative in that it applies music therapy in a behavioral health setting for the Asian/Asian American community across ethnic groups and language.

Izzi recommends this project proposal be approved as it has great potential to provide physical, mental and social well-being for the Asian-American community in San Mateo County and across California.

Best regards,

Angel Barrios
Executive/Program Director
650-578-3424
abarrios@izziearlyed.org

美國華裔精神健康聯盟®
Mental Health Association for Chinese Communities

January 25, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am Elaine Peng 彭一玲, Founder/President/CEO of the Mental Health Association for Chinese Communities (MHACC). I have led and developed multiple mental health programs for the Chinese community. As a consumer and family member, I help to promote mental health services and provide peer support to the underserved Chinese community. My only purpose was to help those who desperately need help; hoping that through programs what the MHACC provide, they do not have to experience the despair I went through.

This project proposal aligns with my purpose and the MHACC's mission to raise awareness of mental health within the Chinese community through advocacy, education, research, support, and services to represent the wide spectrum of Chinese families and individuals affected by mental illness, and to help them develop meaningful and productive lives in the future. Music is an effective and creative way to connect the Chinese and Asian-American community to mental health support. As a matter of fact, our weekly "Sing A Song" program has been very successful.

MHACC strongly supports this project proposal that we think will serve underserved Chinese and Asian-American community in the San Francisco Bay Area, California and beyond.

Thank you for your consideration,

Elaine Peng 彭一玲
Pronouns: She/Her/Hers

美國華裔精神健康聯盟 執行長
Executive Director & Founder
Mental Health Association for Chinese Communities (MHACC)
ep@mhacc-usa.org | 510-362-1456 | www.mhacc-usa.org
3160 Castro Valley Blvd., Ste 210, Mailbox # 15, Castro Valley CA 94546

January 23, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

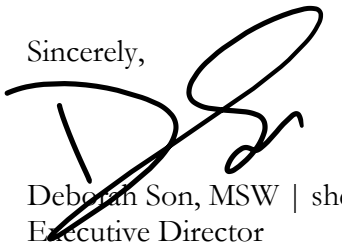
This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

As the Executive Director for the National Association of Social Workers (NASW)-California Chapter, I am well versed in the field of behavioral health and equitable systems of care, particularly as they pertain to marginalized communities and those of immigrant and refugee identities. My work spans across various fields including trauma-informed care, anti-violence, children and family services, and public and behavioral health.

I am happy to see there is a unique behavioral health service being proposed to a community in high need of such services - the Asian and Asian-American community. This project would address a key priority of NASW-California Chapter – health equity and access. The Asian and Asian-American community deserves equitable and meaningful access to behavioral health services. Amid the worldwide pandemic, racial tensions, and economic distress, NASW-CA believes it is important now more than ever that we advocate for equitable access to well-being. This project proposal offers an innovative and accessible program to connect behavioral health services to a community that has a history has limited access to behavioral health services due to various barriers, including behavioral health stigma and limited trust with institutions and western therapy.

NASW-CA is honored to offer our strong support for this innovation project proposal. We hope this project is approved and offered to the community.

Sincerely,



Deborah Son, MSW | she/her
Executive Director
National Association of Social Workers - CA Chapter | naswca.org
2110 K Street, Sacramento, CA 95816
(916) 379-7604 | dson.naswca@socialworkers.org

NEMS NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
a california health+ center

January 12, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

**RE: Proposed MHSA Innovation Project Plan Project: Music Therapy for Asians/Asian Americans**

Dear MHSOAC Commissioners:

On behalf of North East Medical Services (NEMS), I would like to provide my support for the Music Therapy for Asians/Asian Americans MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services. For over 50 years, NEMS has served as one of the largest federally qualified health centers (FQHCs) in the United States targeting the medically underserved Asian population. Based in the San Francisco Bay Area with clinics in San Francisco, Daly City, and San Jose, we offer comprehensive health care and enabling services to over 67,000 patients, including mild to moderate behavioral health services. As a FQHC, we provide care in underserved communities for everyone, regardless of their ability to pay or documentation status. Most of our patients are low-income, immigrants, and prefer to be served in a language other than English. Approximately 90% of our patients identify as Asian, and more than 80% of our patients prefer to be served in a language other than English.

Music therapy is a distinct therapeutic practice—differentiated from simply playing music in a group—as it is goal directed under five goal areas: social, emotional, cognitive, spiritual, and physical. Music therapists are specially trained to be mindful of music that could be triggering and to keep the group focused. Research indicates that music therapy promotes relaxation, verbalization, interpersonal relationships, and group cohesiveness, and can serve as a non-threatening entry point for processing symptoms, including symptoms resulting from trauma.

In San Mateo County, Asian American and Pacific Islanders (AAPIs) make up a third of all residents, but they have the lowest utilization rate of specialty behavioral health services compared to other races and ethnicities. In fact, only 1.6% of AAPI youth and less than 3% of all AAPIs accessed specialty mental health services in 2019-2020. On the contrary, the percent of suicide deaths by race/ethnicity showed an increase for Asians from 15% in 2019 for to 25% in 2020 in San Mateo County, which indicates that the need for behavioral health services is greater than actual utilization.

As a medical and behavioral health care provider for thousands of AAPI residents in San Mateo County, we believe that the stigma of talking directly and openly about behavioral health issues does contribute to a low behavioral health utilization rate. As a result, music therapy could prove to be a promising Innovative project because music is typically valued in AAPI cultures, and it can serve as an initial touch point and avenue for expression in a population where there is often discomfort talking directly about behavioral health. Additionally, group music therapy can help build

connection and community with other individuals who also may also be at-risk for mental health challenges and crises.

For these reasons, we request that you approve the proposed MHSA innovation project that would fund music therapy for Asian Americans in San Mateo County. Thank you for your consideration in advance.

Sincerely,

Paul Fox, Chief Administrative Officer
North East Medical Services (NEMS)
www.nems.org

# REMHDCO

Racial and Ethnic Mental Health Disparities Coalition

January 27, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) is pleased to submit this letter in support of the **Music Therapy for Asians/Asian Americans** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services. REMHDCO represents racial and ethnic communities throughout California in our mental health advocacy efforts at the state level, particularly in regards to the Mental Health Services Act.

We have review countless Innovation projects submitted by counties as REMHDCO attends almost all of the regular Commission meetings of the MHSOAC where the MHSA Innovation plans must be reviewed and approved. While in the past, we have questioned whether what some counties brought forth projects that really fit the category of Innovation, there is no doubt in our minds that the Music Therapy for Asians/Asian Americans qualifies for funding under this component.

Furthermore, in reviewing one of the most important aspects of the proposal to REMHDCO that is Community Planning Process (CPP), San Mateo County appears to understand and embrace the spirit of the Act. First, their 3-year plan included a priority strategy *"…to increase culturally-focused community engagement and create culturally responsive and trauma-informed systems*". Planning started with outreach and then convening a workgroup with community members and service providers including people with lived experience and family members. Counties have been known to start with advisory committees made up of a majority of county staff.

San Mateo County did a lot of work to ensure that a broad range of community stakeholders would be encouraged to submit project ideas for consideration to be chosen as an Innovations proposal. Their simple and informative "Myth Busters" fact sheet was included in the materials for the Commission to review. In addition, they translated the submission packet into Spanish and Chinese.

**5901 Leona Street, Oakland, CA 94605**
**(916) 705-5018 shiramoto@remhdco.org**

We were also delighted to read that the proposal promises that early in the startup, an advisory group of Asian/Asian American clients, family members and community leaders, including representatives from the Chinese Health Initiative and the Filipino Mental Health Initiative, will be established.

It is hard not to be excited about this attempt to utilize music therapy as mental health prevention strategy for the Asian/Pacific Islander community. The success of the dynamic prevention program "Beats Rhymes and Life" that utilizes Hip Hop Therapy is well known. However, to expect the same results with the A/PI community though music therapy is not a given. We applaud San Mateo County for taking this risk.

San Mateo County's proposal notes that in San Mateo County, Asians and Asian Americans make up 1 in 3 residents (31.8%), but only 2.6% of Asian/Pacific Islander adults used specialty behavioral health services and just 1.6% of Asian/Pacific Islander youth used specialty mental health services in fiscal year 2019-2020 – one of the lowest penetration rates by race/ethnicity in the county. Based on this data, frankly, one would have to question why they would NOT propose an Innovation project that targeted the AAPI community.

We urge the Commission to approve this proposal. REMHDCO will look forward to following the progress and results of the **Music Therapy for Asians/Asian Americans** MHSA Innovation project.

Sincerely,

Stacie Hiramoto, MSW
Director

February 2, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Susie Vick, One Life Counseling Services Music for the Mind Program Manager. One Life's Music for the Mind Program assists seniors in San Mateo County by creating customized MP3 players for the seniors to enjoy . Seniors take a step back in time and the music unlocks memories of their past and they share the experience with the teens who assist them with using the players. I love the idea of helping the elderly and those with dementia especially find happiness and joy through this program.

I am particularly excited to see the "Music Therapy for Asian/Asian Americans" community-based program is being proposed to serve the Asian American community, including older adults. With my experience overseeing One Life Counseling's Music for The Mind Program , I see the transformative impact music has on seniors for their memories, grief and mental-emotional well-being. The music also seems to bring a noticeable sense of calmness , improve memory recall and has an overall sense of delight for the seniors.

I support this innovation project and hope that it is approved so seniors and the larger Asian American community can benefit from this program.

Best regards,

Susie Vick
Music for the Mind Program Manager
One Life Counseling Center
Phone: (650) 787-8746
Email: susie_v@onelifecounselingservices.com
www.onelifecounselingcenter.com

SAN MATEO COUNTY
API CAUCUS

"To support the API community through supporting API elected and appointed officials, and to advocate and support policies that further the goals and aspirations of the API community in San Mateo County."



January 30, 2023

Mental Health Services Oversight and Accountability Commission
1812 9th Street
Sacramento, CA 95811

Re: Letter of Support for San Mateo County Behavioral Health and Recovery Services proposal – Music Therapy for Asians/Asian Americans

Dear Commissioners:

The Asian Pacific Islanders diaspora is an underserved community when accessing and taking part in mental health programs. The many reasons are the cultural stigma associated with mental health, language barriers, and economic status. As evident from the recent shooting by an elderly Asian man on the Asian population, mental health was a factor in the tragic violence. The suspect in the Half Moon Bay shootings stated that he was not himself when he shot his victims.

San Mateo County Asian Pacific Islanders Caucus (the API Caucus) is excited about this proposed music therapy program for Asians/Asian Americans. Music bypasses culture and language barriers, making mental health access more palatable.

If more Asians accessed mental health programs, our society would benefit from increased productivity, increased quality of life for all, and the reduction of senseless social violence in general.

We strongly urge you to support this unique program.

Sincerely,

Wayne J. Lee

Wayne J. Lee
President, SMC API Caucus

274 Redwood Shores Parkway, #521, Redwood City, CA 94065 ● FPPC#1417433

COUNTY OF SAN MATEO
COUNTY EXECUTIVE'S OFFICE
OFFICE OF ARTS AND CULTURE

January 27, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

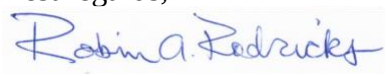
This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am Robin Rodricks (she/her/hers), Executive Director of the San Mateo County Office of Arts and Culture (OAC) and Director of the San Mateo County Arts Commission. The OAC champions the arts as essential for a healthy and vibrant community by shaping innovative cultural policies, creating inclusive and diverse programming, investing in the creative economy, and ensuring access to arts and culture for all.

The OAC and its Commission is enthusiastic about this proposed innovation project as it offers a music therapy program for our underserved constituencies – the Asian American community in San Mateo County. As the OAC strives for in its strategic cultural plan, this program is designed to educate and expose county residents to artistic and cultural expression with the support of behavioral health professionals. The music therapy classes, support groups and intergenerational events/performances align that plan's vision for an arts-rich community with diverse and inclusive arts events, programs, and services accessible and equitable to all residents.

The OAC and Culture and its Arts Commission fully support this innovation project and believes this program will inspire unity and connection across San Mateo County and be model for communities beyond San Mateo County.

Best regards,



Robin Rodricks (she/her/hers)
Executive Director
San Mateo County Office of Arts and Culture
650-347-7865
c_rrodricks@smcgov.org
cmo.smcgov.org/office-arts-and-culture

February 8, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter and attached resolution express the San Mateo County Youth Commission's support for the San Mateo County Behavioral Health and Recovery Services' Mental Health Services Act Innovation Proposal for funding "Music Therapy for Asian and Asian-Americans" program.

The purpose of the San Mateo County Youth Commission is to provide Youth Voice in local government and to advise the Board of Supervisors and County departments on youth issues.

Mental Health is a key issue identified by San Mateo Youth Commissioners; and San Mateo County Behavioral Health and Recovery Services (BHRS) programs directly address mental health issues affecting youth in San Mateo County. Innovative approaches are needed to address multi-faceted and ever-changing challenges associated with mental health.

BHRS's Mental Health Services Act Innovation Proposal for a Music Therapy Program for Asian and Asian-Americans will provide much needed support for a population that disproportionately experiences mental health issues stemming from stigma, limited language proficiency, lack of culturally responsiveness providers, and systemic barriers. This program also offers classes and support groups specific to children and youth community.

The Youth Commission enthusiastically supports this project proposal and hope San Mateo County can offer this innovative program to address the mental health needs of the Asian-American community and youth in San Mateo County and beyond.

Best wishes,

Katelyn Chang, Chair

San Mateo County Youth Commission
smcgov.org/ceo/youth-commission

# SAN MATEO COUNTY YOUTH COMMISSION

## RESOLUTION AUTHORIZING AND DIRECTING THE CHAIR OF THE SAN MATEO COUNTY YOUTH COMMISSION TO SIGN AND TRANSMIT A LETTER IN SUPPORT OF THE BEHAVIORAL HEALTH RECOVERY SERVICES' MENTAL HEALTH SERVICES ACT INNOVATION PROPOSAL FOR FUNDING OF A MUSIC THERAPY PROGRAM FOR ASIAN AND ASIAN-AMERICANS.

**WHEREAS,** the purpose of the San Mateo County Youth Commission is to provide Youth Voice in local government and to advise the Board of Supervisors and County departments on youth issues; and

**WHEREAS,** Mental Health is a key issue identified by San Mateo Youth Commissioners; and

**WHEREAS,** San Mateo County Behavioral Health and Recovery Services (BHRS) programs directly address mental health issues affecting youth in San Mateo County; and

**WHEREAS,** innovative approaches are needed to address multi-faceted and ever-changing challenges associated with mental health; and

**WHEREAS,** BHRS's Mental Health Services Act Innovation Proposal for a Music Therapy Program for Asian and Asian-Americans will provide much needed support for a population that disproportionately experiences mental health issues stemming from stigma, limited language proficiency, lack of culturally responsiveness providers, and systemic barriers; and

**WHEREAS,** for the reasons set forth above, this Commission deems it appropriate to communicate its support for BHRS's proposal for funding of a music therapy program for Asian and Asian-Americans.

***NOW, THEREFORE, BE IT RESOLVED*** *that the San Mateo County Youth Commission does hereby authorize and direct the Chair of the San Mateo County Youth Commission to sign and transmit a letter in support of the Behavioral Health Recovery Service's proposal for funding of a music therapy program for Asians and Asian-Americans.*

*Dated: February 9, 2023*

**2022-23 Youth Commission Chair:**

Katelyn Chang

The Asian American Foundation

**The Asian American Foundation**
**P.O. Box 21749**
**Washington, DC 20009**
**taaf.org**

January 31, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the "Music Therapy for Asians/Asian Americans" Mental Health Services Act Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am Charity Espiritu, Deputy Director of The Asian American Foundation's (TAAF) Anti-Hate Program. TAAF's mission is to serve the Asian American and Pacific Islander community in their pursuit of belonging and prosperity that is free from discrimination, slander, and violence.

"Music Therapy for Asian/Asian Americans" project proposal has great potential to prevent mental illness and promote wellness, connectedness and belonging. The recent tragic shootings in Half Moon Bay and Monterey Park have traumatized our Asian American communities. Our communities have already collectively experienced generations of trauma, including racism and discrimination, family separation and systemic oppression. No better time than now to move forward with innovative ways to help our communities heal and connect within the Asian American community and across racial-ethnic groups.

We at TAAF send strong support for this project proposal and hope this project is shared as a model for other organizations and leaders addressing the behavioral health needs of the Asian American and Pacific Islander communities.

Sincerely,

Charity Espiritu
Deputy Director
Anti-Hate Program

SAN MATEO COUNTY
AFRICAN
AMERICAN
COMMUNITY
INITIATIVE

**January 11th, 2023**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **Recovery Connection Drop-In Center,** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

Hello, my name is Delicia Pennix. I am one of the Co-Chairs of The African American Community Initiative of San Mateo. I am also former resident of the city of East Palo Alto, a daughter of formerly addicted parent and an advocate for recovery.

**Please consider:**

- This program would be a bridge to support clients without judgement at the time of need. When it comes to recovery, we must meet people when they are ready to recover.
- This is an opportunity to extend olive branches that are lacking in the County of San Mateo. This program will help support those who truly are on a path to re direct their lives into a success.
- This program will reach those who are ready and willing to do the work. The great thing about this program is the total WRAP included with the whole health aspect is necessary for people who are not in recovery, so imagine the good it will do for those in recovery. Support those and knocking down the stigma that there is only one way to do recovery. We Can and We Will Recover will be an everyday lifestyle change for people that access the Recovery Connection Drop-In Center.
- I see this helping to reduce our homeless population. Between addiction and mental health this would be an avenue they could pursue with the help of peers who have walked similar paths. This can also help reduce incarceration rates due to addictive behaviors. The program can do great things for the community.

Sincerely,

Delicia "Dee" Pennix
Co-Chair
African American Community Initiative

# Belle Haven Action

advocacy • inclusion • collaboration

January 10, 2023
Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the Recovery Connection Drop-In Center MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

Belle Haven Action recognizes the need for safe and supportive spaces for individuals, especially BIPOC youth, in recovery in San Mateo County and we think that Voices of Recovery is the right organization to create such a space.

Voices of Recovery has done an excellent job of engaging youth and helping to ease the barriers to recovery especially from a social perspective. We have a huge unseen problem with substance abuse and youth suicide in San Mateo County and welcome all ideas that will remind young people that their hurtful thoughts are fleeting and that can help them understand they are not alone and are worthy of help.

We know that the pandemic has increased social isolation and accompanying mental health issues. The Recovery Connection Drop in Center will provide a dedicated place for activites, events, therapy and help, thus increasing access to youth and making impulsive cries for help easier to hear. That will greatly improve health outcomes for families in San Mateo County.

Sincerely,

Julie Shanson
Director of Strategic Partnerships

Belle Haven Action
1371 Hollyburne Avenue
Menlo Park, CA 94025

650.257.0357
bellehavenaction.org

**January 12, 2023**

**Mental Health Services Oversight and Accountability Commission (MHSOAC)**
**1812 9th Street**
**Sacramento, CA 95811**

**Dear MHSOAC Commissioners:**

**My name is Stella Montanez. I have resided in San Mateo County for the last 35 years. This letter is to support the Recovery Connection Drop-in Center MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.**

**I am thankful that there is an organization that support the residents of SMC who are in dire need of direction in their life. Recovery is a long process and I feel that the drop-in center will tremendously help in extending that much needed support of someone in recovery.**

**Having somewhere to feel safe and included is important for someone in recovery. Someone to talk to, somewhere to go to when things get tough and they need that encouragement and support.**

**Voices of Recovery have helped my son turn 360 degrees. Without the people and place to go to, he would probably have not been successful in attaining the goals he worked hard for.**

**Sincerely,**

**Stella Montanez**

January 9, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the Voices of Recovery SMC Drop-in Center, MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Daniel Nava and I am Outreach Coordinator for HealthRight 360's San Mateo County programs. As an alcohol and drug counselor I work directly with clients in residential and outpatient services daily.

I know that Voices of Recovery having this drop-in center will be a great resource for the community. This space will not only create a new environment for Voices of Recovery (VOR) to provide services, but it shall create a hub for connecting individuals to resources. With VOR being heavily involved in the community as it is, I see this center as a place for myself to visit frequently to network, share resources, and learn of other resources in the community. Also, there are times when individuals in the community need to be placed on a waitlist before connecting to direct services and this center can serve as an introduction to recovery support, or a lifeline for individuals that desire a connection to community while receiving direct services.

I again would like to give my full support to this project being approved.

Sincerely,

Daniel Nava
Outreach Coordinator

FACES & VOICES OF RECOVERY

**January 13, 2023**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the Voices of Recovery San Mateo County MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

As the CEO of Faces & Voices of Recovery, and a woman in long-term recovery, with more than two decades of experience in the recovery arena, I understand the long-term outcomes of vital projects such as this.

We are excited to support, Voices of Recovery San Mateo County, a member of our Association of Recovery Community Organizations (ARCO) membership program. Recovery Community Organizations (RCOs) and recovery community centers provide valuable and accessible recovery supportive opportunities that are accessible in communities. Of the national and statewide network of RCOs, Voices of Recovery San Mateo County stands as one of the few BIPOC-led RCOs. Support is needed for organizations such as Voices of Recovery San Mateo County that provide recovery coaching, connect community members to housing and job training resources, and offer ways to contribute to volunteer opportunities.

Ultimately, this project has the ability through expanding its services to improve the behavioral health outcomes and support recovery and mental health wellness for both English-speaking and Spanish-Speaking community members, of which account for nearly half of the current service recipients of Voices of Recovery San Mateo County and nearly 25% of the county population. We are excited to offer our support for your consideration.

Sincerely,

Patty McCarthy

Patty McCarthy
Chief Executive Officer

LAW OFFICE OF CHARLES WOODSON
725 Washington Street
Oakland, California 94607

10 January 2023

**Sent via U.S. Mail**

Commissioners,
Mental Health Services Oversight and Accountability Commission
1812 9th Street
Sacramento, California 95811
Dublin, California 94568

RE: *Support for San Mateo County's Project Recovery Connection Drop-In Center*

Dear Commissioners:

This letter is submitted in support of the proposed project, *Recovery Connection Drop-In Center*, Mental Health Services Act that has submitted by Voices of Recovery in San Mateo County. *See* attachment.

I am a lawyer and my primarily practice is criminal defense in the Northern District of California. I routinely represent individuals who are in need mental health and substance abuse counseling.

I have successfully represented clients who use San Mateo County's mental health and substance abuse services. I am familiar with Voices of Recovery through their involvement in my representation of an individual who was faced charges in Superior Court of San Mateo, before the Honorable Donald J. Ayoob, Judge, and in the Northern District of California, before the Honorable Edward J. Davila, Judge. The services provided by Voices of Recovery played an enormous role in obtaining a favorable resolution for client.

The project proposed by Voices of Recovery will help my clients find support and build healthy bonds with other individuals in San Mateo county. What the proposed project would do is allow individuals have a place to turn when they are in need. When my clients are in crisis, a program like the Connection Drop-In Center would help me send them to a program provider that is respected in state and federal court, and by state and federal probation departments. The project would serve as a great resource for criminal practitioners who represent individuals who become involved in the criminal justice system because of substance abuse and mental health issues. When my clients are released from custody on bail and are in need of services, I would send my clients to Voices of Recovery.

From a case management prospective, the project has the potential to impact not only the individual, but their criminal case. Often, the reason why individuals get arrested for conduct is because were under the influence of legal and illicit substances or their behavior is due to untreated mental illness. In addition, many individuals use drugs (fentanyl for example) to numb their physical and mental traumas.

Tel. (510) 302-8780 ◆ Fax. (510) 228-0444

For my clients who are released on bail, the project can be a starting point for their recovery because it lays the foundation for directing individuals to important services. For many of my clients who are released from custody, they do not have MediCal (Drug MediCal) and without MediCal, the individuals are ineligible for services. The project would provide my clients with a social services program that can get their MediCal application started. Often times the issue is not whether the person wants to get clear, the issue is whether there is a program (i.e., funding) for the individual. Any of my client's do not even realize they are eligible for MediCal and others do not know where to begin.

This project is a wonderful opportunity to provide services to people in need.

Regards,

CHARLES WOODSON

Encl.



Law Office of Charles Woodson
Tel. (510) 302-8780 ♦ Fax. (510) 228-0444

WESTSIDE
COMMUNITY
SERVICES

245 11th STREET
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www.westside-health.org

January 9, 2023
Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

My name is Adrian Maldonado, AMFT 103808 and I am the Director of The Minna Project in San Francisco. The Minna Project is a transitional housing program with on-site clinical and reentry support for clients who are co-occurring and justice involved. The Minna Project is a collaboration between San Francisco Adult Probation, Westside Community Services and The San Francisco Department of Public Health. The Minna Project serves a coed population of up to seventy-five adults in an abstinence-based setting.

This letter is to support the Recovery Connection Drop-in Center MHSA Innovation project being submitted for approval by San Mateo County Behavioral Health and Recovery Services.
It is my view that the proposal currently before you would be an excellent addition to the reentry and recovery services for San Mateo County. The peer-based drop-in center would support the citizens of San Mateo County with recovery and a pathway to recovery at whatever stage the potential client is engaged at the point of contact. A safe and supportive space for clients to address mental health and substance abuse issues and build a network of solidarity and community.
There is substantial evidence of the efficacy of peer-to-peer support and a welcoming community for those who are challenged with substance use disorder and mental health disorders. The WRAP curriculum is effective and well documented. A one stop location which allows for access and relationship development with staff and peers is effective at meeting clients where they are, and supporting their path to recovery.
The County of San Francisco has The Community Assessment and Services Center(CASC) which is facilitated by the San Francisco Adult Probation Reentry Division and Citywide. The drop -in center in San Francisco has developed into a robust and effective hub for supporting recovery, transitional housing and employment for the residents of San Francisco. I have experienced effective coordination, case-consultation and appropriate referrals for clients who have mental health and substance use issues.
I believe that the proposal before you would be an effective resource for the citizens of San Mateo County and would be a good step in supporting behavioral health and wellness. Please feel free to contact me should you have further questions.

Adrian Maldonado, AMFT 103808
Program Director
The Minna Project
415-874-9077
AMaldonado@westside-health.org

Adr Maldonado, AMFT 103808

WESTSIDE FAMILY SERVICES

OUR COMMON GROUND, INC.

Administrative Offices
631 Woodside Road
Redwood City, CA 94061

Telephone: (650) 364-7988
Fax: (650) 364-7987
www.ocgworks.org

**January 9th, 2023**

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **Recovery Connection Drop-In Center** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

**My name is Orville Roache. I am the Executive Director of Our Common Ground. We provide Residential, Intensive outpatient, Outpatient, Recovery Residence, post treatment Transitional, and Clean & Sober Living Environments.**

As a provider of substance use disorder and mental health treatment services in San Mateo County, I write to you to communicate my complete support for the proposed drop in center. I am a firm and strong believer that as a provider of services you should focus your energy on what you do best, and do that. It is well known that sometimes as a provider you find yourself trying to be and do many different things in service of your clients. Although this is with good intentions, the unintended consequence is that your focus gets diverted from what your original mission is, and a sa result that missions suffers. Using ourselves as an example, we are a treatment provider; The only reason we started transitional and SLE homes was because many of our clients had difficulty finding post treatment housing. This is still a high need for obvious reasons, more importantly for clients who desire independent living. To have a dedicated place where our clients can receive assistance, and guidance in this and other areas would be extremely helpful. In addition, it cannot be overstated how impactful it is for persons seeking to begin their recovery journey, or those in the midst looking to develop a plan for themselves, and those on the tail end seeking continued support in different areas, to be able to obtain support and guidance from those with lived experience. The Recovery Connection Drop-in Center and the proposed services will fill an unmet need in our community. Having the service be peer based is the key. Many addicts looking for help either don't want to, or are turned off by having to contact the "government", to seek help. Being able to speak to someone who has been there and done that, breaks down walls, and barriers. Offering bilingual services is very important in this community with a large Spanish speaking population. The behavioral healthcare system needs fine tuning to improve access and reduce barriers to accessing services. Often the possible unintended consequence of a policy, protocol, or practice, are not studied enough to ensure we're not creating a barrier at the same time we're trying to eliminate one. The insertion of the Recovery Connection Drop-In Center would be a significant step in improving access and reducing barriers by formally, organizationally, and in a concentrated manner involving PEERS in the process of assisting others in need of help at all phases of the recovery process.

Sincerely,

Orville L. Roache'
Executive Director
Our Common Ground, Inc.

Retraining the Village
Reignite. Reintroduce. & Redirect

Halley Crumb, CEO and Founder
Email: Halleycrumb@retrainingthevillage.org

To whom it may concern.

This letter is to support the Recovery Connection Drop-in Center MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am Halley Crumb the Executive Director for Retaining the Village, and I am writing to you regarding the Voices of Recovery Program. Retraining The Village has existed for 10 years in East Palo Alto, California. Voices of Recovery Program has supported our community of homeless/Veteran men who were suffering from addiction and in need of peer support/AA/NA counseling.

The Voices of Recovery Program has existed for several decades in the community of San Mateo County it was a breath of fresh air to have such a much-needed service be provided to Retraining the Village's participants.
As a human service provider, we look to Voices of recovery to continue to provide this service to our community in San Mateo County.

Thank you,

Halley Crumb

January 11, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support **The Recovery Drop-in Center** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

I am currently a consultant with San Mateo County Behavioral Health Services and work primarily with the Spirituality Initiative which is a part of the Office of Diversity and Equity. For over a decade I worked as the Executive Director of Cordilleras Mental Health Center which is a 110- bed program for people with serious mental health illnesses (SMI) and substance abuse issues. I am familiar with clients/peers who struggle with co-occurring issues. I am also a faith leader in the community for over 40 years.

San Mateo County has identified the need of such a program that Voices of Recovery is applying to support. Substance abuse issues in the county have soared recently and the need for a way to increase services to the clientele is critical. The model of using peers to assist those targeted is critical. The project will be culturally responsive and accept individuals at all stages of recovery as well as being offered at no cost to those who respond. They will use the strengths model for those whom they will serve which will build confidence, maintain, and enhance recovery. To increase a client's hope and purpose is paramount in the recovery process for any individual. All the above is needed for a program to be effective and successful.

I have worked with VORSMC in my role as the Co-Chair and now Consultant of the Spirituality Initiative for many years now and find that both the leadership and the staff are responsive to the purpose and mission of what the organization tries to accomplish. At the same time they work closely with other organizations of SMCBHRS to coordinate the care of the clients. I know that if they receive this grant that this same intent and hard work will continue to govern this center as well. VORSMC is not only highly professional but provides a caring approach to those whom they serve. This attitude of support and cooperation will directly benefit the targeted clients.

Historically SMCVOR has developed their roots in the community and their eclectic approach will assist them in their outreach. They serve a wide diversity of people currently with staff that reflect the community. Since they will take individuals at all stages of their recovery, that will widen their ability to serve people who otherwise would not receive services as they would not be welcomed unless they were at a specific stage in their recovery. Welcoming people where they are on their wellness journey is critical to helping to fight stigma and other barriers for all clients.

San Mateo County BHRS has a wide variety of services to assist those with co-occurring challenges. I believe that what this program will do will bring an element of creativity that is sorely needed to reduce this latest surge in those with substance abuse by using the Recovery Café model, such as those in San Jose and Seattle. These models have shown positive outcomes resulting from sober social events; opportunities to give back through volunteerism and chores; feelings of connectedness; and having a warm physical space where people feel safe and welcomed. The Recovery Connection will provide similar recovery services to the Cafes just mentioned but, with program and approach differences. The Recovery Connection culture will be free of judgement and will meet participants where they are in their recovery journey. It will give participants choices in programs and services and help them understand those choices which will strengthen their ability to take personal responsibility for their actions and investment in their own recovery.

I enthusiastically endorse San Mateo County Voices of Recovery to receive their requested grant to open **The Recovery Drop In Center**.

Sincerely,
William S. Kruse

Reverent William S. Kruse
Consultant, Spirituality Initiative of the Office of Diversity and Equity

SERVICE LEAGUE

727 Middlefield Road, Redwood City, CA 94063 • 650.364.4664 • F: 650.365.6817 • www.serviceleague.org
Karen Francone, Executive Director

January 9, 2023

Mental Health Services Oversight &
and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the Voices of Recovery (VOR), MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Karen M. Francone, and I am the Executive Director for the Service League of San Mateo County. VOR conducts invaluable WRAP sessions at our Substance Use Disorder Program (SUD), Hope House, which is located in Redwood City. We were one of the first SUD programs in San Mateo County that embraced VOR, and we sure are glad we did. The programming that is offered assists our residents with the tools they need for success not only in their recovery but also for their daily lives.

Having a drop-in center for the recovering community will be invaluable for them in order to have a safe place to network with other folks who are on the same healthy path.

Having a drop-in center will also improve the outcomes for each individual that utilizes the services. Having a Peer Recovery model is an evidence-based practice and has proven to be an effective model. One addict/alcoholic helping another coincides with the 12-step model of "if they can do it so can I."

Sincerely,

Karen M. Francone, CADC II, NCAC I
Executive Director

January 25, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the **Recovery Connection Drop-In Center** MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Angela Lagman and I am a member of the Board of Directors for Voices of Recovery San Mateo. I am also a Certified Addiction Treatment Counselor and Reentry Social Worker who has worked individually with clients experiencing substance abuse and mental health challenges within inpatient, in-custody, and outpatient settings for over 10 years in the San Francisco Bay Area.

What excites me most about this innovation project is its culturally responsive approach and accessibility to community members struggling with co-occurring disorders. With the recent increase in opioid overdoses, overdose related deaths, and lack of recovery support, including services for non-english speaking individuals throughout the Covid-19 pandemic, it is clear that additional support models are necessary to expand access and reduce barriers to community support. Drop-in centers are one of the most effective ways to meet some of the most vulnerable populations where they are in a less intimidating environment where they are comfortable sharing their needs on their own time and terms. It is also important to note that challenges occurring due to both substance use and mental health that prevent individuals from making and keeping appointments in community would be greatly reduced by the accessibility and flexibility of a drop-in center, simplifying the process of getting their needs met. Additionally, with the help of culturally responsive peer mentors with lived experience, each individual has the opportunity to experience being seen and heard (some, for the very first time in their lives) in ways that could greatly increase the understanding they have of themselves, their individual challenges, and about navigating through the world around them. Whether an individual is directed to a drop-in center or comes across one on their own, it is their personal decision to walk through that door. This proposal, if supported, would ensure that there is a door to walk through to begin with and, just as it is believed for everyone seeking a positive change in their circumstances, everyone has to start somewhere. Thank you for taking the time to read this support letter and for considering this innovation project.

Sincerely,

Angela Lagman, CATC III

January 12, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

This letter is to support the MHSA Innovation project being submitted for approval by the San Mateo County Behavioral Health and Recovery Services.

My name is Elaina Wolfe. I work for The County of San Mateo, Correctional Health, Choices Program, employed for 14.5 years.

- What excites me about this proposal is that it will serve many different cultures and ethnicities. We are in need of services that include "Spanish speaking" which is a community so underserved when it comes to Mental Health and Recovery.

- I can attest to the growing population of Mental Health and drug abuse. Some refuse to go to a residential treatment program because they have spent time in jail and now have clean time. Having a place to go to where it feels safe, is a sense of being a part of that community, a place to go to without judgement. To be able to talk to people who have life experience that can be relatable. A place to help with basic needs and resources, learning recovery and job readiness tools. The "Recovery Connection" will give the target population hope and opportunity which is greatly needed.

- I full heartedly believe this new project will reach the intended community. Anytime staff has "lived experience" who has been in the same position as the client, understands with compassion and is there to reach the client there is meaningful connection and atmosphere. It builds a trust and a community that feels safe, which is what Voices of Recovery is famous for.

- I have watched people, even Choice's clients, attend and work for Voices of Recovery and be highly successful. Some even end up working for the county. I, myself have attended WRAP training and participated in the WRAP classes and was encouraged to go to keep a WRAP plan for my own life. I see the Project successful with improving behavioral health outcomes by creating a safe

environment, a community full of compassion, services to help with all areas of the participants needs and introducing WRAP which is an ideal evidence based recovery tool.

Sincerely,

Elaina Wolfe
Choices Program Counselor II

January 7, 2023

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC Commissioners:

I am pleased to provide this letter of support for the Recovery Connection Drop In Center project proposed by Voices of Recovery San Mateo County. Having served as the Board Treasurer for Voices of Recovery (and concurrently employed as Chief Financial Officer for Ravenswood Family Health Network, a Federally Qualified Health Center in East Palo Alto) for over a decade, I have witnessed their success in expansion of programs to serve and assist in the rehabilitation challenges particularly for the most vulnerable low income population. Their peer support model is an effective and cost efficient method to reach clients with substance use, prior incarceration and/or mental health issues.

The Drop In Center has been an objective of both the County of San Mateo BHRS and Voices of Recovery for at least the last 15 years. Their programs have provided a culturally sensitive whole person approach supporting individuals with mental health, substance abuse and other life challenges with evidence based success.

I believe the Drop In Center will expand access to recovery service for between 1,000 and 1,500 new low income clients that are not being reached currently. It will be a cost effective way to:

- Expand service accessibility in San Mateo County where there are many barriers to care;;
- Continue the measurable success of the Peer Recovery model in San Mateo County;
- Provide continuous training for WRAP facilitators in the local area;
- Continue to provide jobs as a stepping stone to success for low income clients;
- Provide a supervised safe and supportive environment for multicultural populations.

I believe support of this project is one of the most important decisions the Commission could make, and I would ask the commissioners to provide support for this vital project.

Sincerely,

R. Wayne Yost

R. Wayne Yost, CPA, CFE

rwycpa@gmail.com – (707) 888-0950

# AGENDA ITEM 6

**Information**

**February 23, 2023 Commission Meeting**

**Workplace Mental Health Report Presentation**

**Summary**: The Commission will hear a presentation on the report Working Well: Supporting Mental Health at Work in California. The Commission will consider adopting the report and discuss opportunities and next steps to support workplace mental health.

**Background**: California's employer community plays a central role in mental health care access and quality. Nearly 49 percent of adults and dependent children have health coverage through an employer sponsored health plan. That coverage includes support for mental health needs. Yet the state has not fully leveraged the capacity of employer-sponsored health coverage – and employers more generally – to address stigma, support prevention, and promote improved access to high-quality behavioral health services, from early intervention to support for serious mental illnesses, for employees and their family members. Promoting mental health in the workplace is an essential element in California's strategy to support resiliency, prevention, and improve access to care, including mental health equity.

To seize this opportunity, Senate Bill 1113 (Monning) directed the 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, Ph.D. (Project Chair) and Mara Madrigal-Weiss. Since 2019, the Commission has engaged employers and employees, subject matter experts, and others to develop policy recommendations and standards for workplace mental health. The standards build upon the work already underway in many workplaces and have benefitted from similar efforts by the Mental Health Commission of Canada, the World Health Organization, and the U.S. Surgeon General.

Should the Commission adopt this report and standards, Commission staff will begin to implement strategies to support workplace mental health. Commission staff will work with the Governor and Legislature to establish the Center of Excellence on Workplace Mental Health. There will be further opportunities to engage employers, including the State of California, to enhance mental health benefits and improve access to a broad spectrum of high-quality mental health care.

**Enclosures (3):** (1) Working Well: Supporting Mental Health in California report and standards, (2) Workplace Mental Health Implementation Opportunities, (3) Public Comment.

**Handout (1):** Powerpoint presentation

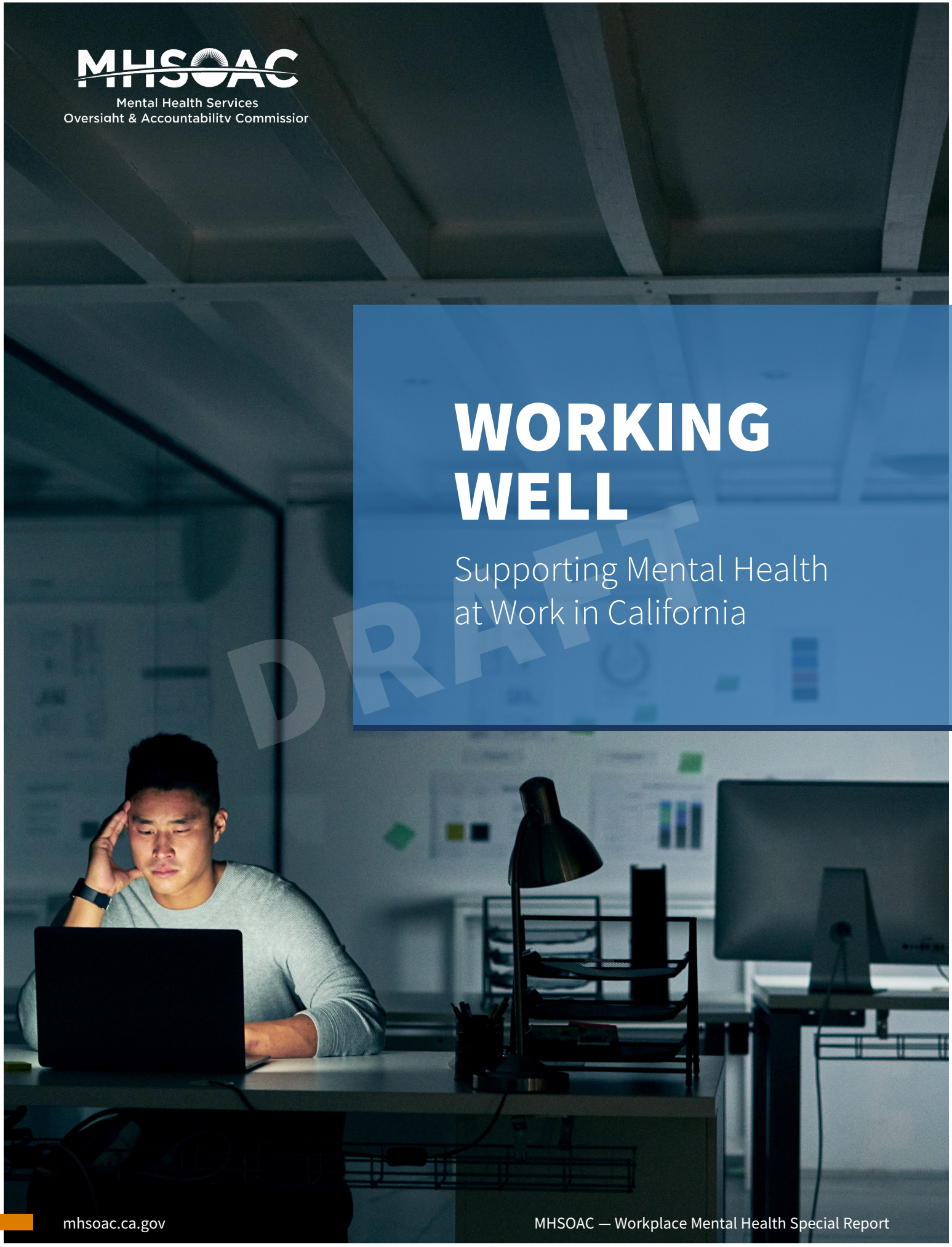
**Motion:** The Commission adopts Working Well: Supporting Mental Health in California report and workplace mental health standards.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

# WORKING WELL

## Supporting Mental Health at Work in California

DRAFT



TRANSMITTAL LETTER TO COME.

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# 01 INTRODUCTION

## Executive Summary

Nearly one in five Californians face an unmet mental health need. To make progress in addressing these needs – and in preventing them – the state must promote mental health and wellbeing in the settings where Californians live, learn, work, and play. The workplace, where working-age adults can spend as much as a third of their time, is a key setting for supporting mental health. Increasingly, employees report that their work environment harms their mental health. Burnout, depression, and anxiety are on the rise. Employers are responding with new strategies to support the mental health of their workforce. To make the most of these opportunities and ensure they reach as many Californians as possible, policymakers should pursue a range of pathways, as outlined in this report, to support employees and employers.

# About the Commission

The Mental Health Services Oversight and Accountability Commission was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. Californians created the Commission to provide leadership and guidance to support the transformation of California's mental health system.

The 16-member Commission is composed of one Senator, one Assembly member, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the Governor's appointees represent different sectors of society, including individuals with mental health needs, family members of people with mental health needs, law enforcement, education, labor, business, and mental health professionals.

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# About the Workplace Mental Health Project

Senate Bill 1113 (Monning, 2018) directed the Commission to establish a framework and voluntary standards for promoting mental health in the workplace. To carry out this directive, the Commission launched a Workplace Mental Health Project and Subcommittee chaired by Commissioner Keyondria Bunch, Ph.D., and Vice Chair Mara Madrigal-Weiss.

The project engaged employers, employees, subject matter experts, and others, to develop the voluntary standards introduced in this report. Developing the standards was a collective effort with input from the following sources (see Appendix D for a complete list of organizations and interviewees)*:

## Employer and employee engagements

The Commission engaged dozens of employer and employee representatives from multiple sectors and industries. The sectors and industries included health care, education, labor, business, cultural advocacy organizations, and more. In addition, the Commission conducted anonymous interviews with representatives of California's largest employers.

## An employer roundtable

The Commission hosted an employer roundtable to gather information about best practices, barriers, and opportunities to promote mental health in the workplace. Participants discussed opportunities to support employees at work through prevention, combating stigma and discrimination, and improving access to mental health services.[1]

## Research and best practices from the literature

The Commission contracted with experts from the University of California, Davis and Amsterdam University Medical Center. The researchers prepared a brief outlining a landscape analysis and foundation for workplace mental health in California. The brief summarizes the challenges and opportunities for mental health at work and compares international models for workplace mental health standards.[2]

## Engagement with international researchers and subject matter experts

The Commission engaged researchers and subject matter experts on workplace mental health from around the United States, Canada, Australia, the Netherlands, and the United Kingdom to discuss models for standards, best practices, and implementation.

## Small group engagements with employees

The Commission met with small groups of employees from both State and local governments to discuss risks, challenges, and opportunities to support employee mental health.

## Individual conversations with Commission-contracted partner groups[3]

The Commission met with contracted advocacy groups. These partners provided insight into cultural diversity in the workplace, needs across different organizations, and strengths that could be leveraged when developing workplace mental health strategies. Partner groups included the African Communities Public Health Coalition, Boat People SOS, the California Association of Local Behavioral Health Boards & Commissions, the California Pan-Ethnic Health Network, Health Access, Healthy House within a MATCH Coalition, the Hmong Cultural Center of Butte County, NAMI California, United Parents, VetART, and Vision y Compromiso.

* Quotations included in this report are anonymous to protect the privacy of employers and their representatives.

### A landscape analysis of the current state of workplace mental health in California

The Commission contracted with One Mind at Work, a global workplace mental health nonprofit organization based in California, to prepare a landscape analysis. The analysis summarizes current trends and needs of employers and employees. It also looks at the state of access to mental health services, organizational culture change, mental health literacy, and stigma reduction.[4]

### Public engagement meetings on employee mental health

The Commission conducted a range of public engagement meetings. The first meeting, on May 27, 2020, included two panels of subject matter experts who were early adopters of workplace mental health programs. These experts represented a variety of organizational, employee, and employer perspectives. The second meeting, on March 23, 2021, included talks by three subject matter experts on workplace mental health. The presentations discussed the workplace as a strategic environment for prevention and early intervention, why workplace mental health matters for business, and how to achieve mental health parity, in which public and private insurance plans treat mental health conditions and physical health conditions equally.

## Acknowledgments

The Commission expresses its gratitude to the many partners and participants who provided time, expertise, and input to help shape this report and the standards it sets forth. In particular, the Commission wishes to thank One Mind at Work, Carolyn Dewa, Ph.D., and Social Finance for collaboration on research, employer engagement, and support for this report. Commission staff who contributed this work include Brian Sala, Ph.D., Ashley Mills, Timothy Smith, and Lynze Thornburg, among others. Finally, the Commission would like to acknowledge and thank all the employer representatives, researchers, advocates, community members, policymakers, providers, and peers who gave their time, energy and expertise to inform these recommendations and standards.



02

# THE WORKPLACE AS A STRATEGIC SETTING TO PROMOTE MENTAL HEALTH

# The Workplace as a Strategic Setting To Promote Mental Health

On average, adults in the U.S. spend a third of their time at work. As a result, the workplace represents an exceptional opportunity to promote employee mental health.[5] A supportive work environment provides stability, purpose, growth, and social identity, all factors that contribute to positive mental health.[6]

An unsupportive work environment can lead to burnout, depression, anxiety, and other mental health challenges.[7] Promoting mental health in the workplace should be an essential element in California's strategy to support resiliency, prevention, and improve access to care, including mental health equity.

California's employer community plays a central role in mental health care access and quality. Nearly 49 percent of adults and dependent children have health coverage through an employer sponsored health plan.[8] That coverage includes support for mental health needs. Yet the state has not fully leveraged the capacity of employer-sponsored health coverage – and employers more generally – to address stigma, support prevention, and promote improved access to high-quality behavioral health services, from early intervention to support for serious mental illnesses, for employees and their family members.

California's employer community is an important and motivated partner in promoting mental health and wellbeing. Unaddressed mental health needs undermine employee attendance, performance, and productivity. Depressive disorders alone cost the U.S. economy an estimated $47.6 billion annually in absenteeism and diminished productivity.[9] In a 2021 survey of 1,500 adults in full-time jobs, 68 percent of millennials and 81 percent of Gen Z workers reported having left a job for reasons linked to their mental health.[10] In the same survey, those who felt their employer supported their mental health were more than twice as likely to say they intended to stay at their company for two or more years. Employees who receive mental health support in the workplace are five times as likely to say they trust their company and its leaders.[11]

The COVID-19 pandemic highlighted the important relationship between work and mental health.[12] The pandemic shifted views about what it means to "go to work" and caused near-term reductions in employee mental health. A 2020 survey of more than 1,000 employees across the U.S. found that 51 percent said their mental health at work had worsened since the pandemic began.[13] Essential workers, parents, and adults who identified as Black, Hispanic, or Latino reported the biggest increases in negative mental health impacts.[14]

*"We must build and promote resilience in our workplace culture. This means we must rise above the adversity that COVID-19 presents and find ways to thrive and protect our employees against harm."*

— Subject Matter Expert
Workplace Mental Health

Many employers also recognize the relationship between mental health and diversity, equity, and inclusion. Progressive employers are aligning their workplace wellness initiatives with opportunities to address inequality and discrimination in the workplace. Those efforts build upon the recognition that bias, toxic environments, lack of representation, and discrimination in the workplace can exacerbate mental health challenges. Targets of inequity and discrimination may include people of color, people who identify as LGBTQ+, people with a disability, those for whom English is a second language, and others. To fully support employee mental health, employers are building inclusive workplaces that respect and address the diverse needs of all employees.

Many employers are addressing workplace mental health challenges by adding or expanding services and supports such as tele-mental health benefits, employee assistance programs, mental health days, or workplace trainings.[15,16] The guidance and recommendations in this report builds upon those efforts. The Commission's goal is to embrace workplace mental health as an opportunity to address stigma, increase awareness of mental health resiliency, promote prevention, and create avenues to improve access to support, treatment, and recovery that improves mental health outcomes for all Californians.

In this work, the Commission has developed voluntary standards for workplace mental health that includes principles, policies, and procedures employers can adopt to promote mentally healthy workplaces. The standards build upon the work already underway in many workplaces and have benefitted from similar efforts by the Mental Health Commission of Canada, the World Health Organization, and the U.S. Surgeon General.

The Commission also has outlined recommendations for the State of California to leverage the workplace as a strategic setting for promoting mental health and wellbeing.

Too many Californians are currently struggling to address their mental health needs. The state must embrace the employer community as a partner in ensuring that every Californian has access to high-quality, effective mental health care when and where it is needed.

# 03 FINDINGS AND RECOMMENDATIONS

# Findings and Recommendations

To ensure that all Californians have access to affordable, high-quality mental health services and supports, the State must leverage strategic settings to address mental health needs. The workplace is an often-overlooked setting for reaching California's working-age adults and their dependents. The workplace represents a powerful lever of change.

FINDING 1

The workplace is a strategic setting to promote the mental health and wellbeing of working-age adults and their dependents through stigma reduction, improved awareness of mental health needs, and better access to care.

Even as the COVID-19 pandemic placed exceptional strains on individuals and families, it also raised awareness among employers of workforce mental health needs. Employers consistently shared with the Commission their challenges in understanding how best to address stigma, improve mental health literacy, and ensure access to care for serious mental illnesses that affect employees and their family members.

**75%**

**of employees struggle with an issue that impacts their mental health**

**80%**

**of employees say shame and stigma prevent them from seeking help**

Research indicates that some 75 percent of employees struggle with an issue that impacts their mental health. Yet eight in 10 say shame and stigma prevent them from seeking help.[17] Assertive anti-stigma strategies that ease shame are essential to workplace mental health efforts.

*For strategies to create a stigma-free culture, see Standard 2.*

Mental health literacy encompasses five key components: **understanding how to obtain and maintain positive mental health, knowledge and recognition of mental health challenges, reducing stigma, promoting help-seeking efficacy, and improving attitudes about seeking mental health support.**[18] It enables individuals and organizations to comfortably discuss mental health needs, recognize the signs of mental health challenges, and find practical help and resources.[19] What constitutes literacy in these areas may vary depending on a person's age, culture, and other contextual factors. Poor mental health literacy prevents people from seeking help when needed, resulting in worse mental health outcomes. Enhancing mental health literacy is a core strategy to reduce mental health risks and promote mental wellbeing among employees.

*For strategies to improve employee mental health literacy, see Standard 3.*

Many employers report not knowing how to access benefits that offer the robust array of services needed to support employee mental health. Furthermore, employers cite a need for more information about best practices in mental health, a prerequisite to obtaining quality mental health services and support. Employers also search for models and resources to guide them as they assist employees. Even companies with the most comprehensive health benefits report that they often face gaps in their ability to support employees who need help, particularly care for serious and persistent mental illness.[20]

## RECOMMENDATION 1

In partnership with the private sector, the Governor and Legislature should launch a center of excellence on workplace mental health that can fully leverage the capacity of employers to address stigma, improve mental health literacy, and ensure access to comprehensive mental health care.

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The center of excellence should be supported by public and private funding. Ideally housed at a research university, the center should harness the expertise of mental health consumers, the employer community, mental health providers, and researchers to:

- Conduct a landscape analysis of existing best practices, tools, and resources for workplace mental health and develop and disseminate information, tools, and strategies to lessen stigma and promote mental health literacy.
- Assess the return on investment of employer support for workplace mental health, as well as the cost-effectiveness of using tax credits or other incentives to encourage employer investments in workers' wellbeing.
- Offer technical assistance and support capacity-building in California's employer community to expand the use of effective workplace mental health strategies.

The California Department of Human Resources, which represents one of the largest employers in the country, should have an active leadership role in the design of the center of excellence. The Department also should position itself as an active client of the center.

FINDING 2

California can improve access to mental health care for working adults and their family members by leveraging employer-sponsored mental health coverage to promote access to high-quality, outcome-driven care.

California has long supported mental health care parity, the equivalency between the quality of care and coverage for mental and physical health needs. Yet despite significant efforts, state and federal initiatives have yet to achieve parity.

Access to robust mental health care through private sector insurance faces a range of challenges. Nearly all employers struggle to ensure that their employees have access to the mental health and related services that are covered through their health plans.

Network adequacy – a health plan's ability to provide enrollees with reasonable access to providers – poses a significant barrier. A 2019 survey by the California Health Care Foundation found that half of California residents reported unreasonably long wait times for mental health care services, a challenge exacerbated by the pandemic.[19] Even when benefits are guaranteed by health insurance plans purchased on behalf of an employee or family member, delays in accessing care far exceed acceptable standards.[15]

Quality of care also is a concern. People with private insurance who receive both mental health and medical care are significantly more likely to rate their mental health network as less adequate than their medical network.[21] This challenge is especially acute for communities of color and members of the LGBTQ+ community, who face the extra hurdle of finding a provider who can offer culturally competent care.[22]

Low private insurance reimbursement rates for mental health providers are among the most significant barriers to improving network adequacy. A recent national multi-year analysis by the Congressional Budget Office showed that private plans paid 13 to 14 percent less than Medicaid for common mental health services. Providers join and remain in health plans only if they are paid enough. Many mental health providers, rather than accept below-market reimbursements for their services, opt to accept no insurance. These providers see only patients who can pay privately, further reducing the pool of providers available within insurance networks.[24]

Most Americans believe that mental health services are too expensive and inaccessible. According to a comprehensive 2018 study, one in four Americans must choose between getting mental health treatment and paying for daily necessities.[25]

1 in 4 Americans

must choose between getting mental health treatment and paying for daily necessities.

*For strategies to aid conversations with insurers to increase access to mental health care, see Standard 3.*

Copayments for mental health also are high. For employees, out-of-pocket costs are one of the main barriers to accessing mental health care, even for those with quality insurance coverage.[19] For example, mental health services often are defined as a specialty benefit, with high employee copays.

Even when mental health services are standard benefits, care coordination often is limited. Many employers and employees report significant challenges navigating between physical and mental health care systems. The public mental health system has models to guide private insurers in addressing this challenge. Such models include case managers, peer navigators, and *promotores*, a Spanish term that describes trusted individuals who empower peers to advance their health through education and to navigate health care resources and services.[26]

Improving access to care will require ensuring that more Californians, including diverse Californians, enter mental health professions. Mental health care works best when there is a high level of comfort between client and provider. Mental health consumers often are more confident seeing a provider with a background like their own. The lack of diversity in mental health professionals is stark, however. According to 2015 data from the American Psychological Association, some 86 percent of psychologists in the U.S. are white, 5 percent are Latino, 5 percent are Asian, and 4 percent are Black – a profile that is significantly less diverse than the U.S. population.[27]

*For strategies to aid conversations with insurers about diversity and cultural competence within provider networks, see Standard 3.*

The range of care covered by private health insurance plans represents another major concern. Too often, private health insurance does not cover the type of care that is required for severe mental health conditions, such as psychiatric hospitalization or coordinated specialty care for psychosis.[28] Providers report that they often encourage eligible families to drop their private health coverage and instead enroll in Medicaid, which typically offers more comprehensive services than private plans.

To address this issue, the State should explore strategies that leverage and shape the private insurance marketplace. Parity enforcement is one such strategy. Another is to call upon the major purchasers of mental health benefits to shape access to care, quality of care, and comprehensive coverage. The California Public Employees' Retirement System is among the largest of these. In 2019, CALPERS spent more than $9.2 billion in health benefits for some 1.5 million public sector employees and their families across more than 2,800 public agencies in California. The Governor and Legislature should consider working with CalPERS to shape the behavioral health marketplace to improve access to high-quality, comprehensive mental health care. California also should consider partnering with other states and the federal government to leverage other pension and health benefits systems to improve the alignment of commercial mental health coverage with needs.

## RECOMMENDATION 2

The State should work with large health care purchasers, beginning with CalPERS, to leverage the purchasing power of public sector employers toward improved access to care, quality of care, and comprehensive coverage.

The State can work with some of the largest purchasers of benefits to enhance mental health coverage for employees. This process should include obtaining feedback from employees, consumers, family members, and others to understand gaps in coverage and opportunities to better meet the mental health needs of consumers and their families.

The State also can partner with other jurisdictions – state and federal – to explore opportunities to enhance mental health-care provider reimbursement rates. This process will encourage parity with medical health coverage reimbursements and bring more providers into insurance networks.

To meet the needs of California's diverse population, networks must ensure provider diversity and cultural competency, and help bring diverse trainees into mental health professions. In developing partnerships, the state should leverage the private sector to meet the demand for a diverse mental health workforce by strengthening the education, training, and support for early career mental health professions, including paraprofessionals.

## FINDING 3

California lacks adequate data about workplace mental health, including information about mental health status, work-related mental health risk factors, workplace intervention strategies, insurance coverage, and access to services.

Without valid, reliable, and timely data, California is unable to measure and monitor workplace mental health. It is also unable to measure and monitor progress in improving access to care, reducing stigma, and promoting mental health literacy. Clear and compelling data are essential to establish benchmarks for employers and employees, and to monitor the progress of workplace mental health initiatives.

*For strategies to build and track metrics related to employee mental health, see Standard 5.*

*"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, and 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."*

— Subject Matter Expert
Workplace Mental Health

## RECOMMENDATION 3

A new State center of excellence – called for above – should establish and implement a research agenda to identify workplace mental health indicators and measure and monitor progress on workplace mental health practices and policy. The center should work in partnership with the private sector. The research agenda should begin by:

- Establishing indicators and benchmarks to measure and monitor progress across a range of workplace mental health practices, including stigma, mental health literacy, and pathways to care.
- Engaging health care purchasing groups, such as the Pacific Business Group on Health, to identify gaps in insurance coverage and establish optimal reimbursement rates where necessary. Special attention should be paid to gaps that create risk for needing public-sector services, such as coordinated specialty care for psychosis.
- Partnering with public and private agencies to identify industries and occupations with the highest risks for creating psychological harm, explore strategies to mitigate these risks, and support resiliency and economic opportunity for employees and employers.



The Commission and its partners in developing this work are available to guide the implementation of these recommendations.

# 04 IMPLEMENTING THE STANDARDS

# Implementing the Standards

The following implementation guide is intended to support employers as they explore opportunities to incorporate mental health standards into their workplaces. Employers are encouraged to conduct the following activities on a recurring basis, as appropriate, to enable successful implementation of the standards.

1. **Establish leadership commitment and support**
   As noted in Standard 1, leadership commitment and support are essential for the success of workplace mental health initiatives and set the tone for discussions related to mental health. Organizations should seek to secure this support as a first step toward embarking on an implementation plan for addressing workplace mental health.

2. **Conduct a situational analysis or "discovery report"**
   A situational analysis collects and reviews data, personal narratives, and other information regarding organizational mental health. Such an analysis is an important initial step in implementing mental health initiatives. A situational analysis will provide data that decision-makers can leverage to better understand the current state of mental health in an organization and identify priority focus areas. The analysis can be based on a variety of data sources, including absenteeism and turnover rates, and use a range of measurement tools, such as in-person discussions, wellbeing surveys, and mental health screenings.

3. **Determine appropriate intervention strategies**
   Based on the situational analysis, organizations can implement workplace mental health strategies to address identified gaps or priority areas. The most effective and appropriate strategies will differ across organizations depending on the current state of mental health and identified gaps or focus areas. Examples of common strategies include promoting physical activity during the workday, establishing team norms around working hours, and investing in mental health training for managers.

4. **Review outcomes**
   Continuous improvement reviews should evaluate both outcomes and the governance processes used to make decisions. Outcomes are assessed by tracking tactical data such as participation rates and survey findings. Governance processes, such as working groups or steering committees, use tactical data to make decisions.

5. **Adjust interventions**
   After reviewing outcomes, leadership and decision-makers should make data-informed decisions regarding adjusting workplace wellbeing initiatives. Steps 2-5 should be conducted on an ongoing basis.

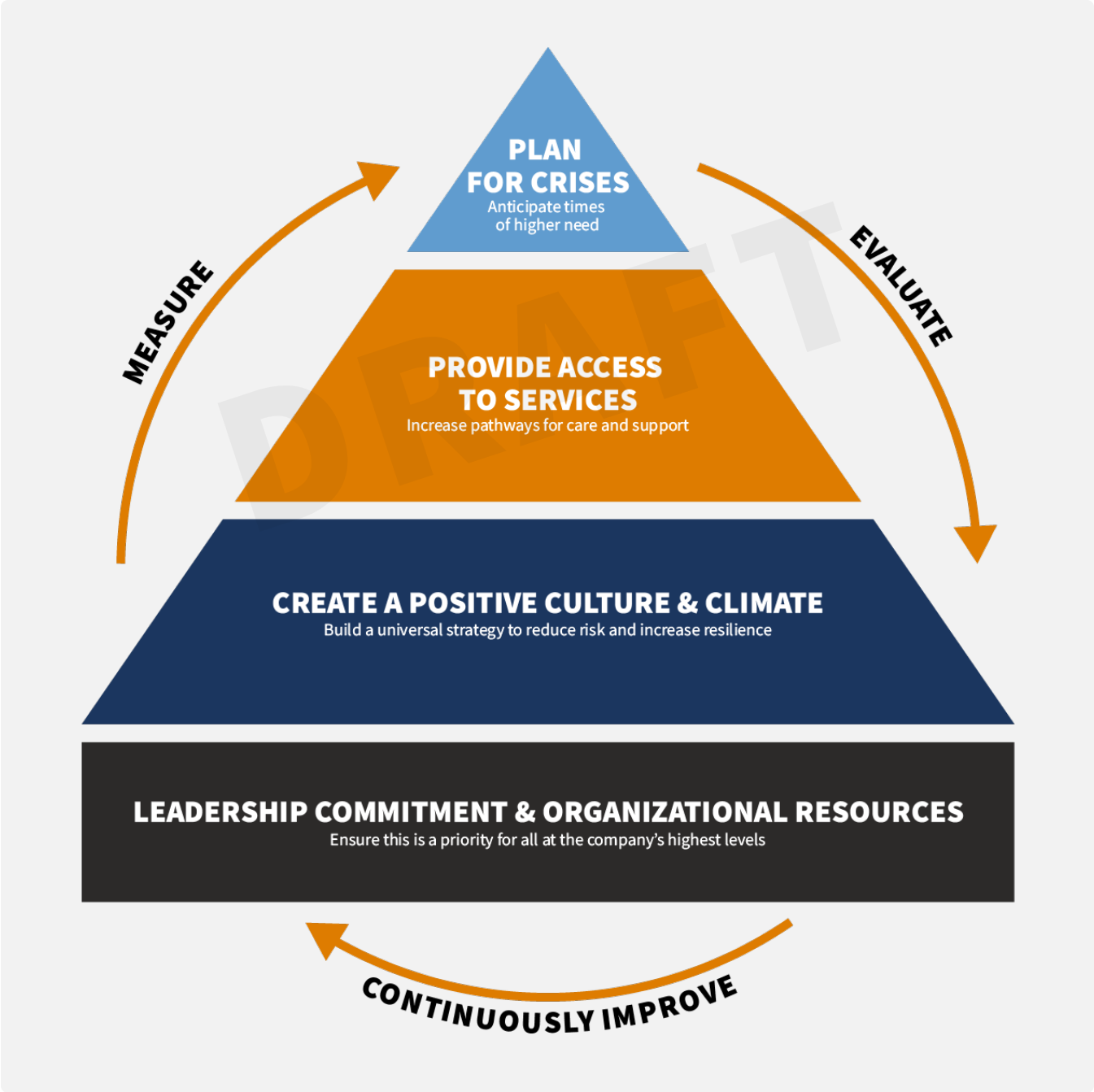
After developing an overarching implementation plan for workplace mental health standards and related interventions, employers should communicate the goals and associated process with all employees to ensure awareness and encourage active participation.

# 05 STANDARDS FOR MENTAL HEALTH IN THE WORKPLACE

# The Mental Health Continuum

## A Framework for Understanding Employee Needs

Our mental health exists on a continuum and fluctuates based on the circumstances in our lives. Depending on where we are on the continuum, different support mechanisms are needed. Strategies to address employee mental health should consider needs across the continuum.



# Standards for Mental Health in the Workplace

The Commission has developed five voluntary standards that organizations may adopt to support the mental health of their employees. The standards can help organizations create policies and processes to address mental health in the workplace in ways that meet employee needs.

Each standard includes subtopics and tactical recommendations aimed at helping all types of organizations on their journeys to promote mental health in the workplace. The report includes with a set of recommendations and a discussion of potential barriers to implementation.

1. **Leadership and Organizational Commitment**
   Workplace mental health initiatives are driven by senior leaders and supported by organizational resources.

2. **Positive Workplace Culture and Climate**
   Practices that promote wellbeing and prioritize mental health are embedded into everyday aspects of the work culture.

3. **Access to Services**
   Employees have access to mental health support and care and know how to navigate these services.

4. **Crisis Preparation, Response, and Recovery**
   Organizations are prepared to respond to workplace crises and support employees in high-need circumstances.

5. **Measurement, Evaluation, and Continuous Quality Improvement**
   Organizations measure, track progress, and make changes based on performance metrics related to workplace mental health.

STANDARD 1

## Leadership and Organizational Commitment

Workplace mental health initiatives are driven by senior leaders and supported by organizational resources.

Leadership buy-in and meaningful organizational commitment are critical for workplace mental health initiatives to have lasting and wide-ranging impact. Leaders can help to set an organization's "tone" by promoting and supporting company programs that allow employees to prioritize mental health. They also can lead by example by prioritizing their own wellbeing in the workplace. Making tangible, organization-wide commitments to employee mental health, with goal setting and measurement, helps to ensure accountability. Such commitments also signal employees that workplace wellness is important.

*"A lot of times, (leaders) fail 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."*

— HR Professional
California Department of Human Resources

### Empower leaders to prioritize and destigmatize mental health.

Leaders who champion workplace mental health initiatives consistently support their colleagues' wellbeing. These leaders also normalize conversations about mental health at work. Such leadership helps to combat stigma and create a strong workplace culture that supports mental health. Research has shown that leaders at all levels benefit from training focused on workplace mental health. Training results in leaders who share more information about mental health and mental health resources, actively encourage employees to use these resources and better support employees' mental health challenges.

**Specific strategies for employers include:**

- → Encouraging leaders to model healthy behaviors by setting clear boundaries between work and personal life and prioritizing their mental wellbeing
- → Supporting leaders who help to reduce stigma by exhibiting openness and vulnerability in talking about personal experiences with mental health, and who share information about organizational policies or programs that may have supported them during challenging times
- → Providing tailored, comprehensive mental health training to leaders and supervisors that promotes "soft skill" capabilities such as communicating appropriately about mental health
- → Appointing a senior leader to sponsor workplace mental health initiatives

*"Our CEO didn't always understand that mental health is a serious issue. It took a major workplace incident for leadership to start prioritizing it."*

— HR Professional
Hospitality Industry

### Build and dedicate resources towards an organization-wide strategy to prioritize mental health.

Leaders should incorporate workplace mental health initiatives into their organization's broader strategic plans and dedicate the necessary resources to support those initiatives. Strategic plans should include continuous review and adjustment of key metrics on workplace mental health, as discussed in more detail under Standard 5.

**Specific strategies for employers include:**

- → Assigning a budget line item to employee mental health initiatives
- → Dedicating sufficient resources, such as budget, staff time, and technology, to workplace mental health efforts
- → Bringing in outside experts when necessary to ensure that policies and procedures reflect best practices in workplace mental health
- → Identifying and monitoring key indicators that will support management accountability, and addressing any indicators that signal risks for employee mental health
- → Communicating commitment and regular updates to leadership, such as boards of directors

*"Our workplace mental health program was driven by a leader who was really struggling with mental health and wanted to share his journey. Without that leadership buy-in I don't think the program would have driven as much awareness."*

— HR Professional
TV & Media Industry

## STANDARD 2

### Workplace Culture and Climate

Practices that promote wellbeing and prioritize mental health are embedded into everyday aspects of the work culture.

Supporting employee mental health requires more than offering programs and benefits. The climate and culture of an organization are closely connected to the wellbeing of its employees. A purposeful, holistic approach to wellness in the workplace can create an environment that encourages employees to perform at their best and make healthy choices throughout the workday.

*"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."*

— Employer
Health Industry

#### Cultivate workplace practices and norms that support a psychologically healthy workplace.

The American Psychological Association defines a psychologically healthy workplace as one that promotes the principles of employee involvement, work-life balance, growth and development, recognition, and health and safety. Embedding practices and norms that support these principles is linked to both increased employee wellbeing and improved organizational performance.[29]

**Specific strategies for employers include:**

- → Encouraging and training managers to foster the creativity and autonomy of their team members
- → Creating concrete opportunities for employees of all levels to participate in organizational decision making
- → Providing employees with increased flexibility regarding when, where, and how they work
- → Understanding how employees want to be supported when they experience mental health challenges and setting expectations for the kind of support that can be provided at work
- → Offering programs and financial or other support for employees to drive their own professional development
- → Offering monetary or non-monetary rewards, such as applause awards or designating managers as champions of mental health, to recognize employee achievements
- → Encouraging employees to express gratitude and appreciation to one another
- → Evaluating company policies and programs to ensure best and current approaches to equity, diversity, and inclusion, including supporting people of color, LGBTQ+ populations, people for whom English is a second language, and people with disabilities[30]

*"Sometimes it's that personal connection that is really important. Programs don't necessarily do it. It's people caring about people."*

— HR Professional
Agriculture Industry

### Create a culture that rejects stigma and openly communicates about and recognizes mental health challenges.

In a 2020 national survey, 80 percent of employees reported experiencing mental health stigma in the workplace.[31] If employees do not have open conversations about mental health at work, employers can be unaware of the full scope of potential mental health needs among their workers. Employers also can be unaware of how to support employees.

To address stigma at work, subject matter experts recommend a two-pronged approach:

1. Creating safe spaces, such as employee resource groups, for employees to share experiences with peers
2. Developing a platform for information sharing and storytelling

This dual focus provides both private spaces and more public platforms where employees can "bring their full identity." This two-pronged approach also can reduce the stigma of seeking treatment and encourage employees to use wellness resources. By empowering employees to seek support for challenges, employers can reduce the gap between those who need mental health services and those who receive support. In addition to empowering employees to seek help for themselves, employers also must establish organizational processes to identify and support employees with mental health needs.

#### Defining "compassion fatigue"

**Compassion fatigue** is a form of burnout that occurs when people who work in caregiver roles or other jobs that support the emotional needs of others, including health-care workers and school guidance counselors, take on the suffering and stress of those they support. Compassion fatigue can leave people emotionally depleted.

**Specific strategies for employers include:**

- → Developing employee resource groups or similar safe places to create a culture in which employees support one another and share experiences
- → Creating space for an honest and supportive dialogue regarding current events that may be affecting a team's wellbeing, such as hosting team conversations on timely topics to share perspectives and promote courage
- → Conducting regular mental health awareness programs and training, supplemented with awareness campaigns, such as World Mental Health Day programming
- → Including mental health education in staff onboarding and professional development

*"People are afraid to ask for help when it comes to mental health – they are afraid it will look like they can't handle the pressure. When we instituted one day a quarter as a personal day, I didn't want to call it a mental health day because of the stigma."*

— HR Professional
Hospitality Industry

## STANDARD 3

### Access to Services

Employees have access to mental health support and care and know how to navigate these services.

More than two-thirds of people with a mental health condition do not receive treatment, partly because they face significant barriers when seeking services and support.[32] Some do not know how to access mental health services. Navigating the complexities of the mental health system overwhelms others. Frustration can result from extended wait times, insurance limitations, high co-pays, and the difficulty of finding culturally appropriate care that aligns with an employee's needs. Ensuring early intervention and support and access to a range of care options, such as telemedicine and EAPs, and focusing on early intervention can help to address these challenges.

#### Deploy tools that can identify potential employee mental health challenges and enable early intervention.

Many people go a long time between developing a mental illness and receiving treatment. Tools that facilitate early identification of mental health challenges help employees connect to the appropriate resources earlier. Proactive, voluntary screening programs are one such tool. Also valuable are training programs that teach employers to identify, understand, and respond to signs of mental illness and substance use disorders in their employees.

**Specific strategies for employers include:**

- → Providing mental health literacy training that is sensitive to diverse cultural and sociodemographic perspectives
- → Offering training, such as the Mental Health First Aid program, that help employees and managers build awareness and skills for identifying and responding to mental health challenges
- → Developing a mechanism, such as a periodic web-based form, to screen employees for mental health challenges, and identifying dedicated people to follow up with individuals who require support or interventions
- → Ensuring that mental health services encompass primary, secondary, and tertiary prevention strategies (see Appendix C)

#### Offer virtual mental health services as part of benefits packages to provide employees with increased flexibility.

The COVID-19 pandemic accelerated a shift toward remote care and telemedicine, approaches that are more convenient for users and can be delivered less expensively than in-person care. Employees who are reluctant to seek or receive mental health support at work may prefer remote care. Employers interviewed for this project reported beneficial results from using digital tools to support employee mental health.

**Specific strategies for employers include:**

- → Ensuring that health plans offer the ability for employees to obtain virtual mental health services, including adding this option if it is not available
- → Communicating the availability and benefits of virtual mental health services to employees

#### Use employee assistance programs (EAPs) to provide employees with a "one-stop shop" to access a variety of services and resources.

Employee assistance programs (EAPs) provide a consolidated portal with a range of different services, including short-term counseling and advice, aimed at addressing challenges that interfere with employee

wellbeing. These services typically are delivered at no cost to the employee. However, while EAPs are a useful immediate access point for employees who need help, they are not a holistic strategy to support mental health or address mental health challenges. EAPs also tend to be underutilized – nationally fewer than 10 percent of eligible employees use them.[33] Therefore, when adopting an EAP, employers should consider how to promote awareness of the benefit.

**Specific strategies for employers include:**

- → Ensuring that any new or existing EAP or related program is robust and evidence-based
- → Reviewing EAP offerings and ensuring that a diverse group of mental health professionals has been enlisted to meet the needs of employees with diverse identities and backgrounds[34]
- → Communicating the availability and scope of EAP benefits to employees, including information about employee privacy when using EAP services
- → Understanding current EAP utilization and performance and considering adjustments if necessary

*"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."*

— Subject Matter Expert
Workplace Mental Health

### Strive for parity in coverage across mental and physical health.

Employers have a responsibility to ensure that the coverage they offer complies with the federal Mental Health Parity and Addiction Equity Act. This 2008 law requires equal coverage for behavioral health services and physical health services. Employers can ensure that they are complying – and that they are providing robust mental health coverage to their employees – by conducting a careful review of health plans. Employers also should gather data from employees and insurers or third-party administrators.

**Specific strategies for employers include:**

- → Reviewing current medical health and mental health plans for gaps in mental health coverage; the Department of Labor's "warning signs" checklist and self-compliance tool can identify potential parity violations
- → Following best practices developed by the Substance Abuse and Mental Health Services Administration for implementing the Mental Health Parity and Addiction Equity Act
- → Working with vendors to adjust plan benefits as needed to comply with parity requirements, such as adding in-network benefits for out-of-network behavioral health providers
- → Going beyond compliance by asking insurers or third-party administrators for data on wait times, limitations on insurance coverage, cost sharing, and the availability of culturally competent care; mental health advocates have created a model data request form to aid these inquiries
- → Conducting a periodic-and ideally anonymous-survey of employees about their satisfaction with their mental health coverage
- → Choosing a plan with out-of-network mental health benefits so that employees can access clinicians who may not be in network[35]

### Tailor services and resources towards employees' unique backgrounds and roles, with a focus on equity.

Each employee in an organization has a unique background and set of experiences that shape mental health needs. In a 2021 survey of workplace mental health, younger employees and employees who identified as LGBTQ+, Black, or Latinx were significantly more likely to report mental health symptoms.[36] Members of these groups also are more likely to experience bias, microaggressions, lack of representation, or discrimination in the workplace, any of which can create or exacerbate mental health challenges. In addition to personal background, job-related conditions such as work hours, exposure to trauma, and income may impact an employee's mental health. Employers should consider employees' backgrounds and roles when designing mental health supports and services, and tailor resources toward those who need them most.

*For additional information on the risks and protective factors that can impact employee mental health, see* Appendix B.

**Specific strategies for employers include:**

- → Integrating workplace mental health initiatives with diversity, equity, and inclusion initiatives
- → Surveying employees about their unmet mental and social needs, such as childcare support, and designing services and supports in response to those needs
- → Offering tailored supplemental support for employees in roles with high-risk factors for mental health, such as roles that involve a high degree of exposure to trauma

### Communicate to employees about the services and benefits available to them.

Comprehensive mental health services are of no use if employees don't know how to access them. To improve awareness about available resources, employers should consider the types, timing, and frequency of messaging that will resonate most with employees.

**Specific strategies for employers include:**

- → Providing mental health information and resources through multiple channels such as email campaigns, manager-led conversations, and benefits websites; if appropriate, information should be presented in multiple languages
- → Creating opportunities, such as an annual organization-wide benefits webinar, for colleagues at all levels to understand the mental health services and benefits available through their work
- → Educating both HR staff and managers on the spectrum of available offerings provided by your organization so that they can accurately communicate these resources to all employees

*"When I first joined, no one knew about our EAP and that blew my mind. I sent a PowerPoint deck around to managers and now I get inbound requests from people wanting to learn more."*

— HR Professional
Hospitality Industry

## STANDARD 4

### Crisis Preparation, Response, and Recovery

Organizations are prepared to respond to workplace crises and support employees in high-need circumstances.

While a strong workplace mental health strategy prioritizes prevention, organizations also must be prepared for mental health crises. Developing and maintaining a process to support employees who are experiencing or have experienced high levels of trauma or stress, either inside or outside the workplace, is critical for a holistic approach to wellbeing.

Having a crisis response plan is particularly important for industries and roles where employees experience high levels of trauma as part of their jobs, including firefighters, health-care workers, and mental health clinicians. Many employees in these fields tend to resist professional services. They may prefer to confide in colleagues or peers who have had similar experiences. One way employers have addressed this reluctance is by encouraging employees to talk with their colleagues about how they have used EAP resources. Sharing resources in the context of a personal experience helps to demonstrate their value. It also destigmatizes help seeking.

**Specific strategies for employers include:**

INDIVIDUAL-LEVEL STRATEGIES

- Offering work-directed care plus evidence-based mental health clinical care (such as the Collaborative Care Model) to support recovery and reduction of mental health symptoms
- Providing return-to-work programs or partial sickness absence leaves
- Deploying recovery-oriented strategies that enhance vocational skills – including, but not limited to, supported employment

#### Defining trauma in the workplace

In the context of workplace mental health, **trauma** is our emotional response to any situation or event that causes severe stress in the workplace and that may disrupt present or future productivity.[37]

ORGANIZATION-WIDE STRATEGIES

- Instituting procedures and protocols for supporting employees during critical incidents, such as through individual check-ins or by circulating information about EAP resources
- Ensuring that comprehensive aftercare and safe transitions are available to employees following a crisis or trauma, such as after hospitalization or incarceration
- Establishing suicide prevention and postvention plans, and ensuring that sufficiently trained individuals are in place and prepared to address suicide that impacts employees
- Developing a process for acknowledging traumatic news or world events that may impact employee wellbeing, such as communicating empathy and support through all-hands meetings, video messages, or social media channels

For more information on building a trauma-informed workplace, see The Substance Abuse and Mental Health Services Administration's Concept of Trauma and Guidance for a Trauma-Informed Approach. The publication includes a framework that encompasses trauma-informed concepts. It is meant for use by organizations.[38]

## STANDARD 5

### Measurement, Evaluation, and Continuous Quality Improvement

Organizations measure, track progress, and make changes based on performance metrics related to workplace mental health.

Organizations need a strong process for measurement and continuous evaluation of workplace mental health initiatives. Such a process helps employers understand what is going well, the extent to which they are making progress toward goals, and where they should focus efforts for improvement. Every organization's process will look different. For example, one organization might want to measure EAP utilization while another may want to track key performance indicators (KPIs) for managers. However, all should focus on defining, tracking, analyzing, and making decisions based on metrics that "tell the story" of employee mental health.

*"Just because one person in an organization has had mental health trouble and gotten connected to resources doesn't mean you're done [as an employer]. You need to think about how you can get ahead so you don't have to wait for people to raise their hand. Better, better, never best."*

— HR Professional
Technology Industry

Identify and track key performance metrics to monitor progress and inform data-driven decision-making.

Organizations should begin by aligning partners on core metrics that measure desired outcomes of workplace mental health initiatives. Metrics will vary by industry and organization size, but common examples include turnover, employee satisfaction, and program utilization. It is critical to gain consensus across the organization about what to measure and what success looks like. The next step is to determine a process for obtaining and analyzing data. Data collection strategies could include mental health screening, employee satisfaction surveys, or claims analysis.

**Specific strategies for employers include:**

- → Assessing your organization's mental health initiatives, processes, and metrics and agreeing which metrics to track; the metrics could be absenteeism, turnover, EAP utilization, claims data, self-reported employee wellbeing, or other measures
- → Generating a baseline measurement of the agreed-upon metrics
- → Requiring providers and insurers to report on key metrics; such a requirement can be a part of your contracts with these groups
- → Continuing to collect data and analyze it at quarterly or other regular intervals, re-visiting and adjusting the list of tracked metrics as needed

Practice continuous quality improvement to assure sustained impact over time.

Organizations should create a forum where partners can meet regularly to review progress on agreed-upon metrics, discuss challenges, and identify strategies for improvement. This ongoing cycle of performance management will provide leaders with a consistent, clear view of the organization's health and enable data-based decision making.

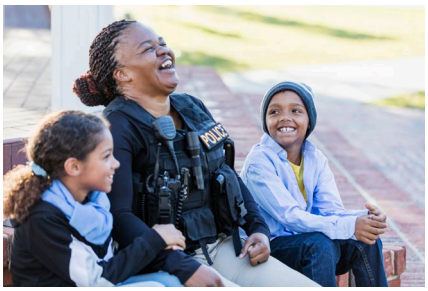
**Specific strategies for employers include:**

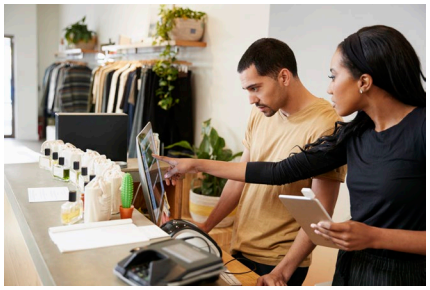
- → Creating a forum to review metrics and develop a plan to improve performance based on the metrics
- → Communicating the performance plan to the broader employee population and providing a mechanism for feedback to ensure that employees feel connected to and have a voice in the process
- → Revisiting the plan and related outcomes, such as metric results, on an ongoing basis to track success and identify areas that require follow-up

## Concluding Thoughts

Nearly one in five Californians faces an unmet mental health need, while most adults spend a third of their time at work. If California is to meet the mental health needs of its people, employers must play an active role in ensuring the quality of mental health care for their employees. Because employers can directly shape the lives of many people, the workplace represents an opportune platform to both improve employee access to care through employer-sponsored health coverage as well as drive awareness of, and reduce stigma related to, mental health issues.

California can become a national leader in mental health in the workplace and demonstrate how to incorporate wellness at work holistically. The recommendations provided in this report seek to catalyze that change.





# 06 APPENDICES

APPENDIX A

# International Workplace Mental Health Models

California joins the World Health Organization (WHO) and the U.S Surgeon General in releasing a framework to support workplace mental health. These three models follow earlier standards and guidelines put forth by the Mental Health Commission of Canada, the United Kingdom: Health and Safety Executive Management Standards, and the World Health Organization: Psychosocial Risk Management Excellence Framework Guidance (PRIMA-EF).

Each of the workplace mental health models has a unique purpose and target audience; however, there are also commonalities across the models. These commonalities provide perspective on the key features that make up an effective approach to workplace mental health:

1. All indicate the importance of primary prevention strategies.
   Each standard focuses on preventing employee mental illnesses rather than addressing illnesses after they develop. Primary prevention interventions can include providing health benefits such as mental health screening as well as supporting healthy lifestyle practices such as wellness education.
2. **All are voluntary for employers.**
   Each standard provides voluntary guidance for organizations rather than mandating standards through a formal law.
3. All emphasize flexible guidelines instead of prescriptive processes.
   Each standard provides recommendations, resources, and tools that employers can use to improve mental health in the workplace rather than dictating specific rules and regulations.
4. All recognize the need for buy-in from all levels of an organization.
   Each standard discusses the importance of support from senior leaders in driving sustained improvements in workplace wellbeing. Each also notes that the backing of employees and related partners is also critical to success.

California's standards reflect the needs of its employees by emphasizing the importance of diversity, equity, and inclusion as it connects with workplace mental health. The standards also specifically call out the need for leadership engagement and buy-in. This was a common theme in the community engagement process of developing this report. California also included lessons from the implementation of standards on workplace mental health in Canada and Australia by including emphasis on data collection and evaluation to measure and monitor progress.

## WHO Guidelines on Mental Health at Work

**PUBLICATION DETAILS**

The WHO Guidelines on Mental Health at Work were published in 2022 and were prepared by the World Health Organization (WHO) Department of Mental Health and Substance Use and the Department of Health.

**PURPOSE**

Provide evidence-based recommendations to promote mental health, prevent mental health conditions, and enable people living with mental health conditions to participate and thrive at work.

**OVERVIEW**

The recommendations cover organizational interventions, manager training and worker training, individual interventions, return to work, and gaining employment. The guidelines indicate whether and what interventions can be delivered to whole workforces (universal), to workers at risk of mental health conditions (selective), for workers experiencing emotional distress (indicated), or for workers already experiencing mental health conditions.

**LINK TO READ MORE**

https://www.who.int/publications/i/item/9789240053052

## U.S. Surgeon General's Framework for Workplace Mental Health & Well-Being

**PUBLICATION DETAILS**

The U.S. Surgeon General's Framework was published in 2022.

**PURPOSE**

Provide a starting point for organizations in updating policies, processes, and practices to support the mental health and wellbeing of employees.

**OVERVIEW**

Centered on the worker's voice and equity, the framework includes Five Essentials that support workplaces as engines of wellbeing. Each essential is grounded in two human needs, shared across industries and roles. The essentials are protection from harm, connection and community, work-life harmony, mattering at work, and opportunity for growth.

**LINK TO READ MORE**

https://www.hhs.gov/surgeongeneral/priorities/workplace-well-being/index.html

## Canada: The National Standard of Canada for Psychological Health and Safety in the Workplace

**PUBLICATION DETAILS**

The Standard was developed in 2012 by the Mental Health Commission of Canada (MHCC).

**PURPOSE**

Guide organizations in promoting mental health and preventing psychological harm at work by providing a set of voluntary guidelines, tools, and resources.

**OVERVIEW**

The Standard identifies 13 workplace factors that organizations can address to affect the mental health and psychological safety of their employees: culture, psychological and social support, clear leadership and expectations, civility and respect, psychological demands, growth and development, recognition and reward, involvement and influence, workload management, engagement, balance, psychological protection, and protection of physical safety.

**LINK TO READ MORE**

https://mentalhealthcommission.ca/national-standard/

## United Kingdom: Health and Safety Executive Management Standards

**PUBLICATION DETAILS**

The United Kingdom Health and Safety Executive introduced the Standards in 2004.

**PURPOSE**

Help organizations understand how to assess and manage risks to employee wellbeing posed by work-related stress.

**OVERVIEW**

The Management Standards comprise a series of "states to be achieved," or statements of good practice in six key stressor areas: demands, control, support, relationships, role, and organizational change. These six areas of work design, if not properly managed, are associated with poor health, lower productivity, and increased absence rates due to accident and sickness.

**LINK TO READ MORE**

https://www.hse.gov.uk/stress/standards/

## The World Health Organization: Psychosocial Risk Management Excellence Framework Guidance (PRIMA-EF)

**PUBLICATION DETAILS**

PRIMA-EF was a collaborative initiative led by the University of Nottingham's Institute of Work, Health and Organisations from 2006 to 2009. The initiative received further funding in 2009 to develop training.

**PURPOSE**

Provide a framework to promote policy and practice at both national and organizational levels within the European Union.

**OVERVIEW**

The European framework for psychosocial risk management at the workplace (PRIMA-EF) outlines 10 areas to assess for psychosocial hazards: job content, workload, control, environment, organizational culture and function, interpersonal work relationships, organizational role, career development, and home-work interface. The framework identifies three levels of prevention: primary prevention to create changes to the way work is organized and managed, secondary prevention to develop individuals' skills through training, and tertiary prevention approaches to reduce further risks to workers' health by developing rehabilitative, return-to-work, and occupational health processes. The guidance focuses on primary prevention activities and uses the European Commission's definition of risk assessment.

**LINK TO READ MORE**

http://www.prima-ef.org/

APPENDIX B

# Risk and Protective Factors in the Workplace

Every workplace and job function involves factors that can protect an employee's mental health or put it at risk. Ambiguous roles and unpredictable hours are example of risk factors. Meaningful work and positive relationships are protective. Experts have categorized workplace and job characteristics as risks or protective factors based on evidence for their impact on employee mental health.

## Risk and Protective Factors

This section outlines risk and protective factors identified by researchers at Simon Fraser University in British Columbia, Canada.[39]

### BALANCE

A workplace that provides a positive work-life balance allows employees to effectively manage responsibilities at work and at home. A negative work-life balance causes cumulative home and job stress that jeopardizes health and wellbeing.

### CIVILITY AND RESPECT

A workplace where employees are respectful and considerate can provide greater job satisfaction, improved morale, and better teamwork. Without civility and respect, staff can become emotionally exhausted, experience increased conflict at work, and burnout.

### CLEAR LEADERSHIP AND EXPECTATION

Effective leadership and support that helps employees know what they need to do and how their work contributes to the organization can increase employee morale, resiliency, and trust. An absence of effective leadership and support can lead to feelings of powerlessness and stress.

### ENGAGEMENT

Engaged employees feel connected to their work and motivated to do their jobs well. Employees who do not feel engaged are less productive and more likely to leave.

### GROWTH AND DEVELOPMENT

When employees receive encouragement and support to expand and develop their skills, their wellbeing improves. Without such opportunities, employees can feel bored at work and neglect their performance.

### INVOLVEMENT AND INFLUENCE

Being involved in important discussions and decisions related to their work helps highlight the meaning behind the work and increases employee engagement and morale. Without involvement and influence, employees can feel indifferent and become more likely to experience burnout.

### ORGANIZATIONAL CULTURE

A workplace that is characterized by trust, honesty, and fairness provides a positive, supportive environment. When positive organizational culture is lacking, it can undermine the effectiveness of programs and policies that were otherwise meant to support employees.

### PROTECTION OF PHYSICAL SAFETY

Employees who feel safe are more engaged at work. When physical safety is not protected, employees are more likely to be injured and ill.

### PSYCHOLOGICAL COMPETENCIES AND DEMANDS

Employees whose jobs match their competencies and skills have less depression and greater self-esteem. Mismatches can cause job strain and emotional distress.

### PSYCHOLOGICAL AND SOCIAL SUPPORT

Employees in workplaces where co-workers and supervisors support psychological and mental health have greater job attachment, commitment, and involvement. A lack of such support leads to increased absenteeism and conflict at work.

### RECOGNITION AND REWARD

A workplace that acknowledges and appreciates employees' efforts promotes motivation and self-esteem. Lack of recognition and reward leads to low confidence and demoralization.

### PSYCHOLOGICAL PROTECTION

Employees who feel psychologically safe – a term referring to the feeling and belief that a person can share their thoughts, opinions and ideas without fear of being degraded or shamed[40] – at work perform better and feel more connected. Employees who feel unsafe become demoralized and disengaged.

### WORKLOAD MANAGEMENT

When tasks and responsibilities can be accomplished successfully within the time available, job satisfaction is high. Poor workload management can lead to physical, psychological, and emotional fatigue.



## Other Issues That Affect Mental Health in the Workplace

Along with the risk and protective factors discussed above, several other important issues can affect mental health in the workplace. The following issue areas have been adapted from The Health Communication Unit at the Dalla Lana School of Public Health at the University of Toronto and the Canadian Mental Health Association, Ontario.[41]

### STIGMA AND DISCRIMINATION

Stigma is defined as negative attitudes, beliefs, or behaviors about or toward individuals or groups because of a characteristic they share. Stigma happens when someone sees you in a negative way. Discrimination happens when someone treats you in a negative way.

### PRESENTEEISM

"Presenteeism" describes employees who come to work despite having a physical or mental condition that justifies an absence. Such employees are not performing optimally and not giving themselves adequate time to get better.

### DEMAND VERSUS CONTROL AND EFFORT VERSUS REWARD

Major causes of job stress stem from conflicts in demand versus control and effort versus reward. Stress results if job demands increase without a proportionate increase in worker control over hours or workload. Stress also results if increased effort goes unrewarded.

### STRESS

Stress can come from both good and bad stressors and can have positive or negative effects. Stress becomes a problem when individuals are not able to handle an event or situation and become overwhelmed.

### JOB BURNOUT

Job burnout is a state of physical, emotional, and mental exhaustion caused by long-term exposure to demanding work situations. Burnout is the cumulative result of stress. Anyone can experience job burnout. However, burnout is more prevalent in professions with high job demands and few supports. Burnout rates are also high in the helping professions, including health care, teaching, and counseling.

### SUBSTANCE USE

Substance use can have a significant impact on mental health at work. Addictions and mental health conditions often co-occur. However, often the addiction gets noticed first, especially in the workplace. Generally, substance use becomes a problem when individuals have lost control over their use or continue to use despite experiencing negative consequences. Employers should look for warning signs that indicate an employee may be struggling with substance use.

### HARASSMENT, VIOLENCE, BULLYING, AND MOBBING

Workplace violence is any act in which a person is abused, threatened, intimidated, or assaulted in their employment. Workplace violence includes the following:

- **Threatening behavior**
  Such as shaking fists, destroying property, or throwing objects
- **Verbal or written threats**
  Any expression of an intent to inflict harm
- **Harassment**
  Any behavior that demeans, embarrasses, humiliates, annoys, alarms, or verbally abuses a person, and is known to be or would be expected to be unwelcome.
- **Verbal abuse**
  Swearing, insults or condescending language
- **Physical attacks**
  Hitting, shoving, pushing, or kicking
- **Bullying**
  Repeated, unreasonable, or inappropriate behavior directed towards an employee or group of employees that creates a risk to health and safety
- **Mobbing**
  Ongoing, systematic bullying of an individual by his or her co-workers, including rudeness and physical intimidation, as well as more subtle and possibly unintentional behaviors involving social ostracism and exclusion

APPENDIX C

# Prevention Strategies

Prevention strategies can be divided into three types: Primary, secondary, and tertiary. Each prevention strategy is described in further detail below. Table 2 contains examples of each level of prevention.

1

## Primary Prevention Strategies

Primary prevention strategies aim to reduce exposure to psychological and physical risk factors in the workplace among healthy employees. Examples of primary prevention strategies include a livable wage, affordable health benefits and services, mental health information, and support for healthy lifestyle practices. Other organizational strategies that prevent mental health risk include policies to promote inclusion, combat harassment and bullying, and ensure fair hiring and promotion. Paid leave, family leave benefits, and policies that permit job redesign and flexibility also prevent job stress. Accommodations for employees with sensory, learning, developmental, or physical disabilities are important strategies as well.



2

## Secondary Prevention Strategies

Secondary prevention strategies include screening, early identification, and brief treatment.[42] Secondary prevention strategies most often come into play after an employee develops symptoms. The strategies typically focus on an individual employee.

3

## Tertiary Prevention Strategies

Tertiary prevention strategies aim to minimize the impact that a diagnosed mental health need has on an individual. These strategies typically focus on improving functioning, minimizing the impact of a mental health need, and preventing complications.[43] Significant support and direction from mental health professionals often is needed at this stage.

Table 2: Examples of Strategies by Prevention Level

| PREVENTION LEVEL | CATEGORY | EXAMPLES OF STRATEGIES |
|---|---|---|
| Primary Prevention | Designing and managing work to minimize harm | • Enhancing flexibility of working locations and hours<br>• Encouraging employee participation in organizational decisions<br>• Offering educational resources on mental health support available through employer<br>• Supporting wellness activities, such as through “walking meetings" |
| | Promoting protective factors at the organization level | • Assessing and addressing internal policies and practices that reinforce discrimination and bias against individuals based on race, ethnicity, gender, sexual orientation and identity, linguistic background, or disability<br>• Offering mental health training to all employees to encourage an informed, non-stigmatizing work culture<br>• Promoting social cohesion, belonging, and purpose among employees to foster an inclusive, equitable culture<br>• Offering paid leave or paid family leave<br>• Providing a healthy, safe work environment that offers sufficient lighting, reduced noise, and more |
| **Secondary Prevention** | Enhancing personal resilience for employees | • Offering cognitive behavioral therapy (CBT)-based stress management or resilience training<br>• Offering contemplative prevention strategies such as meditation and mindfulness |
| | Promoting and facilitating early help seeking | • Providing wellbeing checks or health screening<br>• Employee Assistance Programs and workplace counseling that can be accessed during work |

| PREVENTION LEVEL | CATEGORY | EXAMPLES OF STRATEGIES |
|---|---|---|
| Tertiary Prevention | Supporting the recovery of employees | • Delivering leadership support and training on how to recognize and respond to a mental health crisis<br>• Designing CBT-based return-to-work programs |
| | Preventing additional negative outcomes for employees | • As appropriate, providing educational resources to all employees regarding mental health challenges and treatments as a way to increase awareness and support for colleagues with mental health needs<br>• Offering flexible, holistic support to employees to preserve consistency in their lives, including maintaining employment |

APPENDIX D

# List of Organizations That Provided Project Input

The Commission interviewed or held focus group discussions with representatives of the following organizations*:

| | | |
|---|---|---|
| **LABOR** | California Teachers Association | SEIU |
| **ACADEMIA AND RESEARCH** | Stanford University<br>University of California, Davis<br>Tufts University | FM:3 – COVID Research<br>University of California, Los Angeles |
| **PUBLIC SECTOR EMPLOYERS** | California Government Operations Agency<br>California Department of Human Resources<br>CalPERS<br>California Department of Managed Care<br>California Department of Industrial Relations-Workers Comp<br>California Department of Rehabilitation<br>California Department of Social Services<br>California Committee on Employment of | People with Disabilities<br>Former Mental Health Advisor to the Governor<br>Los Angeles County Behavioral Health<br>San Luis Obispo County Behavioral Health<br>Madera County Behavioral Health<br>San Mateo County Behavioral Health<br>Stanislaus County Behavioral Health<br>U.S Department of Veterans Affairs |
| **RETAIL AND HOSPITALITY** | CVS Pharmacies<br>Levi Strauss & Co. | Mulvaney's B&L |
| **HEALTH CARE** | Kaiser Permanente<br>Futuro Health<br>Alexion<br>Behavioral Health Services Inc.<br>Morneau Shepell<br>Cedars-Sinai Hospital | Cardinal Health<br>Johnson & Johnson<br>American Ambulance<br>National Alliance of Social Workers, California Chapter<br>California Psychological Association |

* Note: Inclusion in this list does not reflect agreement with recommendations.

| | | |
|---|---|---|
| **UTILITIES AND ENGINEERING** | PG&E | Northrop Grumman |
| **BANKING, LEGAL, REAL ESTATE, INVESTMENT, AND CONSULTING** | Reed Smith LLC<br>Bank of America<br>Liberty Mutual<br>TPG | Ernst and Young<br>Hispanic Realtors Association<br>Kearney |
| **BUSINESS GROUPS** | Business Group on Health<br>Pacific Business Group on Health<br>Fresno Business Group | California Chamber of Commerce<br>California Black Chamber of Commerce |
| **EDUCATION** | California Department of Education<br>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<br>Center for Workplace Mental Health<br>The Steinberg Institute<br>The Stability Network<br>Empower Work<br>Unmind | Mind Share Partners<br>Health Education Resources and Outreach Program (HERO)<br>Mental Health America: Mind the Workplace<br>The Kennedy Forum |
| **OTHER MENTAL HEALTH ADVOCACY** | Young Presidents Organization | The Steve Fund |

Additionally, the Commission interviewed all of its contractual partner groups to learn about cultural diversity in the workplace and 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

VetART

California Association of Local Behavioral Health Boards (CALBHB/C)

Boat People SOS

United Parents

California Pan-Ethnic Health Network

NAMI California

Health Access

Additionally, the Commission interviewed all of its contractual partner groups to learn about cultural diversity in the workplace and needs and strengths that can be leveraged in workplace mental health strategies. These groups include:

Agriculture

Film and Television

Health care

Hospitality

Technology

## END NOTES


1. Mental Health Services Oversight and Accountability Commission (2020). *Workplace Mental Health Project Roundtable Summary.* https://mhsoac.ca.gov/wp-content/uploads/MHSOAC-Workplace-Mental-Health-Project-Roundtable-Summary.pdf
2. Dewa, C., Nieuwenhuijsen, K. (2019). *Evidence for Supporting the Mental Health and Wellness of the Labor Force.* https://mhsoac.ca.gov/wp-content/uploads/03_CWPMH_Evidence-for-Support.pdf
3. The Commission contracts with partner organizations to advocate in support of the MHSA's goals. See more at: https://mhsoac.ca.gov/connect/stakeholder-advocacy/
4. The completed landscape analysis can be found here: https://mhsoac.ca.gov/wp-content/uploads/04_CWPMH_Landscape-Analysis.pdf
5. Mental Health Services Oversight and Accountability Commission, One Mind at Work (2020). *Workplace Mental Health in California: A Landscape Analysis.* https://mhsoac.ca.gov/wp-content/uploads/04_CWPMH_Landscape-Analysis.pdf
6. World Health Organization (2018). *Mental Health: Strengthening Our Response.* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
7. Mind Share Partners (2021). 2021 *Mental Health at Work Report.* https://www.mindsharepartners.org/mentalhealthatworkreport-2021
8. Kaiser Family Foundation (2021). https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
9. Gallup (2022). https://www.gallup.com/workplace/404174/economic-cost-poor-employee-mental-health.aspx
10. Mind Share Partners (2021). https://www.mindsharepartners.org/mentalhealthatworkreport-2021
11. Harvard Business Review (2021). https://hbr.org/2021/10/its-a-new-era-for-mental-health-at-work
12. Peters, S., et al. (2022). Work and Worker Health in the Post-Pandemic World. https://www.thelancet.com/action/showPdf?pii=S2468-2667%2821%2900259-0
13. Paychex (2020). *Mental Health at Work During COVID-19.* https://www.paychex.com/articles/human-resources/mental-health-at-work-during-covid19
14. Cox, C., Garfield, R., Kamal, R., Panchal, N. (2021). *The Implications of COVID-19 for Mental Health and Substance Abuse.* https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
15. McKinsey & Company (2020). *National Employer Survey Reveals Behavioral Health in a COVID-19 Era as a Major Concern.* https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/national-employer-survey-reveals-behavioral-health-in-a-covid-19-era-as-a-major-concern
16. Business Group on Health (2020). *Large U.S. Employers Accelerating Adoption of Virtual Care, Mental Health Services for 2021, Business Group on Health Survey Finds.* https://www.businessgrouphealth.org/en/who-we-are/newsroom/press-releases/large-us-employers-accelerating-adoption-of-virtual-care-mental-health-services-for-2021
17. Mordecai, D. (2019). *Mental Health at Work – Why Stigma is a Workforce Health Issue.* https://business.kaiserpermanente.org/insights/mental-health-workplace/stigma-at-work#:~:text=Mental%20health%20at%20work%20%E2%80%94%20why%20stigma%20is%20a%20workforce%20health%20issue,-Posted%3A%20March%2018&text=Share%3A,from%20seeking%20mental%20heal
18. Chao, H. J., Lien, Y. J., Kao, Y. C., Tasi, I. C., Lin, H. S., & Lien, Y. Y. (2020). Mental health literacy in health care students: An expansion of the Mental Health Literacy Scale. International Journal of Environmental Research and Public Health, 17(3), 948. https://doi.org/10.3390/ijerph17030948
19. Heazlewood, F. *Mental Health Literacy Mastery for Mangers.* https://blueberryinstitute.com/wp-content/uploads/2020/03/mental-health_whitepaper_web_v2.pdf
20. Washington Post (2022). https://www.washingtonpost.com/dc-md-va/2022/10/20/er-mental-health-teens-psychiatric-beds/
21. Busch, S., Kyanko, K. (2021). *Assessment of Perceptions of Mental Health vs. Medical health Plan Networks Among US Adults with Private Insurance.* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2785383

22. Families USA (2014). *Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color.* https://familiesusa.org/wp-content/uploads/2019/09/ACT_Network-Adequacy-Brief_final_082214_web.pdf

23. Hayford, T., Pelech, D. (2019). *Medicare Advantage and Commercial Prices for Mental Health Servies.* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05226

24. National Alliance on Mental Illness (2016). https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf

25. Guido, A. (2018). *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America.* https://www.prweb.com/releases/new_study_reveals_lack_of_access_as_root_cause_for_mental_health_crisis_in_america/prweb15828321.htm

26. CDC (retrieved 2022). https://www.cdc.gov/minorityhealth/promotores/index.html

27. American Psychological Association (2018). https://www.apa.org/monitor/2018/02/datapoint

28. https://smiadviser.org/wp-content/uploads/2020/08/CSC-Issue-Brief_v2-081320.pdf

29. Ballard, D., Grawitch, M. (2016). *The Psychologically Healthy Workplace: Building a Win-Win Environment for Organizations and Employees.* https://www.apa.org/pubs/books/4318134?tab=1

30. Adapted from: American Psychological Association. *Take a critical look at equity, diversity, and inclusion policies.* https://www.apa.org/topics/workplace/mental-health/edi-policies

31. McKinsey & Company (2021). *National Surveys Reveal a Disconnect Between Employees and Employers Around Mental Health Needs.* https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/national-surveys-reveal-disconnect-between-employees-and-employers-around-mental-health-need

32. Wang, P., et al. (2007). *Use of Mental Health Services for Anxiety, Mood, and Substance Disorders in 17 Countries in the WHO World Mental Health Surveys.* https://pubmed.ncbi.nlm.nih.gov/17826169/

33. Agovino, T. (2019). *Companies Seek to Boost Low Usage of Employee Assistance Programs.* https://www.shrm.org/hr-today/news/hr-magazine/winter2019/pages/companies-seek-to-boost-low-usage-of-employee-assistance-programs.aspx

34. Adapted from: American Psychological Association. *Striving for mental health excellence in the workplace: Develop programs and policies that support employee mental health.* https://www.apa.org/topics/workplace/mental-health/develop-programs

35. Adapted from: American Psychological Association. *Striving for mental health excellence in the workplace: Reexamine health insurance policies with a focus on employee mental health.* https://www.apa.org/topics/workplace/mental-health/reexamine-health-insurance

36. Mind Share Partners (2021). *2021 Mental Health at Work Report.* https://www.mindsharepartners.org/mentalhealthatworkreport-2021

37. Colorado State Employee Assistance Program. *Critical Incidents and Workplace Trauma.* https://cseap.colorado.gov/toolkits/critical-incidents-workplace-trauma#:~:text=Critical%20incidents%20include%20situations%20that,productivity%20in%20the%20work%20setting

38. Substance Abuse and Mental Health Servies Administration (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

39. Canadian Centre for Occupational Health and Safety. *Mental Health – Psychosocial Risk Factors in the Workplace.* https://www.ccohs.ca/oshanswers/psychosocial/mentalhealth_risk.html

40. Edmonson, A (1999). *Psychological Safety and Learning Behavior in Work Teams.* http://www.jstor.org/stable/2666999?origin=JSTOR-pdf

41. Canadian Mental Health Association, Ontario. *Workplace Mental Health: Core Concepts and Issues.* http://wmhp.cmhaontario.ca/workplace-mental-health-core-concepts-issues

42. Miller, J. (2014). *Mental Illness Prevention.* https://www.amhca.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=d0b3bd65-7a6d-70e0-38b0-4314176ba2ee

43. Miller, J. (2014). *Mental Illness Prevention.* https://www.amhca.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=d0b3bd65-7a6d-70e0-38b0-4314176ba2ee

Mental Health Services
Oversight & Accountability Commission

# Workplace Mental Health

## Implementation Opportunities

This document provides an implementation plan to support the Commission's report, *Working Well: Supporting Mental Health at Work in California*. In the report, the Commission identified three recommendations to address systemic barriers and improve access to care for employees. These recommendations fall into the broad categories of: technical assistance and capacity building, access to care, and establishing a research agenda.

To implement the recommendations of the Workplace Mental Health Subcommittee, the following steps are suggested.

**Technical Assistance and Capacity Building**

The State should prioritize strategies to improve employer capacity to support mental health by creating a Center of Excellence that will support the development and dissemination of evidence-informed tools and resources.

**Implementation:**

a. Engage the governor and the legislature to establish the Center of Excellence.
b. Facilitate a partnership between CalHR and the Center of Excellence.
c. Recommend strategies to support CalHR to adopt the Standards and to support whole-person wellness by incorporating employee mental health support with physical health and diversity, equity, and inclusion.
d. Explore funding opportunities to launch a pilot program to implement the Standards in one or more local public sector agencies.

**Access to Care**

The State should partner with the private healthcare sector to improve access to and the quality of comprehensive, affordable mental health care.

**Implementation:**

a. Engage CalPERS, CalSTERS, the Department of Managed Care, health insurers, and others to enhance mental health coverage to include evidence-based practices such as Early Psychosis Intervention, Alcove Youth Drop-In Services, and wraparound services that include peers, cultural navigators, and case management benefits, consistent with public sector investments.

b. Work with the Center of Excellence to create easy-to-use referral pathways for workers with mental health needs to access appropriate, high-quality mental health care for themselves and their families.
c. Collaborate with other states and the federal government to explore financial strategies to improve reimbursement rates and leverage purchasing power across jurisdictions.
d. Collaborate with colleges and universities to increase pathways to work in the mental health profession. This includes expanding opportunities for peer certification in the private health sector.

**Research Agenda**

In partnership with the Center of Excellence and the private sector, the State should establish a research agenda to identify workplace mental health indicators and to measure and monitor progress on workplace mental health practices and policy.

**Implementation:**

a. Work with the Center of Excellence to establish indicators and benchmarks to measure and monitor progress on workplace mental health practices.
b. Explore opportunities to work with a purchasing group (such as the Pacific Business Group on Health) to identify benefits missing from current plans and establish optimal reimbursement rates for a broad range of mental health services and services supports.
c. Partner with the Department of Managed Care to share data about health care plans with the public.
d. Work with the Department of Insurance to use data to identify which industries have employees who are at risk of psychological harm at work and connect them with technical assistance.

**Next Steps**

Based on the Commission's direction, the staff will work with the Chair, the Workplace Mental Health Subcommittee and other Commissioners to pursue the steps outlined above. To fully implement each of these activities, additional staff and funding may be required.

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February 3, 2023

Toby Ewing, Executive Director
Mental Health Services Oversight & Accountability Commission
1812 9th Street
Sacramento, CA 95811
*Via email*

**Re: Comments on *Working Well: Supporting Mental Health at Work in California***

Dear Director Ewing:

The Steinberg Institute team is grateful for the opportunity to share feedback on the ***Working Well: Supporting Mental Health at Work in California*** report. The institute was a proud sponsor of Senate Bill 1113 (Monning), the legislation that led to the report. This legislation was born from a place of ensuring equal protection for those in the workforce living with mental illness. Appropriate accommodations for these employees are a matter of equity and should be emphasized more emphatically within this report.

As noted in the report, fostering a workplace culture that supports employee mental health is vital to ensuring quality mental health care for all Californians. Our primary concern is that, while well-researched, some aspects of the report language do not reflect the urgency required to address mental health concerns in the workplace. These concerns have never been sufficiently met, and disparities have only worsened throughout the pandemic.

Our recommendations:

1. **Include Standards in the Executive Summary:** The *Findings, Recommendations, and Standards* are each critical elements of the report and present an opportunity for change that will impact workers' lives. The *Standards* offer excellent actions that employers can implement now without further policy change. Yet, the *Standards* are not mentioned in the Executive Summary and only appear late in the report. We recommend that the *Standards* be highlighted in the Executive Summary along with the *Findings* and *Recommendations.*

2. **Express Increased Urgency in Finding 1 to Reflect the Workplace Mental Health Crisis**: While the current finding is accurate, refining it in a way that more clearly articulates the employer feedback (page 8) will reinforce the current opportunity and urgency presented to policymakers in this report. Our proposed language:

*Despite recognizing the importance of workplace mental health, many employers do not know how to access benefits that offer the robust array of services needed*

*to support employee mental health. Furthermore, employers cite a need for more information about best practices in mental health, a prerequisite to obtaining quality mental health services and supports.*

3. **Highlight the Need for Parity in Finding 2 and Recommendation 2:** We recommend refining this finding and recommendation to emphasize the disparity in mental health and physical health insurance coverage, utilizing the findings in that section of the report. Our proposed language:

   *Finding 2:*
   *Nearly all employers struggle to ensure that their employees have access to mental health and related services covered through their health plans. Access to robust mental health care through private sector insurance continues to face a range of challenges though the State has been clear about its commitment to behavioral health parity.*

   *Recommendation 2:*
   *The State should work with large healthcare purchasers, beginning with CalPERS, to leverage the purchasing power of public sector employers to **ensure parity** and improve access to care, quality of care, and comprehensive coverage.*

4. **Ensure Ongoing Research and Technical Assistance without Duplicating Work in Recommendations 1 and 3:** While we applaud the Commission for recognizing the need for ongoing workplace mental health research and technical assistance, the recommendation to create a center of excellence is costly and duplicative of existing centers with similar mandates. We urge you to update these recommendations and instead recommend that our existing centers of excellence's mission be expanded to include workplace mental health. If the Commission believes a separate center of excellence dedicated solely to workplace mental health is needed, we ask that you expand upon the rationale, suggest an expedited timeline for the establishment, and identify and propose a source of available funding for this work.

5. **Finding 3 and Recommendation 3:** We suggest merging these into the *Finding 1 and Recommendation 1* section, as they lay out the foundation for the work of the center of excellence and demonstrate the overarching challenge and opportunity presented in the report.

6. **Organize the Report to Highlight the Standards for Mental Health in the Workplace:** These sections are the most meaningful aspect of the report, clearly reflecting the spirit of SB 1113, and should come before the *Findings and Recommendations*.

When Governor Jerry Brown signed SB 1113 into law, none of us could have anticipated how the COVID-19 pandemic would bring the importance of workplace mental health to light. It's clear that the attitudes of employees and employers have shifted, and mental health is now a top priority for both. This report presents an opportunity to develop a framework for policymakers to finally address workplace mental health disparities. We must seize the moment. We appreciate the opportunity to share our feedback on this critical report.

Sincerely,

**Karen Larsen**
Steinberg Institute
karen@steinberginstitute.org

# AGENDA ITEM 7

**Information**

**February 23, 2023 Commission Meeting**

**Insight into Action: Results from the State Mental Health Commission's Innovation Incubator Evaluation**

**Summary**: The Mental Health Services Oversight and Accountability Commission will hear a report out on Insight into Action: Results from the State Mental Health Commission's Innovation Incubator Evaluation.

**Background**: Implementing and evaluating the innovation incubator was an activity linked to strategic objective in the Vision for Transformational Change: 2020-2023 Strategic Plan (Strategic Goal 3a).

During the January meeting, the Commission discussed the Innovation Implementation Plan to assess and revise the Commission's strategy for helping counties develop better Innovation Plans and streamlining the Commission's review and approval process. The Commission was also told that an evaluation of the Innovation Incubator was being finalized. The evaluation provides valuable feedback on the value and potential of multi-county learning collaboratives, which are an essential element of the Commission's model for driving transformational change. In addition to the incubator, the Commission has sponsored learning collaboratives as part of other initiatives, such as the Early Psychosis Intervention initiative. Learning collaboratives are also being considered for providing technical assistance to Mental Health Student Service Act partners.

A presentation of the Innovation Incubator evaluation will focus on what was learned about the process and structure of the project and will not discuss findings of the individual projects within the Innovation Incubator. The Innovation Implementation Plan, presented at the November 2022 meeting, included several of the findings with associated actions found in this evaluation and outlined a strategy for capturing lessons learned for innovation projects more broadly. While no additional action is required by the Commission, the evaluation will be a resource to the Commission as it moves forward with the Innovation Implementation Plan and develops its 2024-27 strategic plan.

**Enclosure (1):** *Insight into Action: Results from the State Mental Health Commission's Innovation Incubator Evaluation*

**Handouts (1):** The presentation will be supported by PowerPoint slides.

**Proposed Motion:** None.

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# INSIGHT TO ACTION

## Results from the State Mental Health Commission's Innovation Incubator Evaluation

**February 2023**

# CONTENTS

# 01 INTRODUCTION

# Executive Summary

Innovation is difficult. It requires taking risks on something untested. It demands that organizations step outside of their comfort zone. It also challenges business-as-usual approaches that have long held the buy-in of decision-makers, even in the absence of evidence of effectiveness. Innovation can be particularly challenging for local governments, as their resources are mainly devoted to meeting basic needs and filling critical service gaps.

Developing and delivering innovative mental health strategies was in the minds of California voters in 2004 when they approved Proposition 63, which later became the Mental Health Services Act (MHSA). The MHSA explicitly incentivizes local spending to test new approaches for delivering mental health services and supports. To help meet this goal, then Governor Jerry Brown and the California-state legislature authorized the Mental Health Services Oversight and Accountability Commission to launch a $5 million initiative, creating an Innovation Incubator in 2018.

The Innovation Incubator aimed to prevent and reduce criminal justice involvement among people with mental health challenges. It was a novel approach geared toward bolstering innovation and intentionally building the capacities of counties across California so that they could implement and test new mental health strategies. The Innovation Incubator used the $5 million to contract with subject matter experts (SMEs)/consultants to lead counties in collaborative projects to explore ways to improve their systems and meet their community's needs. Eight projects were born out of this Innovation Incubator Model; they are referred to in this report as Incubator Projects.

Once contracts with SMEs were in place, counties were given the option to join these projects, many of which ultimately became multi-county collaboratives. SMEs led all of the Incubator Projects, and counties were able to participate in as many as they wished. Descriptions of the eight projects can be found in Appendix A. The projects began between 2019 and 2021, and all projects concluded by the end of 2022.

Given that the Innovation Incubator Model was itself a promising but untested approach, the Commission launched an evaluation of it through the lens of the eight projects. This evaluation took place between August 2021 and June 2022. The evaluation's goals were to gauge the effectiveness of the model in enhancing collaboration and innovation as well as to determine how to improve the model to facilitate greater innovation in the future. To this end, the evaluation focused on two main questions:

1. Did the Innovation Incubator Model help counties enhance their capacity for designing and implementing innovative practices?
2. How can the Innovation Incubator Model be improved upon to build further capacity for innovation?

To answer these questions, Commission staff began by organizing two virtual convenings to discuss the merits of the model and identify areas for improvement. These convenings included county staff, SMEs, and others who participated in one or more of the eight projects. Between the two convenings, the Commission also surveyed county staff to gather information and insights on implementation of the model. Next, Commission staff conducted a series of interviews with county staff to gather additional information and feedback. Finally, Commission staff conducted a small number of "lived experience interviews." These interviews were conducted with individuals who participated in their county's incubator project and were also consumers of mental health services or family members of consumers.

The evaluation showed that county staff and SMEs agreed that the Innovation Incubator Model was generally effective. County staff deemed the implemented projects valuable experiences that were worth the time and effort the county invested. They and the SMEs identified several factors that contributed to the project's effectiveness, including:

- The opportunity for cross-county collaboration
- Working with consultants who understood the county context
- Establishing new collaborations within the county with a broad range of partners
- Time for a thorough project planning phase
- An ability to draw from a broad range of expertise
- Regular and consistent project engagement with partners.

The evaluation also showed that the Innovation Incubator Model helped counties work toward long-term solutions to problems rather than offering short-term fixes. Although many challenges were identified and prepared for prior to project launch, implementing the projects shed additional light on ways to mitigate potential issues and streamline the Model's process. Suggestions for improving and refining the Model in the future include:

- Educate partners on the project purpose and process before launching the project.
- Set clear project expectations and goals.
- Define project participants' roles and responsibilities.
- Collaborate with project partners (particularly other counties) early in the contracting process.
- Align timelines among partners whenever possible.

Information gathered provided insights into how the State (i.e., the Commission and other State agencies and departments) can improve collaboration with counties and other partners to advance innovative mental health strategies. The main insights were:

- The State should create more opportunities to build relationships with each county, learn their unique needs and challenges, and partner with communities in exploring systems improvements. State/county relationships should be built with one-on-one and small group interactions, bidirectional communication, and in-person site visits to the counties. These relationships should be built proactively and not as the result of a compliance issue.
- The State should prioritize sharing information statewide on how other counties are delivering mental health services and supports; the State should also create tools for identifying and elevating practices that show the most promise.
- The State should provide more opportunities for counties to collaborate with each other to address shared challenges.
- The State should make its goals, needs, and challenges clearer to county partners to further shared understanding across the state.

Finally, findings from the lived experience interviews highlighted the importance of including the perspective of consumers and family members in all the work happening in mental health. People with lived experience are often eager to act as advocates and to assist with outreach to other consumers and family members. Perhaps most importantly, integrating their perspective into planning and implementation is vital for ensuring the effectiveness of any strategies adopted or programs established.

These findings can be applied to improve upon and enhance the work happening in the Innovation component of the MHSA, but can also be applied more broadly to all of the work in which the Commission engages.

# Background

The Innovation component of the Mental Health Services Act (MHSA) is intended to advance transformational change of the mental health system by providing vision and funding to test novel approaches that improve mental health outcomes for all Californians. To learn more about building an ecosystem that supports the Innovation component of the MHSA, the Mental Health Services Oversight and Accountability Commission (the Commission) launched a $5 million Innovation Incubator Model in 2018.

The Innovation Incubator Model was designed with a broad, high-level goal in mind: to learn how to best support counties in doing innovative mental health work. To keep the projects organized around a common theme, the Commission chose to focus this Model on another, more specific goal: reducing the overlap between experiencing mental health challenges and criminal justice involvement. Research shows that with the right tools and supports, people with mental health challenges can live healthy and fulfilling lives; yet, without support, a person is more likely to suffer and experience circumstances that lead to other negative consequences, one of which is criminal justice involvement.

To do this, the $5 million funding stream was used to contract with subject matter experts (SMEs) (also referred to as "consultants" by the counties) to lead counties in collaborative projects exploring ways to improve their systems and meet their community's needs. This was accomplished through the development and implementation of eight collaborative projects. These eight projects tackled problems that required creativity and "systems thinking:" an approach to solving large scale, system-wide problems that are not solvable through quick fixes or existing strategies. These projects became known as the Incubator Projects and focused on:

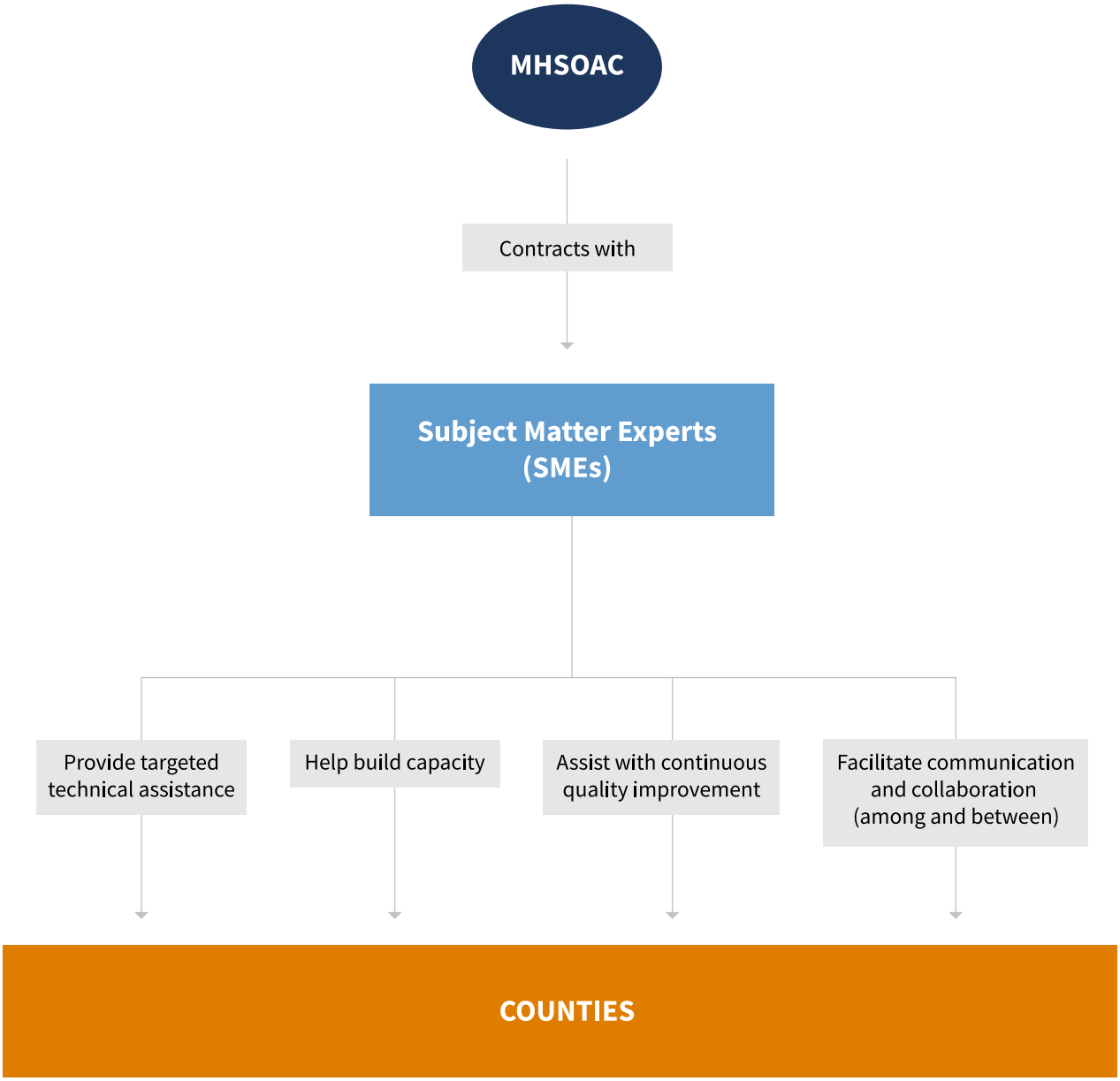
- Mobile crisis response
- The use of psychiatric advance directives for people at risk of incapacitation due to a mental health crisis
- Using data to advance understanding of the mental health needs of people in the criminal justice system
- Evaluating and refining the county's Full Service Partnership (FSP) program
- The use of sustainable funding to reduce criminal justice involvement among those with mental health needs
- The identification of existing revenue streams that counties can tap into to prevent and reduce criminal justice involvement among those with mental health needs
- The dissemination of lessons learned from the Innovation Incubator
- Assessing and recommending ways to support effective Innovation projects

Brief descriptions of the projects can be found in **Appendix A** and on the Innovation Incubator webpage.

The SMEs led the projects based in their area of expertise. Three projects focused on statewide goals and opportunities, while the other five were multi-county collaboratives. Counties had the opportunity to join these multi-county collaborative projects with no additional financial investment. Through these multi-county collaborative projects, the SMEs deployed targeted technical assistance and facilitated learning among counties to bolster their ability to develop strategies to meet their local needs and build the capacity for system-level changes and improvement. (See Figure 1.)

This approach was a significant change from the typical Innovation project process in which counties prepare their own project proposal, submit it to the Commission for approval, and use their own MHSA funds earmarked for Innovative projects. The Incubator Model allowed the Commission to retain some ownership over the projects and continue collaborating with counties while contracting out the technical work to those with the necessary expertise. It also enabled county staff to work closely with SMEs to customize each project, tailoring them to their community's unique challenges, resources, and goals.

**FIGURE 1. INNOVATION INCUBATOR MODEL AS ADOPTED BY THE COMMISSION**



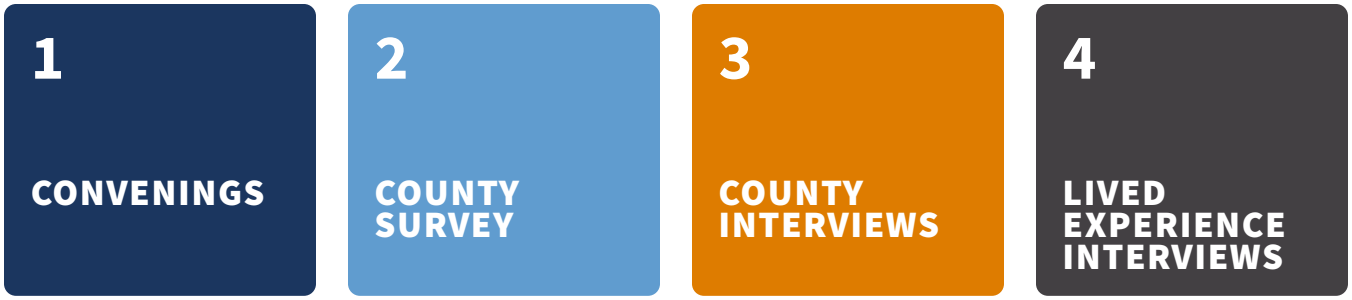

Counties were invited to join as many of the eight projects as they wished. The SMEs led the projects by organizing groups, facilitating meetings, and providing individualized technical assistance to counties. Meanwhile, behavioral health staff employed at the county level carried out project tasks, collected and explored data, engaged in learning collaboratives, and partnered with other counties to share knowledge and resources.

In total, 26 counties participated in one or more of the projects. The projects began between 2019 and 2021, and all projects concluded by the end of 2022.

# 02 EVALUATION PLAN

# Evaluation Plan

The Commission used four qualitative methods to evaluate the effectiveness of the Innovation Incubator Model. These methods were used to gather insights about lessons learned from participation in the Innovation Incubator Model from SMEs, county staff, and mental health consumers and/or their family members. They included:




These methods allowed Commission staff to seek clarification and details about the experiences of people who participated in the Innovation Incubator Model and their guidance for how it could be applied to other areas—either within mental health or to solve other problems. Below is a detailed description of each qualitative method, the results that emerged, and the action steps revealed to advance innovative approaches in mental health. The evaluation took place between August 2021 and June 2022.

## 1. CONVENINGS

Commission staff organized two virtual convenings. These convenings brought together SMEs and other partners to discuss the strengths and weaknesses of the Innovation Incubator Model and identify areas for improvement. The first two-hour virtual convening, held on August 6, 2021, included Commission staff and a small group of at least one SME from each project. For the second virtual convening (held on October 7, 2021), the Commission partnered with the public policy program at the McGeorge School of Law. This two-hour meeting brought together Commission staff, the SMEs, county staff, and other thought leaders to assess what was being learned about incubating innovation and how to evolve and scale such efforts to catalyze transformational change.

These convenings identified several insights regarding what led to success when implementing the Innovation Incubator Model. These insights included:

- A solid understanding of the county context, the infrastructure, and the resources available prior to each project's launch
- A thorough planning phase that articulated the broad vision, outlined clear and achievable goals, and identified county touchpoints and project partners
- Project monitoring built into each project's design to collect data, track progress, and assess needs on an ongoing basis
- Regular and frequent partner engagement, relationship building, and collaboration throughout each project
- Cross-county information and resource sharing throughout each project
- Setting expectations for incremental learning, emphasizing a learning agenda, and making it "okay to fail."

## 2. COUNTY SURVEY

Staff designed the county survey to collect data on the Innovation Incubator Model from the county behavioral health perspective. Its intent was to form a baseline understanding of the model's issues, challenges, and factors for success. These were then used as a guide for collecting more in-depth information in the subsequent county and lived experience interviews.

The survey was sent out to county staff via email on October 1, 2021, and closed October 20, 2021. It was distributed to all county behavioral health contacts for the 26 counties that participated in one or more of the projects. In total, 21 individuals from 18 unique counties completed the survey.

In addition to demographic and contact information, the survey gathered information on the following topics:

- How effective the technical assistance, capacity building, and continuous improvement strategies were in meeting their project's goals – and what factors or conditions influenced them
- The right mix of group learning vs. individualized technical assistance
- Outcomes and impacts of participating in the project(s) in terms of data collection methods, relationship development with other county partners, and more
- Challenges or difficulties faced in participating in their project(s)
- Barriers for collaboration with the Commission, other counties, and other partners
- Desired support and technical assistance from the Commission
- Plans to continue their work going forward

The full list of survey questions can be found in Appendix B.

Results from the survey indicated that the Innovation Incubator Model was very effective in helping counties meet their project goals and boost their ability to plan and implement future innovation projects. According to survey respondents, the right mix of individualized assistance to group learning in these types of projects is approximately 60% individual and 40% group.

Based on the survey results, participating in the Innovation Incubator Model helped counties develop relationships with other county partners, change the way they collect and use data, and modify the way they deliver services to mental health consumers. Survey respondents indicated that collaboration with State partners was vital for improving mental health outcomes, but even within this Model, there were still collaboration barriers. These barriers included a lack of understanding of the county's unique context and needs, differing priorities among project partners, and differing timelines within and between counties.

Survey respondents also identified the following factors for success when working within the Innovation Incubator Model:

- A shared vision and purpose
- Clear and specific goals
- Dedicated staff time
- Strong leadership and guidance from qualified and knowledgeable subject matter experts

## 3. COUNTY INTERVIEWS

The county survey provided useful findings at a high level, but more in-depth information was required to evaluate the Innovation Incubator Model. To collect this information, the Commission conducted a series of interviews with county staff.

Most interviews were scheduled in 1.5-hour time slots and held via a Zoom video call. The two exceptions were 45-minute interviews due to scheduling challenges. Twenty-six counties engaged in at least one Innovation Incubator Project, and county staff from 24 of these counties participated in an interview, resulting in a total of 46 interview participants. All behavioral health staff who were significantly involved in the project were invited to attend their county's interview, although not all staff responded to the invitations or were able to schedule an interview.

The Interviews followed a semi-structured format with a list of 11 questions but allowed for fluid discussion and additional information from interviewees. Commission staff secured each participant's consent to record each interview for review and analysis purposes, and each interview was recorded (with one exception due to technical difficulties).

Researchers used ATLAS.ti Version 7, a qualitative analysis software, to code and analyze the interview data. A content analysis approach was applied in which qualitative interview data were coded for a broader category (an initial set derived from findings from the convenings and survey) and a more detailed subcategory (subcategories emerged based on participants' responses). The categories generally correlated to the initial set derived from the convenings and county survey, although participants often shared insights that touched on a variety of categories across their answers. As coding continued, new categories and subcategories were added to encompass all insights that were shared.

During the interviews, participants were asked questions about the following topics:

- Their overall experience in the Innovation Incubator Model
- Their outcomes, gains, and factors for success from participating in the Innovation Incubator Model
- The support they would like from the Commission in doing Innovation work, particularly in the area of fostering meaningful community engagement
- What can be done to build and sustain relationships with the Commission, State agencies, other counties, and partners
- Suggestions for topics to be covered in learning communities
- Ways to improve the Innovation Incubator Model

The full list of interview questions can be found in Appendix C.

The following categories emerged from the data and are explored below, with subcategories itemized in tables:

- Overall Experience with the Innovation Incubator Model
- Factors for Project Success
- Challenges
- Consultant/SME Strengths and Skills
- Outcomes of the Innovation Incubator Projects
- Long-Term Value of Participation
- Gains from Project Participation
- Strengths of the Innovation Incubator Model
- Lessons Learned for Future Projects
- Collaboration Suggestions and Opportunities
- Ways to Build Effective Relationships
- Support Counties Would Like to Receive from the Commission
- Helping Counties Get Meaningful Stakeholder Engagement
- Topic Areas for Learning Communities
- General Feedback (non-specific feedback)

See the tables below for more information on the main findings by category and subcategory. The "n" refers to the number of mentions across all interviews. The tables show the most commonly reported subcategories only; a full list of all subcategories can be found in Appendix D.

## CATEGORY: OVERALL EXPERIENCE WITH THE INNOVATION INCUBATOR MODEL

| SUBCATEGORY | n |
|---|---|
| project was worth the time and effort invested | 30 |
| project was worth the time and effort, but results were mixed | 8 |
| county dropped out of the project or did not fully participate | 4 |

Overall, most participants reported that the project was worth the time and effort they invested into it (n=30). Some participants reported that while their participation was generally worthwhile, there were mixed results (n=8); the mixed results were often related to the inflexibility of the SME or the model they used, or a low return on investment due to the amount of time and energy it took to participate. For example, when describing their experience, one participant said:

> *"It's proving to have been valuable in that it's definitely shaped my thinking about … understanding where the crisis system writ large is moving to, nationally and at the state level. And, that is shaping my ongoing thinking about what that [is] going to mean for us locally. I will say that the actual, tangible model of the process … was kind of not individualized, that [it] didn't work well and we kind of struggled to … get people to make the two-hours every week or every other week."*

Participants from four counties reported interest or initial participation in an Innovation Incubator project, but they eventually dropped out due to not having enough time to fully participate, not getting buy-in from their partners, or feeling that the topic or goal was not relevant for their county (n=4).

### CATEGORY: FACTORS FOR PROJECT SUCCESS

| SUBCATEGORY | n |
|---|---|
| cross-county collaboration | 32 |
| effective consultants | 25 |
| multi-county collaborative environment | 14 |
| intra-county collaboration | 14 |
| draw from broad range of expertise | 9 |
| regular project engagement | 9 |
| consultant was external | 7 |
| internal commitment | 7 |
| consultant they already knew | 6 |
| community buy-in | 5 |
| relevant/timely topics | 5 |

Participants mentioned several factors that contributed to project success. Chief among them were cross-county collaboration (n=32). Cross-county collaboration helped participants learn about what other counties were doing and build valuable relationships. One participant noted:

> *"It's been really valuable having the meetings with the other counties because it's created the relationship where I can reach out to [behavioral health staff in other counties] … First there was the educational learning about the other counties, then making those connections to reach out to, get support, share ideas."*

Participants also cited the value of working with effective consultants who had subject matter expertise (n=23). One participant explained:

> *"As a new director who came in during COVID and had to learn a whole lot, having that sense of security from [the consultant] who has been doing it for a while, who understood the project, who wasn't afraid to tell us, 'yeah, you might want to reconsider that' but in a very kind way was very helpful and I very much appreciated it."*

Several participants also specifically noted the multi-county collaborative environment of the project (n=14), in which they could see how other counties worked toward project goals and handled challenges, borrowed and shared resources and ideas, and asked targeted questions about specific issues. Intra-county collaboration was also cited as a factor for success (n=14) along with internal commitment (n=7), indicating that communication between county departments was also vital to success.

Participants also noted that drawing inspiration and information from a broad range of third-party expertise was valuable, including subject matter experts within the county, in other organizations, and those brought in by the contractors (n=9). Having an external consultant was also important for project success in multiple ways, including having a "bad guy" who could push county partners in ways the behavioral health department was not able or didn't want to do (n=7). However, it was also helpful for counties to already have some familiarity with the consultant (n=6).

Factors for success also included regular, frequent project engagement that was often led by the contractor (n=8), getting buy-in from the community on the project (n=5), and the relevance and timeliness of the project topic (n=5).

## CATEGORY: CHALLENGES

| SUBCATEGORY | n |
|---|---|
| amount of work/number of meetings | 14 |
| COVID-19 | 13 |
| lack of staff time | 12 |
| aligning priorities/work between counties | 11 |
| lack of capacity to take advantage/implement ideas | 11 |
| workforce/finding staff | 11 |
| silos/lack of communication | 9 |
| staff wearing multiple hats | 9 |
| confusion about project purpose/process | 8 |
| consultant/SME/model was inflexible | 8 |
| contracting is difficult/time-consuming | 7 |
| turnover/lack of historical knowledge | 7 |
| Data Collection and Reporting (DCR) issues/State handling of data | 7 |
| getting stakeholder engagement | 7 |
| being a small/rural county | 6 |
| differing county needs/challenges (by size, rural/urban) | 6 |
| differing county timelines | 6 |

Participants mentioned a number of challenges that made participating in their Innovation Incubator project difficult. The most frequently mentioned challenge was the amount of work and/or meetings that county staff were expected to engage in (n=15). As one participant shared, "It's great to get free resources, but it still required a lot of commitment and time." Another participant noted:

> *"The Incubator idea is one that has a lot of potential, but I do think that from a staff resource perspective, it was a bigger commitment than we realized it would be going into it."*

In this vein, there were several mentions of a lack of staff time (n=12) and difficulty finding staff to fill roles (n=12). This was on top of high turnover that led to a lack of context and historical knowledge within the county behavioral health department (n=7). Further, participants indicated that they "wear multiple hats" and juggle many different priorities (n=9). All of this led to a lack of capacity to take advantage of opportunities or implement exciting new ideas (n=11).

Participants also found it challenging to align priorities when working in a multi-county environment (n=11), especially when it came to contracting (n=7) and managing differing timelines (n=6). Counties had unique needs and challenges, making it hard to get on the same page, especially with counties of different sizes and population densities (n=6). Small and rural counties had their own unique challenges (n=6), like feeling unseen and unknown by the State, fewer resources, and difficulty bringing

people together in large but sparsely populated counties. Staff in counties of all sizes indicated that silos and communication issues within the county itself were big challenges (n=9).

Some participants also struggled with their county's Innovation Incubator project itself, either due to confusion about the project's purpose or the process (n=8) or the inflexibility of the SME/contractor or approach used (n=7). There were also several participants who mentioned issues with reporting data, either with the Data Collection and Reporting system (DCR) in particular or more general concerns about how the State collects, handles, and shares (or fails to share) county data (n=6). Some counties also struggled with getting meaningful stakeholder engagement on this project (n=6).

Finally, participants also mentioned that the COVID-19 pandemic presented challenges in their project participation (n=13), mostly due to behavioral health staff being pulled away on more urgent work or restrictions placed on the ability to meet and collaborate.

### CATEGORY: CONSULTANT/SME STRENGTHS AND SKILLS

| SUBCATEGORY | n |
|---|---|
| bringing people together | 15 |
| flexibility | 9 |
| communication and facilitation skills | 8 |
| helpful resources | 7 |
| understanding of county context | 7 |
| individualized technical assistance | 6 |
| experience with MHSA | 5 |
| project management skills | 5 |

Participants mentioned a number of strengths and skills in the consultant(s) that led to project success. The most commonly cited strength was in the consultant's ability to bring people together, including people from different levels within behavioral health, from different departments, and across counties (n=15). As one participant noted,

> *"He spent time working with other department heads, probation, the sheriff, and so ...they have ownership of it too."*

Several participants also noted the consultant's facilitation skills (n=5) as an important factor.

Participants also indicated that the consultant's ability to be flexible (n=9) and their understanding of the county's context (n=7) — its unique needs, goals, strengths, and challenges — were vital for project success. Related to these strengths, participants found the individualized technical assistance, grounded in an understanding of the county's unique environment and the consultant's willingness to be flexible, to be particularly valuable (n=6). One participant explained:

> *"I think what has made it so valuable is he brings a combination of subject matter expertise together with individualized consulting that is responsive and adaptive to our local situation. He brings ideas to the table but he always kind of adapts them to where we're at, what we need, and how to make it work for us, but then he very gracefully connects us up with what other people, other places are doing."*

The helpful resources consultants provided, including tools and guides for decision-making, also were appreciated

by county staff (n=7). Finally, having experience working in the development, evaluation, and delivery of Mental Health Services Act (MHSA) funded programs and projects (n=5) and project management skills (n=5) were also commonly cited as consultant strengths.

### CATEGORY: OUTCOMES OF THE INNOVATION INCUBATOR PROJECTS

| SUBCATEGORY | n |
|---|---|
| better communication within county | 11 |
| common goals within county | 10 |
| relationship building | 10 |
| perspective/mindset change | 9 |
| project-specific learning | 9 |
| leveraging project/data to apply for grants/funding | 8 |
| better understanding of the population they serve | 7 |
| continuing the work | 7 |

Participants identified communication and collaboration within their county as positive outcomes of their Innovation Incubator project(s). The most cited outcome was better communication within the county (n=11), followed by common goals within the county (n=10) and relationship building both within and across counties and with other partners (n=10). As an example, one participant noted:

> *"As a behavioral health department, we really can't do anything without our partners in the community – law enforcement, CHP, sheriff, district attorney's office, public defender's office – all of us being willing, knowing that there's gaps in our system, and being willing to come to the table and work together – that's huge … That's kind of bled over into other areas … All the DDRP [Data-Driven Recovery Project] work really did lead us into this path where we're in statewide workgroups now … and listening to other counties."*

Outcomes were also commonly mentioned in relation to looking ahead and planning for the future. Participants indicated that the projects resulted in a perspective shift or change in mindset, often around the use of data, a focus on strengths, and a more client-centered approach (n=9). Several participants also stated that they were already moving forward and continuing the work that began in the Innovation Incubator project, some even before the project officially concluded (n=7).

Participants also mentioned project-specific learning, such as lessons learned in mobile crisis services or psychiatric advance directives (n=9). Finally, several participants noted that the projects led to a better understanding of the population their county behavioral health department serves (n=7).

### CATEGORY: OUTCOMES OF THE INNOVATION INCUBATOR PROJECTS

| SUBCATEGORY | n |
|---|---|
| relationship building and understanding | 18 |
| better outcomes for clients/patients | 14 |
| culture change/shift in perspective | 14 |
| data-driven approach | 14 |
| leads into/informs future projects | 14 |
| too early to tell | 11 |
| on same page within county | 9 |
| ability to report outcomes/better reporting | 8 |
| statewide, systemic change | 8 |

When asked about the long-term value of their participation in the Innovation Incubator projects, participants again elevated relationship building and understanding as one of the most common long-term outcomes. This was true within their county, across counties, with state agencies, and with other partners (n=18). Because of its inherent uncertainty, innovation requires connection and trust; forging relationships can streamline the process and build capacity to innovate together. Further, it builds the foundation for future projects and partnerships. One participant explained the power of relationship building by saying:

> *"We went from this adversarial relationship with the hospitals and law enforcement around people placed on 5150 holds, and we were able to come together, the three entities, and talk about this as a three-legged stool… The in-fighting has stopped, we all realized we have a role. It happened in the jail, it happened in the community… it's nice to see."*

Several participants indicated that a long-term result of participating is a greater ability to report outcomes for their clients (n=8), such as graduation rates for FSP clients.

Related to this finding, participants reported that their work with the Innovation Incubator project has already led to better outcomes for the population they serve (n=14). These improvements could be linked to the data-driven approach that these projects encouraged counties to adopt (n=14), and the culture change that the projects drove (n=14). These outcomes are likely also supported by better communication between departments, resulting in staff getting "on the same page" within the county (n=9).

Further, participants reported that the results of these projects are informing or directly leading into new projects (n=14). Though some participants indicated that while they are hopeful for positive long-term value, it is simply too early to tell (n=11); others felt this work, along with the multi-county format, is fostering the statewide, systemic change (n=8), which was the goal of the Innovation Incubator.

### CATEGORY: GAINS FROM PROJECT PARTICIPATION

| SUBCATEGORY | n |
|---|---|
| hands-on experience builds confidence in doing Innovation work | 10 |
| connections and communication (within & between counties) | 10 |
| helped identify gaps/needs; informed conversations | 5 |
| "soft" skills | 4 |
| seeing Innovation projects play out | 4 |

Participants also shared some of the skills, abilities, and knowledge they gained from participating in their project – even though they were not directly related to the project's topic area. The most commonly reported gain was greater confidence in doing this type of work, which was attributed to getting hands-on experience (n=10). One participant noted "it doesn't feel like Mount Everest," referring to doing Innovation work after participating in the Innovation Incubator Model. Another commonly reported gain was greater communication both within and between counties (n=8).

Other cited gains included "soft" skills, such as negotiation and facilitation (n=4), help in identifying gaps and needs in their county (n=4), and simply seeing innovation projects play out in other counties (n=4).

### CATEGORY: GAINS FROM PROJECT PARTICIPATION

| SUBCATEGORY | n |
|---|---|
| allows small/frontier counties to participate | 7 |
| don't have to "reinvent the wheel" | 7 |
| allows counties to "dive deeper" | 6 |
| flexible State-sponsored support | 6 |
| having someone else write the plan | 5 |
| allows counties to try new things | 4 |
| multi-county format | 4 |

Several factors were cited as strengths of the Innovation Incubator model that led to project success and made it a valuable experience for the county. Participants listed several ways that the model removed barriers or opened new avenues, specifically for small and rural or frontier (very low population density) counties (n=7). In particular, participants noted the multi-county format (n=4) that allowed them to learn from and share knowledge and resources with other counties, meaning they didn't have to "reinvent the wheel" to do work in innovation (n=7). As one participant explained:

> *"I can see multi-county projects – especially for ourselves in a small county that is more disconnected. We have counties neighboring us that have similar issues, and so how are they addressing some of these problems and how can we help each other?"*

Further, participants also appreciated that the model allowed them to "dive deeper" into particular issues or challenges within their county (n=6) and try new things without the fear of failure or pressure to succeed (n=4).

Finally, participants also appreciated the flexible State-sponsored support (n=6). They also appreciated having a third party write the project plan, which has been noted as a burden for many counties (n=5).

### CATEGORY: LESSONS LEARNED FOR FUTURE PROJECTS

| SUBCATEGORY | n |
|---|---|
| set expectations/define goals upfront | 15 |
| let counties lead | 7 |
| educate counties on project beforehand | 6 |
| align timelines/have counties start at the same time | 5 |
| collaborate early on multi-county contract | 5 |
| consultants need to understand county context | 5 |
| allow counties flexibility to customize in project | 4 |
| plan for the end of the project/sustainability | 4 |

Although participants generally reported success with their Innovation Incubator project, they also shared lessons learned that can be applied to future projects. The biggest lesson learned related to setting expectations and defining the goals of the project at the beginning (n=15). As one participant noted:

> *"One of the factors that could help managing expectations that lead to success is identifying – setting this out to begin with – that the timeline should take into account laying the foundation between the participating counties."*

Related to this lesson, they noted that it is vital to educate counties on the project beforehand so that counties can make informed decisions about whether or not to join and how much staff time and resources to set aside (n=6).

Three of the biggest lessons learned were around roles and responsibilities of the county, SMEs/consultants, and other partners. First, participants felt that future projects would be more successful if counties led the effort rather than the consultants or the Commission (n=7). Second, participants felt that consultants need to have a solid understanding of the context of the county (or counties) they are working with to provide effective technical assistance (n=5). And third, participants felt that consultants need to offer counties the flexibility to customize the project to fit their county's needs (n=4). Though 26 counties participated in Innovation Incubator projects, there are 59 counties/jurisdictions in California – and a "one size fits all" approach does not work in such a large, diverse state.

Another large set of lessons learned were related to working with other counties. Participants recommended aligning timelines across counties and attempting to have counties start their projects at the same time (n=5). They also learned that contracting takes longer than anticipated when multiple counties are involved and that the contracting process should start early in such instances (n=5).

Finally, participants emphasized the importance of planning for the end of the project and building in sustainability from the beginning (n=4). Some counties felt their project was a success but were not sure how to move forward as the project ended or wound down.

## CATEGORY: COLLABORATION SUGGESTIONS AND OPPORTUNITIES

| SUBCATEGORY | n |
|---|---|
| more collaboration, less punitive oversight | 12 |
| share information on other counties statewide | 12 |
| educate counties on Commission workings/goals/needs | 10 |
| more opportunities for collaboration | 10 |
| bidirectional communication/communication across roles | 8 |
| bring multiple departments/agencies together | 7 |
| facilitate broader conversations | 7 |
| fewer "strings"/mandates/hoops to jump through | 7 |
| gather counties to talk about gaps/challenges | 7 |
| regular opportunities to ask questions | 7 |
| consistent/regular communications | 5 |
| make local and cross-county connections | 5 |

Participants had several suggestions for how the Commission can foster collaboration across the state more broadly. Chief among them were two important insights: Counties need to know what other counties are doing (n=12) and counties need to feel that the Commission is supportive and collaborative rather than focusing on what they are doing wrong (n=12). One participant explained it this way:

> *"If we can change it a little bit to be less punitive… not this sort of one-time auditing, but more of like, 'We're just really curious, what are you struggling with, what's happening here, is there any community meeting you'd like us to attend, is there a presentation that you'd like for us to come [to] and tell your staff about the work?'*

One way the Commission can focus on partnering with counties is to educate them on the Commission's goals, needs, and mandates(n=10); the more counties understand the Commission's work, the better they are able to partner. Further, counties are hoping for fewer strings attached to funds and fewer hoops to jump through when it comes to using those funds (n=7).

Participants would like more opportunities for collaboration with other counties (n=10), and more opportunities to talk with other counties about needs, gaps, and challenges (n=7). To facilitate these interactions, they would like the Commission to facilitate broader, statewide conversations (n=7) and intentionally make more local and cross-county connections (n=5).

But participants would also like to have more opportunities for bidirectional communication with the Commission (n=8) and more opportunities to interact with multiple departments and agencies (n=7). They would also appreciate having regular opportunities to ask the Commission questions (n=7) as well as consistency in overall communications (n=5).

### CATEGORY: WAYS TO BUILD EFFECTIVE RELATIONSHIPS

| SUBCATEGORY | n |
|---|---|
| keep it up | 13 |
| humanize the Commission | 12 |
| be responsive/available for questions | 9 |
| in-person visits/sessions/forums | 9 |
| be the linkage between counties and partners | 6 |
| communicate opportunities for collaboratives | 5 |
| help counties report out on successes | 5 |
| reach out frequently/regularly | 5 |

Participants also had several helpful suggestions for ways the Commission can foster trust and build better relationships with counties. The most frequently cited suggestion was to "keep it up;" this specifically meant to continue reaching out, providing compassionate technical assistance, and offering opportunities for learning and collaboration (n=13).

The next most common suggestion was to humanize the Commission, meaning to help counties get to know Commissioners and Commission staff and to form meaningful relationships (n=12). As one participant noted on the importance of this sort of relationship building, "It's a lot harder to mistrust an individual than it is to mistrust an organization."

One way this can be encouraged is through more in-person/site visits and opportunities to interact (n=9). The Commission can also keep up a good relationship by being responsive and available for questions (n=6) and reaching out to counties frequently and regularly (n=5).

Participants would also like the Commission to help them work with other counties, specifically through intentionally linking counties, other State agencies, advocates, subject matter experts, and other partners (n=6), communicating opportunities for collaboration such as the Innovation Incubator projects (n=5), and helping counties report out on their successes (n=5).

### CATEGORY: SUPPORT COUNTIES WOULD LIKE TO RECEIVE FROM THE COMMISSION

| SUBCATEGORY | n |
|---|---|
| broad data framework/database(s)/improvements to existing database(s) | 9 |
| clarification what is innovative/innovation | 8 |
| guidance through project life cycle | 7 |
| help counties educate partners and the community on Innovation | 7 |
| help counties share out successes | 6 |
| assistance in plan development | 6 |
| assistance with engagement/Community Planning Process (CPP) | 5 |
| mentorship on MHSA and/or Innovation projects | 5 |
| more resources/education | 5 |
| sample/suggested timeline | 5 |

The interviews captured information on ways the Commission can better support counties in doing innovation work in particular as well as work in the mental health space in general.

Participants would like some improvements to existing databases and/or some new, statewide databases that foster consistency in reporting (n=9). One participant provided an example of a statewide database that would be valuable for him and his county, stating "I can't log into a database to see how many people are coming out of DSH (Department of State Hospitals) or how many people are being released and entered into [other programs]... that there is not a statewide coordinated dashboard that will give me all the data that I need to know about referrals is frustrating for me."

Participants also requested clarification on Innovation as a component of the MHSA and, for project planning purposes, knowing specifically what counts as innovative (n=8). They also would appreciate more assistance from the Commission throughout all stages of the project process (n=7), including project plan development (n=5), the Community Planning Process (CPP) (n=5), and mentorship (n=5).

Participants also requested help educating their partners and their community on MHSA Innovation (n=7) and assistance reporting on their successes in this area (n=6). Finally, participants would appreciate more resources and education, such as the Innovation toolkit (n=5), along with more informed expectations around the project timeline (n=5).

### CATEGORY: HELPING COUNTIES GET MEANINGFUL STAKEHOLDER ENGAGEMENT

| SUBCATEGORY | n |
|---|---|
| county has best practices to share on engagement | 10 |
| Commission-branded education | 10 |
| sharing best practices | 5 |
| providing tools | 4 |
| brining in external voices (e.g., Commission, consultants) | 3 |
| clarifying expectations on engagement | 3 |

Participants in several counties indicated that they were already doing well on stakeholder engagement and volunteered to present or provide resources and strategies to other counties on how to do so (n=10).

However, other participants had several ideas for ways the Commission could help them improve on their stakeholder engagement – and particularly around MHSA and Innovation-related work. First, participants would like to have Commission "branded" educational materials to present to their community during engagement meetings or events. This would help provide their stakeholders with a foundation of knowledge in MHSA and Innovation before gathering their feedback (n=10). This would add value, as one participant explained:

> *"Trainings, materials, information that counties can pass out to stakeholders on a regular basis would be helpful. And it's not that we don't do that ourselves — we do — but there's just something about having it backed by the OAC [Oversight and Accountability Commission] … [it] pulls more weight than if the county is saying it."*

Participants were also open to other tools that the Commission could provide in this area, including guidelines for inviting and engaging the community and sample questions to solicit feedback (n=4).

Another suggestion was to gather and disseminate best practices gleaned from other counties that had success engaging their communities (n=5). In addition, participants appreciated when the Commissioners and/or Commission staff attended and contributed during stakeholder engagement events (n=3).

Finally, participants believe counties would benefit from the Commission clarifying expectations around what specifically constitutes meaningful stakeholder engagement (n=3).

### CATEGORY: TOPIC AREAS FOR LEARNING COMMUNITIES

| | |
|---|---|
| stakeholder engagement/Community Planning Process (CPP) | 7 |
| CalAIM (California Advancing and Innovating Medi-Cal) | 4 |
| diversion | 4 |
| trauma-informed work | 3 |
| housing/supportive housing/homelessness | 3 |
| incompetent to stand trial (IST) population | 3 |

Participants had dozens of ideas about topics for future learning communities. Though there was overlap among them, they spanned many topic areas.

The most commonly suggested topic area was stakeholder engagement and the Community Planning Process (n=7). Participants were also interested in learning more about how other counties are handling CalAIM changes (n=4) and diversion (n=4).

Several participants also mentioned interest in learning about doing trauma-informed work (n=3), promoting supportive housing and reducing homelessness (n=3), and managing the incompetent to stand trial (IST) population (n=3).

### CATEGORY: GENERAL FEEDBACK

| SUBCATEGORY | n |
|---|---|
| county would not have been able to do this work without the Innovation Incubator project | 14 |
| Innovation Incubator project required a lot of hard work to participate in | 7 |
| appreciated the interview | 7 |
| belief in the power of innovation | 4 |

Overall, many participants noted that they would not have been able to do this important work without the support and guidance they received from participating in the Innovation Incubator project (n=14). One participant noted:

> *"It's something I would not have ever done on my own; I think I would have been too afraid of it to even begin to try."*

However, the Innovation Incubator Model was not without its challenges. Participants noted, for example, that participating in it required a lot of hard work (n=7). Several participants shared that they appreciated being interviewed and that it was a way to connect and interact with Commission staff; they also liked having the opportunity to provide their feedback (n=7). Finally, participants emphasized their belief in the power and potential of Innovation funding through the MHSA (n=4). As one participant noted, "Innovation is a very untapped area of the MHSA."

## 4. LIVED EXPERIENCE INTERVIEWS

During the county interviews, staff asked for contact information for consumers and/or their family members who were involved in their county's Innovation Incubator project and would be willing to speak with Commission staff about their experience.

Through this networking, staff were connected with two individuals who identified as having lived experience (as a consumer of public mental health services, a family member of a consumer, or both) who also actively participated in their county's project. These interviews were scheduled for 45 minutes and conducted remotely via Zoom, with a promise of confidentiality for each participant. See Appendix E for the interview questions.

These interviews highlighted three key lessons about incorporating the lived experience perspective into transformational mental health work:

1. People with lived experience are eager to act as advocates on project teams, sharing their experience and building understanding.
2. It is vital to reach people with lived experience when doing community engagement. This may require doing extra outreach and offering participation incentives.
3. Consumers and family members can act as effective conduits for outreach to people with mental health challenges by more easily connecting with them and building trust.

Innovation requires a deep understanding about the problem being solved. To gain this understanding and more effectively fill gaps and address challenges in our mental health system, it is necessary to include perspectives from actual consumers and family members. Going forward, the State and its partners should conduct meaningful engagement with people who have lived experience and integrate their input into mental health strategies, policies, and programs.

# 03 INSIGHTS & ACTIONS

# Action Steps to Advance Innovative Mental Health Approaches

Seven key insights from implementing the Commission's Innovation Incubator Model revealed actions to help advance innovative mental health approaches in California. These insights can streamline and boost the effectiveness of MHSA Innovation projects and improve future use of the Innovation Incubator Model. Some of these findings align with the findings of the Systems Analysis project, adding weight to calls for meaningful changes to the way the Commission handles projects within the Innovation component and how it engages with counties in general. They can also be leveraged to expand beyond the Innovation component and beyond the Commission itself to guide how all State partners and other organizations work with counties and community members to foster transformational change in California's mental health system.

The Innovation Incubator Model is an effective method of bringing partners together and delivering expert assistance to apply an untested approach to population mental health issues that communities are facing.

**ACTION 1A**

The Commission, counties, and other partners working in the mental health space can expand use of the Innovation Incubator Model to other issues and areas — both within and outside of the mental health space.

The Innovation Incubator Model can be improved upon in several ways, including educating counties and partners on their project's purpose, goals, and expectations ahead of time. Much of the findings in this area echoed what Social Finance (one of the Innovation Incubator's SMEs) gleaned from the Systems Analysis project.

**ACTION 2A**

The Commission can move forward with recommendations from Social Finance on refining and improving the MHSA Innovation project process.

**ACTION 2B**

The Commission, counties, and other partners working in the mental health space can modify the Innovation Incubator Model to improve its effectiveness based on insights from this evaluation. This includes more education and more thorough planning.

Building relationships is key to success for the Innovation Incubator Model. It is also a valuable outcome of projects within this model.

**ACTION 3A**

The Commission can coordinate with county behavioral health departments to create a sharable database of contact information. This database should be disseminated to counties and other partners and updated frequently.

**ACTION 3B**

The Commission, county behavioral health staff, and SMEs can make connections between counties and other partners that are doing similar work and/or have information and resources to share.

**ACTION 3C**

The Commission, State agencies, and counties can hold more in-person events to increase opportunities to make connections.

Counties lack the capacity to engage in available opportunities to experiment and learn. With improved support from their partners, they can take advantage of these opportunities.

**ACTION 4A**

The Commission and State agencies can foster and incentivize capacity building to help counties get the staff time, resources, and skills necessary to experiment.

**ACTION 4B**

The Commission, State agencies, and other partners can raise awareness about opportunities to experiment that require minimal resources (e.g., State-sponsored opportunities).

**ACTION 4C**

The Commission, State agencies and other partners can raise awareness about flexible funding streams (e.g., planning funds) that allow counties to engage in more innovative work.

Counties want more opportunities for collaboration and shared learning with other counties, including more multi-county collaboratives.

**ACTION 5A**

The Commission, State agencies, and other partners can host and publicize more events that bring multiple counties and partners together.

**ACTION 5B**

The Commission and State agencies can sponsor more multi-county collaboratives and share out information on these opportunities.

**ACTION 5C**

The Commission, State agencies, SMEs, and other partners can foster learning communities by bringing together counties that are facing similar challenges or doing similar work.

Counties are eager to learn what other counties are doing in mental health, including current projects and best practices, and also what is not working well in other counties.

**ACTION 6A**

The Commission can develop and share a user-friendly database of county projects in mental health, including contact information and easily searchable terms.

**ACTION 6B**

The Commission, State agencies, and other partners can highlight innovative or highly effective work happening around the state in emails, newsletters, through social media posts, and/or in meetings.

**ACTION 6C**

The Commission, State agencies, counties, and other partners can add a standing agenda item to relevant meetings for discussing what was tried and did not work well and/or faced significant challenges.

People's lived experience as consumers or family members of consumers of mental health services is vital to include in planning and implementation, and they are often eager to partner on work happening within the mental health space.

### ACTION 7A

The Commission and counties can enhance their outreach and incentives for people with lived experience to participate in community engagement opportunities.

### ACTION 7B

The Commission, State agencies, and other partners can invite and incentivize people with lived experience to partner on project teams and other collaborations within the mental health space.

# 04 CONCLUSION

# Limitations

Commission staff worked diligently to collect the best possible data for this evaluation. However, the findings in this report are limited by the factors outlined below.

First, not all individuals who participated in Innovation Incubator projects — either as county staff, contracted SMEs, or other SMEs — provided feedback. Commission staff may not have had all current contact information, and not all who were contacted agreed to provide feedback. This may have introduced a bias into the information collected and potentially influenced the polarity of feedback; survey and interview respondents are generally more likely to provide feedback if they feel strongly about a topic than if they feel neutral.

Second, there may be perspectives on the Innovation Incubator Model that were not taken into consideration. For example, no feedback was collected from consumers who received mental health services that were provided or affected through Innovation Incubator projects. This would have been difficult to do in most cases, as the projects were generally systems-level and did not influence direct care. In addition, there was limited awareness of the Innovation Incubator and its related projects. In general, only county staff, Commission staff, and contracted SMEs knew about it; there were few external stakeholders who were aware of the Incubator opportunity and who would have been able to provide informed feedback.

Third, the data collected are qualitative. These data are rich and detailed but are reflective of only the opinions and experience of those interviewed. Findings were not triangulated with quantitative data.

Finally, Commission staff conducted all of the evaluation activities, including the interviews. Though staff did so in as unbiased a way as possible, some participants may have felt apprehensive in providing negative feedback to the organization making funding decisions that affect their community.

# Conclusion

The findings from the Innovation Incubator Model evaluation represent an opportunity to effect change on a grand scale. They can be applied to improve upon and enhance the work happening within the Innovation component of the MHSA and also more broadly to all work in which the Commission and its partners engage. The insights can be used to bolster collaboration and build relationships across the state, helping the State, counties, and other partners improve upon default processes and foster transformational change in the mental health system.

# 05 APPENDICES

# Appendix A

## The eight Innovation Incubator Projects are described below.

### CRISIS NOW PROJECT

Ten counties – Butte, Inyo, Mono, Nevada, Placer, Plumas, Sacramento, Shasta, Solano, and Yolo – plus the city of Berkeley worked together to develop comprehensive and financially sustainable crisis response systems that were designed to better meet people's mental health needs during a crisis and reduce unnecessary incarcerations and hospitalizations.

### DATA-DRIVEN RECOVERY PROJECT

Ten counties working through two cohort projects linked criminal justice and behavioral health data to better understand the mental health needs of people in the criminal justice system. The first project cohort included Sacramento, San Bernardino, Nevada, Plumas, and Yolo counties. The second project cohort included Calaveras, El Dorado, Lassen, Marin, and Modoc counties. The third project expanded on the first two by deploying new data and assessment capacities in participating counties and incorporating lessons learned to drive continuous improvement.

### FISCAL MAPPING PROJECT

Three counties – Sacramento, San Luis Obispo, and Santa Barbara – participated in this project. It aimed to identify, assess, and develop existing revenue streams that counties could tap into to develop policy options that would lead to more manageable and sustainable funding streams. These funding streams would support cost-effective strategies and services to prevent and reduce criminal justice involvement among those with mental health needs.

### FISCAL SUSTAINABILITY PROJECT

Three counties – Sacramento, San Luis Obispo, and Santa Barbara – assessed the effectiveness of interventions aimed at reducing the criminal justice involvement of people with unmet mental health needs and developing strategies for improving performance and financial sustainability.

### FULL SERVICE PARTNERSHIPS PROJECT

Nine counties signed on to evaluate and refine their Full Service Partnerships (FSPs) to improve the results from the "whatever it takes" approach. More than $1 billion is spent annually on FSPs statewide, meaning improvements in effectiveness can have significant impacts. Fresno, Napa, Sacramento, San Bernardino, San Mateo, Siskiyou, Stanislaus, Lake, and Ventura counties worked together to assess their FSP programs and develop metrics for improvement efforts (Napa County joined the project in October 2022 after some of the evaluation activities were completed, so their experience may not be fully represented in the evaluation findings).

### INNOVATION INCUBATOR LESSON DISSEMINATION PROJECT

Two projects focused on the dissemination of Innovation Incubator's learnings. The first project disseminated lessons and key issues that the Commission's multi-county collaboratives identified in seeking to reduce justice involvement of individuals with mental health needs; these were disseminated to state and county leaders.

The second project worked with other Innovation Incubator contractors, state agencies, and participating counties to develop, in consultation with state and local agencies, a policy framework to support a more coherent approach to the state agencies' policymaking and program implementation. This project provided targeted technical assistance to counties interested in deploying the practices and lessons learned through all the Innovation Incubator projects.

### PSYCHIATRIC ADVANCE DIRECTIVES (PADS) PROJECT

Five counties – Fresno, Orange, Shasta, Mariposa, and Monterey counties – explored options to deploy psychiatric advance directives to improve the response from law enforcement to individuals who are in crisis, in partnership with physical health and behavioral health workers. A second project was launched to follow up and improve upon the results of the first project with the same group of counties.

### SYSTEM CHANGE ANALYSIS PROJECT

The Commission partnered with Social Finance, a national nonprofit, to work with county leaders, stakeholders, and the Commission to assess and recommend ways to support effective innovation projects. Partners from multiple counties and agencies across the state participated in this project.

# Appendix B

## COUNTY SURVEY QUESTIONS

1. In your county's experience, how effective have the technical assistance, capacity building, and/or continuous improvement strategies been in…
   - **a.** Helping you meet your project goals? (1 = not at all effective, 5 = extremely effective)
   - **b.** Increasing your county's ability and confidence in developing future innovation projects? (1 = not at all effective, 5 = extremely effective)
2. What factors or conditions made the technical assistance, capacity building, and/or continuous improvement strategies effective?
3. Both group learning and individualized assistance have been identified as valuable aspects of Incubator projects. What is the right mix for your county? (slider question from 100% group learning to 100% individualized assistance)
4. What has changed in your county as a result of your participation in the Innovation Incubator? Please select all that apply.
   - ☐ Changes in the way data is collected
   - ☐ Developed core capacities to use data
   - ☐ Developed relationships with other county partners
   - ☐ Changes in the way services are delivered
   - ☐ Other (please specify)
5. Please rank the following reasons why it may have been difficult to participate in Incubator projects from 1 (most difficult) to 4 (least difficult).
   - **a.** Time available to managers and other support staff
   - **b.** Lack of executive support
   - **c.** COVID-related issues
   - **d.** Other
6. What are some of the other reasons why it has been difficult to participate in Incubator projects?
7. What does your county plan to do with the knowledge and information gained through participation in the Innovation Incubator project(s)? Please select all that apply.
   - ☐ Inform development of Innovation plans
   - ☐ Improve system of care
   - ☐ Work with other agencies within the county to improve results
   - ☐ Work with neighboring counties to improve results
   - ☐ Other (please specify)
8. How important is it for the State and counties to work collaboratively to build capacity and improve mental health outcomes? (1 = not at all important, 5 = extremely important)
9. What are the barriers to effective State and County collaboration?
10. What form of technical assistance does your county need the most when it comes to engaging in Innovation projects?
11. What makes for a successful multi-county collaborative environment?
12. How can the Commission support your work going forward?

# Appendix C

## COUNTY INTERVIEW QUESTIONS

1. Overall, was your participation in the Incubator project worth the time and effort you invested into it? How can you tell?
2. From the county survey, we learned that working with consultants who had subject matter expertise and participating in cross-county collaboration were two of the biggest factors for success. How does this finding apply in your county, if at all?
    a. What else has made your participation valuable?
    b. What support or assistance would have made it even more so?
3. What are your expectations for long-term value? What changes do you expect to see or implement based on your Incubator project experience?
    a. Do you expect to see any broad system or culture changes from your Incubator project experience?
4. The experts at Social Finance have been gathering feedback on things the Commission can do to support counties in doing innovation work. We've heard that counties would like more focus and support groups, more community engagement resources, and more clarity around innovation plan development, among other things. Does this resonate with you and your county? What else can the Commission do to help counties feel confident in the innovation space?
5. What did you learn or gain from your participation in the Incubator project that has helped build your confidence in planning and implementing other innovation projects? What skills can you bring to bear on future projects like these?
6. How can the Commission and other State partners build and sustain effective relationships and trust with counties?
7. What else can the Commission do to facilitate effective State/local collaboration?
8. What can the Commission and other State partners do to help counties effectively engage community members and local partners?
9. The Commission is exploring opportunities to engage counties in learning communities to share learning and resources and to facilitate group problem-solving. Are there any topics that you would like to see covered in learning communities like these? Are there any topics that you feel your county could contribute to?
10. We would like to interview people with lived experience and their family members to share their perspectives on and experience with Incubator projects. Is there someone we could contact who you worked with on the Incubator project?
11. Is there anything else you'd like to share about your experience participating in the Incubator project(s)?

# Appendix D

## ALL CODES

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| best practices in engagement | including leadership individuals as stakeholders | 2 |
| best practices in engagement | working with Community Based Organizations (CBOs) /providers/partners to engage community | 2 |
| best practices in engagement | transparency and partnership in community engagement | 1 |
| best practices in engagement | reporting back to the community | 1 |
| best practices in engagement | using wellness centers to get engagement | 1 |
| challenge | amount of work/number of meetings | 14 |
| challenge | COVID-19 | 13 |
| challenge | lack of staff time | 12 |
| challenge | aligning priorities/work between counties | 11 |
| challenge | lack of capacity to take advantage/implement ideas | 11 |
| challenge | workforce/finding staff | 11 |
| challenge | silos/lack of communication | 9 |
| challenge | staff wearing multiple hats | 9 |
| challenge | confusion about project purpose/process | 8 |
| challenge | consultant/SME/model was inflexible | 8 |
| challenge | contracting is difficult/time-consuming | 7 |
| challenge | turnover/lack of historical knowledge | 7 |
| challenge | Data Collecting and Recording (DCR) issues/State handling of data | 7 |
| challenge | getting stakeholder engagement | 7 |
| challenge | being a small/rural county | 6 |
| challenge | differing county needs/challenges (by size, rural/urban) | 6 |
| challenge | differing county timelines | 6 |
| challenge | differing programs and data collection in counties | 5 |
| challenge | fires/floods/natural disasters | 4 |
| challenge | subject matter expertise not totally applicable in county | 4 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| challenge | aligning priorities/work within counties | 3 |
| challenge | CalAIM (California Advancing and Innovating Medi-Cal) | 3 |
| challenge | getting approval, board/council issues | 3 |
| challenge | pushback/lack of understanding from stakeholders | 3 |
| challenge | keeping leadership apprised/getting approval on transformational projects | 2 |
| challenge | lack of administrative support | 2 |
| challenge | lack of leadership understanding | 2 |
| challenge | lack of sustainable funding | 2 |
| challenge | balance between flexibility and standardization | 1 |
| challenge | counties slow to change | 1 |
| challenge | county services mostly contracted out | 1 |
| challenge | getting buy-in on the ground level | 1 |
| challenge | getting peer engagement | 1 |
| challenge | health insurance/Medi-Cal issues | 1 |
| challenge | inflexibility in funding | 1 |
| challenge | Innovation process is burdensome | 1 |
| challenge | knowing who should be involved | 1 |
| challenge | lack of funding | 1 |
| challenge | lack of leadership support/prioritization | 1 |
| challenge | lack of technical skills within county | 1 |
| challenge | turnover in consultants | 1 |
| challenge | working with data systems/databases/pulling data | 1 |
| collaboration | more collaboration, less punitive oversight | 12 |
| collaboration | share information on other counties statewide | 12 |
| collaboration | educate counties on Commission workings/goals/needs | 10 |
| collaboration | more opportunities for collaboration | 10 |
| collaboration | bidirectional communication/communication across roles | 8 |
| collaboration | bring multiple departments/agencies together | 7 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| collaboration | facilitate broader conversations | 7 |
| collaboration | fewer "strings"/mandates/hoops to jump through | 7 |
| collaboration | gather counties to talk about gaps/challenges | 7 |
| collaboration | regular opportunities to ask questions | 7 |
| collaboration | consistent/regular communications | 5 |
| collaboration | make local and cross-county connections | 5 |
| collaboration | ask counties to assist/present/share best practices | 4 |
| collaboration | facilitate information-sharing at multiple levels | 4 |
| collaboration | facilitate standardized data-sharing | 3 |
| collaboration | places to share resources between counties | 3 |
| collaboration | coordinate with other State agencies/partners/advocates | 2 |
| collaboration | involve counties early and during development | 2 |
| collaboration | make it okay to fail | 2 |
| collaboration | small group discussions | 2 |
| collaboration | statewide data committee (Full Service Partnership [FSP]) | 2 |
| collaboration | work more closely with County Behavioral Health Directors Association (CBHDA) | 2 |
| collaboration | clarify roles (county, Commission, other partners) | 1 |
| collaboration | collect and share contact information | 1 |
| collaboration | in-person meetings | 1 |
| collaboration | invite more partners to trainings/technical assistance (TA) sessions/ webinars etc. | 1 |
| collaboration | join Stepping Up initiative as a state | 1 |
| collaboration | make connections between counties | 1 |
| collaboration | make direct/personal contact on important things | 1 |
| collaboration | provide education on MHSA | 1 |
| collaboration | send out materials prior to meetings/events | 1 |
| concern | sustainability of Incubator project(s) | 2 |
| concern | transformational change takes time, reporting might not reflect changes made yet | 2 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| concern | driving innovation by state, not community engagement | 1 |
| consultant | bringing people together | 15 |
| consultant | flexibility | 9 |
| consultant | communication and facilitation skills | 8 |
| consultant | helpful resources | 7 |
| consultant | understanding of county context | 7 |
| consultant | individualized technical assistance | 6 |
| consultant | experience with MHSA | 5 |
| consultant | project management skills | 5 |
| consultant | communication skills | 4 |
| consultant | framing the issue/opportunity | 4 |
| consultant | asked the right questions | 3 |
| consultant | big picture perspective | 3 |
| consultant | responsiveness | 2 |
| consultant | technical skills | 2 |
| consultant | focusing on sustainability | 1 |
| effective relationship | keeping it up | 13 |
| effective relationship | humanize the Commission | 12 |
| effective relationship | be responsive/available for questions | 9 |
| effective relationship | in-person visits/sessions/forums | 9 |
| effective relationship | be the linkage between counties and partners | 6 |
| effective relationship | communicate opportunities for collaboratives | 5 |
| effective relationship | help counties report out on successes | 5 |
| effective relationship | reach out frequently/regularly | 5 |
| effective relationship | share accurate and current information | 4 |
| effective relationship | avoid reversion | 3 |
| effective relationship | open door/open communication/being available | 3 |
| effective relationship | orientation/bootcamp for new MHSA coordinators | 3 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| effective relationship | understand our community | 3 |
| effective relationship | distinguish Commissioners from staff | 2 |
| effective relationship | engage multiple/small/rural counties | 2 |
| effective relationship | streamline Innovation project process | 2 |
| effective relationship | TA and support | 2 |
| effective relationship | help with budgeting/financial aspect | 1 |
| effective relationship | offer "free" money/resources | 1 |
| effective relationship | offer flexibility | 1 |
| effective relationship | require counties to do projects like these | 1 |
| effective relationship | start to build relationship early | 1 |
| effective relationship | work with California State Association of Counties (CSAC) | 1 |
| engagement | county has best practices to share on engagement | 10 |
| engagement | Commission-branded education | 10 |
| engagement | share best practices from other counties | 5 |
| engagement | providing tools | 4 |
| engagement | bringing in external voices (e.g., Commission, consultants) | 3 |
| engagement | clarifying expectations on engagement | 3 |
| engagement | facilitating cross-county sharing/collaboration | 2 |
| engagement | facilitating focus groups | 2 |
| engagement | sharing info about opportunities to engage | 2 |
| engagement | supporting with stigma reduction | 2 |
| engagement | best practices for using social media | 1 |
| engagement | expert support | 1 |
| engagement | identifying experts in Community Planning Process (CPP) | 1 |
| engagement | in-person engagement | 1 |
| engagement | listening sessions and forums | 1 |
| engagement | searchable clearinghouse of county CPP summaries | 1 |
| engagement | staffing/resources for stakeholder engagement | 1 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| factor | cross-county collaboration | 32 |
| factor | effective consultants | 25 |
| factor | multi-county collaborative environment | 14 |
| factor | intra-county collaboration | 14 |
| factor | draw from broad range of expertise | 9 |
| factor | regular project engagement | 9 |
| factor | consultant was external | 7 |
| factor | internal commitment | 7 |
| factor | consultant they already knew | 6 |
| factor | community buy-in | 5 |
| factor | relevant/timely topics | 5 |
| factor | individualized/customized technical assistance | 4 |
| factor | consultant experience with other counties | 3 |
| factor | shared resources between counties | 2 |
| factor | support from the "right" people | 2 |
| factor | existing connections from other counties | 1 |
| factor | State/county communication | 1 |
| gains | hands-on experience builds confidence in doing Innovation work | 10 |
| gains | connections and communication (within & between counties) | 10 |
| gains | helped identify gaps/needs; informed conversations | 5 |
| gains | "soft" skills | 4 |
| gains | seeing Innovation projects play out | 4 |
| gains | made valuable connections/built relationships | 3 |
| gains | ability and knowledge to advocate | 2 |
| gains | more engaged in MHSA | 2 |
| gains | working with data/technical skills | 2 |
| gains | experience doing non-standard agreements | 1 |
| gains | experience writing Innovation plans | 1 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| gains | familiarity with Commission | 1 |
| gains | more informed conversations with county/State partners | 1 |
| general | county would not have been able to do this work without the Innovation Incubator project | 14 |
| general | Innovation Incubator project required a lot of hard work to participate in | 7 |
| general | appreciated the interview | 7 |
| general | belief in the power of innovation | 4 |
| learning communities | stakeholder engagement/Community Planning Process (CPP) | 7 |
| learning communities | CalAIM (California Advancing and Innovating Medi-Cal) | 4 |
| learning communities | diversion | 4 |
| learning communities | trauma-informed work | 3 |
| learning communities | housing/supportive housing/homelessness | 3 |
| learning communities | Incompetent to stand trial (IST) population | 3 |
| learning communities | 988/crisis call centers | 2 |
| learning communities | basics of MHSA | 2 |
| learning communities | Data-Driven Recovery Project (DDRP) | 2 |
| learning communities | employment support for adults with Serious Mental Illness (SMI) | 2 |
| learning communities | finances/budget for Innovation | 2 |
| learning communities | Innovation for small/frontier/rural county | 2 |
| learning communities | legislative changes | 2 |
| learning communities | mobile crisis in rural counties | 2 |
| learning communities | other Innovation projects | 2 |
| learning communities | peers/peer workforce | 2 |
| learning communities | working across agencies/departments | 2 |
| learning communities | best practices/examples | 1 |
| learning communities | building connections with primary care | 1 |
| learning communities | CalAIM and Prevention and Early Intervention (PEI) | 1 |
| learning communities | community levels of care | 1 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| learning communities | community trauma healing | 1 |
| learning communities | concerns about learning communities | 1 |
| learning communities | connecting children and adult systems | 1 |
| learning communities | crisis response team | 1 |
| learning communities | Department of State Hospitals (DSH) and their role | 1 |
| learning communities | extracting information from criminal justice data system | 1 |
| learning communities | hubs/collaborating with county partners | 1 |
| learning communities | Innovation plans and grant applications | 1 |
| learning communities | one on each component | 1 |
| learning communities | peer support network | 1 |
| learning communities | planning for end of project | 1 |
| learning communities | program evaluation (PEI) | 1 |
| learning communities | providing FSP services | 1 |
| learning communities | Senate Bill 317 | 1 |
| learning communities | school support (through PEI) | 1 |
| learning communities | school-based/Mental Health Student Services Act (MHSSA) | 1 |
| learning communities | standardizing data definitions | 1 |
| learning communities | Strengths Model for Case Management | 1 |
| learning communities | suicide prevention | 1 |
| learning communities | training law enforcement in critical incident response | 1 |
| learning communities | treating juvenile sex offenders and their victims | 1 |
| learning communities | working with CBOs | 1 |
| learning communities | working with forensics | 1 |
| lesson learned | set expectations/define goals upfront | 15 |
| lesson learned | let counties lead | 7 |
| lesson learned | educate counties on project beforehand | 6 |
| lesson learned | align timelines/have counties start at the same time | 5 |
| lesson learned | collaborate early on multi-county contract | 5 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| lesson learned | consultants need to understand county context | 5 |
| lesson learned | allow counties flexibility to customize in project | 4 |
| lesson learned | plan for the end of the project/sustainability | 4 |
| lesson learned | define/standardize measures early | 2 |
| lesson learned | emphasize incremental changes | 2 |
| lesson learned | get everyone on board early | 2 |
| lesson learned | have in-county champion support external consultant | 2 |
| lesson learned | leadership support/prioritization | 2 |
| lesson learned | narrower focus/goals | 2 |
| lesson learned | need shared fiscal intermediaries | 2 |
| lesson learned | organize/collaborate by region | 2 |
| lesson learned | slow down and work together | 2 |
| lesson learned | align counties before bringing in consultant/SME | 1 |
| lesson learned | balance of individual TA and cross-county collaboration | 1 |
| lesson learned | consider different contracts for different counties | 1 |
| lesson learned | convene small groups of counties | 1 |
| lesson learned | counties should make time commitment before joining | 1 |
| lesson learned | in-person collaboration is important | 1 |
| lesson learned | meetings should be carefully planned (avoid wasting time) | 1 |
| long-term | relationship building and understanding | 18 |
| long-term | better outcomes for clients/patients | |
| 14 | | |
| long-term | culture change/shift in perspective | 14 |
| long-term | data-driven approach | 14 |
| long-term | leads into/informs future projects | 14 |
| long-term | too early to tell | 11 |
| long-term | on same page within county | 9 |
| long-term | ability to report outcomes/better reporting | 8 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| long-term | statewide, systemic change | 8 |
| long-term | changes in the system of care | 6 |
| long-term | perspective shift | 6 |
| long-term | client-centered approach | 5 |
| long-term | policy/procedure updates | 5 |
| long-term | better collaboration with other counties | 3 |
| long-term | better data sharing | 2 |
| long-term | prevention focus | 2 |
| long-term | development of platform/technical tools | 1 |
| long-term | standardizing/aligning programs | 1 |
| outcome | better communication within county | 11 |
| outcome | common goals within county | 10 |
| outcome | relationship building | 10 |
| outcome | perspective/mindset change | 9 |
| outcome | project-specific learning | 9 |
| outcome | leveraging project/data to apply for grants/funding | 8 |
| outcome | better understanding of population they serve | 7 |
| outcome | continuing the work | 7 |
| outcome | data to back up intuition/anecdotes/common sense | 6 |
| outcome | data framework | 4 |
| outcome | helpful materials/resources developed through project | 4 |
| outcome | community/partners more engaged | 3 |
| outcome | focusing on data | 3 |
| outcome | better communication with State/other partners | 2 |
| outcome | process improvements | 2 |
| outcome | changing the way contracting is done | 1 |
| outcome | continuing to work with contractor | 1 |
| outcome | county staff more engaged | 1 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| outcome | focusing on quality improvement | 1 |
| outcome | more focused on meeting community needs | 1 |
| outcome | sustainability perspective | 1 |
| overall | project was worth the time and effort invested | 30 |
| overall | project was worth the time and effort, but results were mixed | 8 |
| overall | county dropped out of the project or did not fully participate | 4 |
| strength | allows small/frontier counties to participate | 7 |
| strength | don't have to "reinvent the wheel" | 7 |
| strength | allows counties to "dive deeper" | 6 |
| strength | flexible State-sponsored support | 6 |
| strength | having someone else write the plan | 5 |
| strength | allows counties to try new things | 4 |
| strength | multi-county format | 4 |
| strength | Commission pre-approved opportunities | 3 |
| strength | pre-identified experts | 3 |
| strength | allows for focused conversations within county | 2 |
| strength | county as lead | 2 |
| strength | shared/statewide goal(s) to guide counties | 2 |
| strength | offers collaboration opportunities for counties | 1 |
| strength | project doesn't necessarily have to be sustained | 1 |
| strength | pushes counties to get on the same page | 1 |
| strength | reduces administrative/process burden | 1 |
| strength | solutions-oriented | 1 |
| strength | voluntary/optional | 1 |
| support | broad data framework/database(s)/improvements to existing database(s) | 9 |
| support | clarify what is innovative/innovation | 8 |
| support | guidance through project life cycle | 7 |
| support | help counties educate partners and the community on Innovation | 7 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| support | help counties share out successes | 6 |
| support | assistance in plan development | 6 |
| support | assistance with engagement/Community Planning Process (CPP) | 5 |
| support | mentorship on MHSA and/or Innovation projects | 5 |
| support | more resources/education | 5 |
| support | offer sample/suggested timeline | 5 |
| support | help with staffing for implementation/coordination | 4 |
| support | emphasize "slow and steady" perspective | 3 |
| support | focus on sustainability | 3 |
| support | funds for administrative support | 3 |
| support | more multi-county collaboratives | 3 |
| support | more workforce development/expansion | 3 |
| support | share data benchmarks/goals to aspire to | 3 |
| support | develop peer support network | 2 |
| support | don't need more meetings | 2 |
| support | intentional relationship building | 2 |
| support | keep it up | 2 |
| support | more guidance early on | 2 |
| support | more individual/customized TA | 2 |
| support | open to anything | 2 |
| support | upfront funding/planning dollars | 2 |
| support | align Commissioner/staff feedback | 1 |
| support | annual conference on best practices | 1 |
| support | assistance in ensuring accurate reporting | 1 |
| support | county-led groups (not OAC-led) | 1 |
| support | cut down on length of Three-Year Plan | 1 |
| support | facilitate learning communities | 1 |
| support | funding for facilities | 1 |

| TOPIC AREA | SUBCATEGORY | n |
|---|---|---|
| support | help with evaluation | 1 |
| support | help with fiscal/avoiding reversion | 1 |
| support | legal counsel | 1 |
| support | liaison or other admin support person | 1 |
| support | more funding for services | 1 |
| support | raise awareness about resources/tools available | 1 |
| support | regular check-ins | 1 |
| support | repository of other Innovation projects | 1 |
| support | revising rejected plans | 1 |
| support | searchable clearinghouse of best practices | 1 |
| support | share information with leadership | 1 |
| support | TA and support for contracting | 1 |

# Appendix E

## LIVED EXPERIENCE INTERVIEW QUESTIONS

1. Tell us a little bit about yourself. What is your story? [If they haven't addressed it yet:] What is your experience with receiving mental health services?
2. [If they haven't addressed it yet:] How did you end up working with the county? How did you end up working with this specific project?
3. [If they haven't addressed it yet:] Why did you want to get involved in this project? Did the county do outreach to get you involved?
4. [If they haven't addressed it yet:] Did you receive any compensation or incentives to participate?
5. What was your experience with this project like? How did your participation go?
6. Do you feel your expertise was valued?
7. Do you feel your participation was worthwhile? Why or why not?
8. What can we do to facilitate involvement of other people with lived experience in projects like these?
9. Is there anything else you'd like us to know?

# AGENDA ITEM 8

**Action**

**February 23, 2023 Commission Meeting**

**Prevention and Early Intervention Report & Future Opportunities for Establishing PEI Priorities**

**Summary**: The Mental Health Services Oversight and Accountability Commission will consider adopting the Prevention and Early Intervention Report and discuss future opportunities for establishing priorities for the use of MHSA prevention and early intervention funding.

**Background**:
The prevention and early intervention component of the MHSA seeks to prevent mental health challenges from becoming severe and disabling, with an emphasis on improving timely access to services for underserved Californians and preventing the negative outcomes that may result from unsupported mental health challenges including suicide, incarceration, school failure, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

In 2018, legislation established key priorities for county use of PEI funding and authorized the Commission to expand upon those when warranted. The legislation also directed the Commission to develop a strategy for monitoring, evaluating, and providing technical assistance to support implementation of state-identified PEI priorities and to track progress of statewide prevention and early intervention efforts.[i]

In its draft report– *Well and Thriving* – the Commission's Prevention and Early Intervention Subcommittee presents a conceptual framework, including four findings and recommendations, to instill a shared vision that guides prevention and early intervention in mental health.

This report is intended to support the Commission as it considers its process and next steps to improve prevention and early intervention opportunities in California.

**Enclosure (1):** *Well and Thriving: Advancing Statewide Prevention and Early Intervention*

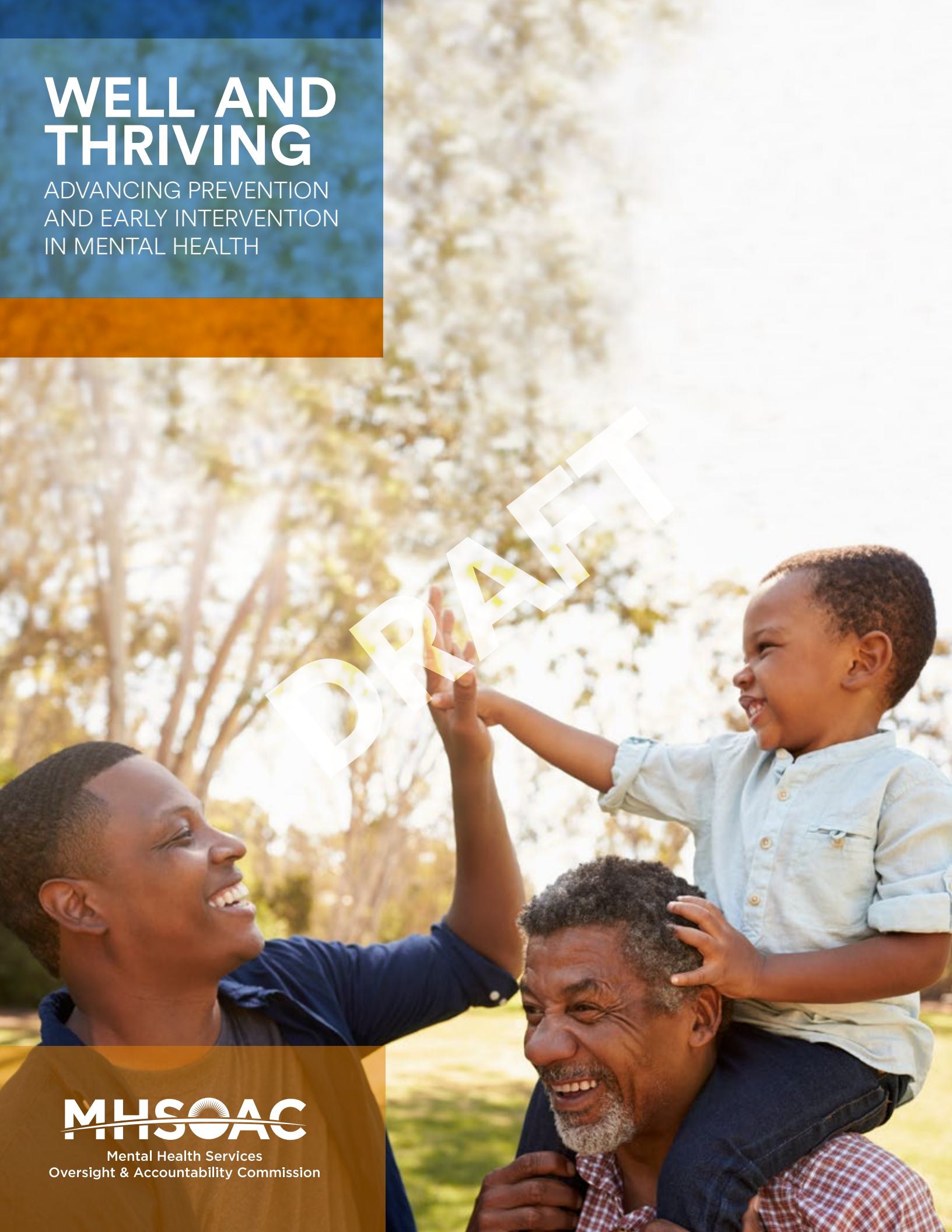
**Handouts (1):** The presentation will be supported by PowerPoint slides.

**Proposed Motion:** That the Commission adopt the PEI draft report.

[i] Welfare and Institutions Code Section 5840.5

# WELL AND THRIVING

## ADVANCING PREVENTION AND EARLY INTERVENTION IN MENTAL HEALTH




MHSOAC

Mental Health Services
Oversight & Accountability Commission

"Prevention and early intervention strategies promote mental health and wellbeing in people, families, and entire communities by building resiliency, increasing awareness, and connecting people with timely care and support. Within these pages is a framework for delivering these strategies across California and beyond."

Transmittal letter to come

# ABOUT THE COMMISSION

The Mental Health Services Oversight and Accountability Commission, an independent State agency, was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. Californians created the Commission to provide oversight, accountability, and leadership to guide the transformation of California's mental health system. The 16-member Commission is composed of one Senator, one Assembly member, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the Governor's appointees represent different sectors of society, including individuals with mental health needs, family members of people with mental health needs, law enforcement, education, labor, business, and mental health professionals.

## COMMISSIONERS

**MARA MADRIGAL-WEISS,** Chair; Executive Director, Student Wellness and School Culture, Student Services and Programs Division, San Diego County Office of Education

**MAYRA E. ALVAREZ;** Vice Chair; President, The Children's Partnership

**MARK BONTRAGER;** Director of Regulatory Affairs, Partnership HealthPlan of California

**JOHN BOYD, Psy.D.;** Hospital Division Chief Executive Officer, Rogers Behavioral Health

**BILL BROWN;** Sheriff, County of Santa Barbara

**KEYONDRIA BUNCH, Ph.D.;** Supervising Psychologist, Los Angeles County Department of Mental Health

**STEVE CARNEVALE;** Executive Chairman, Sawgrass

**WENDY CARRILLO;** California State Assemblymember, District 51

**RAYSHELL CHAMBERS;** Co-Executive Director and Chief Operations Officer, Painted Brain

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**DAVID GORDON;** Superintendent, Sacramento County Office of Education

**GLADYS MITCHELL;** Former Staff Services Manager, California Department of Health Care Services and California Department of Alcohol and Drug Programs

**ALFRED ROWLETT;** Chief Executive Officer, Turning Point Community Programs

**KHATERA TAMPLEN;** Consumer Empowerment Manager, Alameda County Behavioral Health Care Services

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**TOBY EWING, Ph.D.;** Executive Director



# ACKNOWLEDGEMENTS

The Mental Health Services Oversight and Accountability Commission would like to express its thanks to the peers, advocates, community members, family members, administrators, providers, researchers, and policymakers who contributed to the development of this report. We greatly appreciate the time, commitment, and energy devoted to exploring the challenges and solutions to improving our mental health system.

The report underscores the imperative for a strategic statewide approach to prevention and early intervention, in addition to high quality mental health care. The state's population is exceptionally diverse, yet a fundamental need for human connection, information, and resources to promote and protect wellbeing is a shared need. This work recognizes that all people, with or without a mental health challenge, can thrive when given appropriate and early support. This report is an invitation for a broad audience, especially those outside the mental health system, to learn about and act on opportunities that promote and protect the wellbeing of people, families, and communities while recognizing how all are interconnected.

## PREVENTION AND EARLY INTERVENTION SUBCOMMITTEE

**MARA MADRIGAL-WEISS,** Commission and Subcommittee Chair; Executive Director, Student Wellness and School Culture, Student Services and Programs Division, San Diego County Office of Education

**MAYRA E. ALVAREZ;** Commission and Subcommittee Vice Chair; President, The Children's Partnership

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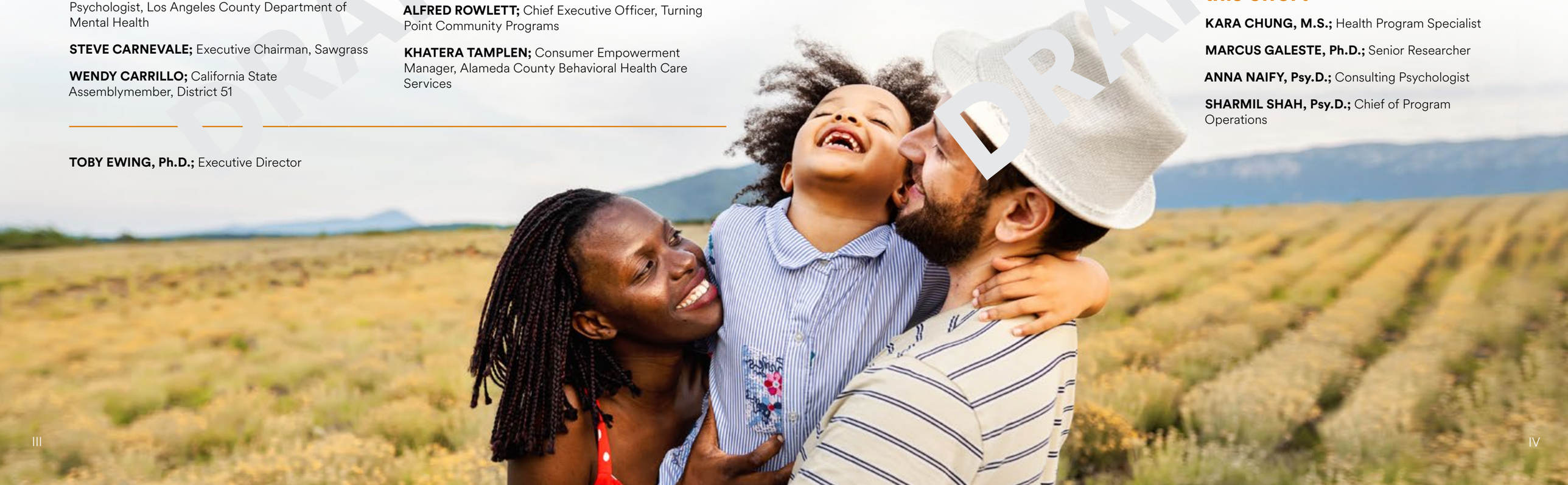

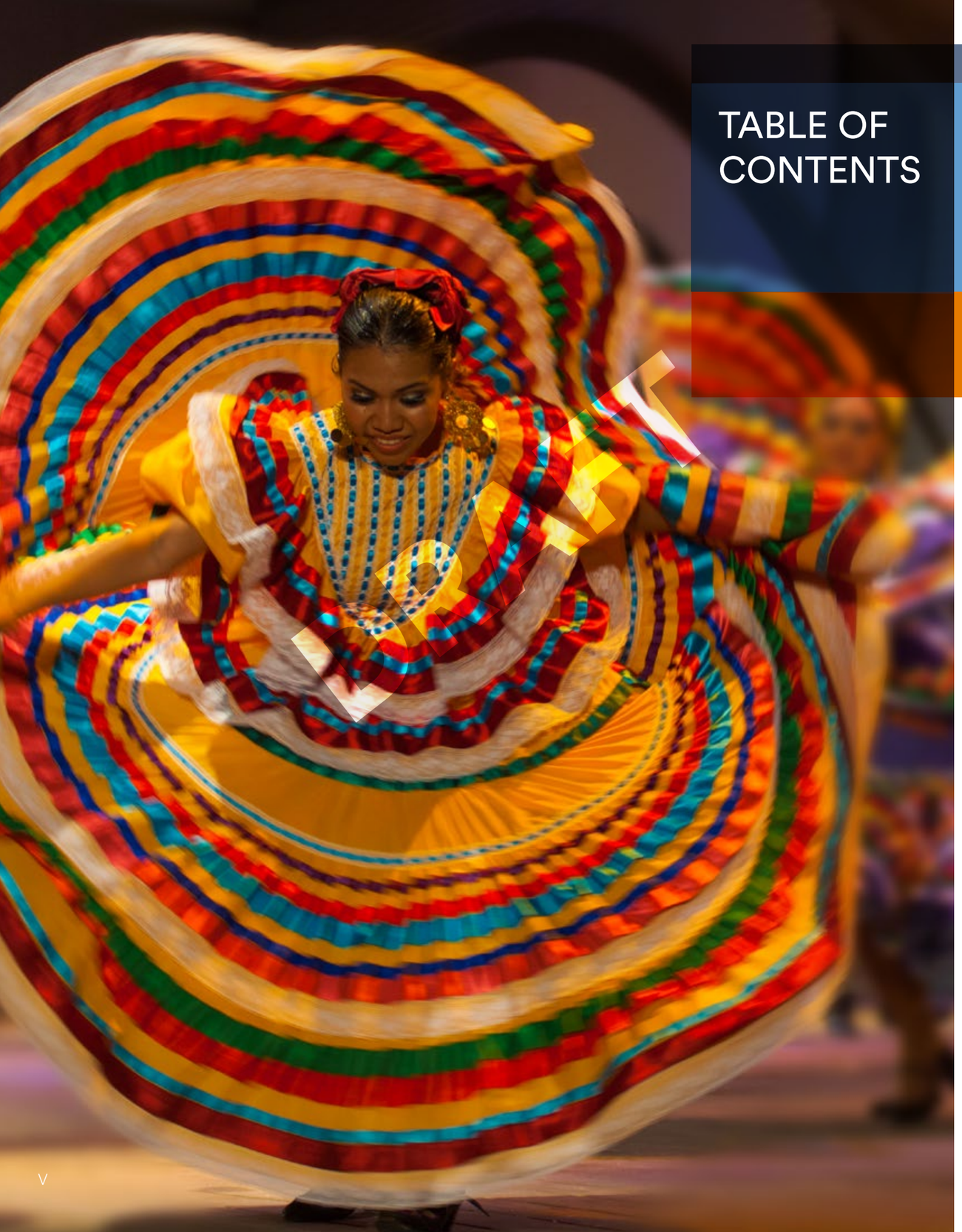

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Mental Health Services
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# EXECUTIVE SUMMARY

The year 2020 marked a time of profound devastation and reckoning in California and around the world. The global COVID-19 pandemic threatened the health and mental health of billions worldwide, damaged the economy, and forced many to shelter in isolation. However, even as the pandemic exposed gaps and inequities in our health care system and public health infrastructure, it created opportunities to reconsider how California can best support and protect the health and wellbeing of its people.

With these great challenges come great opportunities to reorient systems and approaches toward prevention and early intervention and rebuild. Now is the time to rebuild and reimagine an equitable path forward so that all Californians have an opportunity to be well and thrive. Such a path would minimize factors that increase or worsen mental health challenges and promote factors that strengthen mental wellbeing, including self-esteem, community connectedness, and nurturing relationships. At the same time, interventions that address mental health challenges early – including screening, triage, and connection to care – can help minimize harm to individuals, families, and communities.

With these great challenges come great opportunities to reorient systems and approaches toward prevention and early intervention in mental health. Now is the time to rebuild and reimagine an equitable path forward so that all Californians have an opportunity to be well and thrive. Such a path would minimize factors that increase or worsen mental health challenges and promote factors that strengthen mental wellbeing, including self-esteem, community connectedness, and nurturing relationships. At the same time, interventions that address mental health challenges early – including screening, triage, and connection to care – can help minimize harm to individuals, families, and communities.

California's Mental Health Services Oversight and Accountability Commission (the Commission) in 2019 embarked upon an effort to advance statewide prevention and early intervention in mental health. This effort was launched by Senate Bill 1004 (Weiner, 2018) and guided by the Mental Health Services Act (MHSA) and its Prevention and Early Intervention (PEI) component. Accounting for only a fraction of California's $8–10 billion public mental health budget, PEI represents a rare instance in mental health policy where funds are set aside specifically for preventive strategies. The nearly $520 million in PEI funds allocated each year to local mental health departments bolster programs and providers tasked with overcoming deeply embedded community challenges, including stigma and insufficient services and support. The funds also help to foster resilience among those who have been unserved, underserved, or harmed by services in the past.

Under the direction of a subcommittee led by Commission Chair Mara Madrigal-Weiss and Commission Vice Chair Mayra Alvarez, the Commission engaged national and local experts in the mental health prevention and early intervention field, reviewed research, and convened in-person and virtual events. During these events, community members, researchers, administrators, and other subject matter experts provided guidance and insight.




# ACTION IS NEEDED NOW

Funding earmarked for prevention and early intervention programs is essential for improving outcomes, especially in unserved and underserved communities. Yet funding alone is not enough. Without broader initiatives, statewide barriers – such as systemic inequities, injustices, and socioeconomic disparities – will continue to stymie progress. Through its research and community events, the Commission identified four findings and corresponding recommendations. These finding and recommendations lay the groundwork to overcome key systemic barriers, guide future funding decisions, and advance a statewide strategic approach to prevention and early intervention.

### Finding 1

California does not have a strategic approach in place to address the socioeconomic and structural conditions that underpin mental health inequities or to advance statewide prevention and early intervention.

### Recommendation

The Governor and Legislature should establish a state leader for prevention and early intervention, charged with establishing a statewide strategic plan for prevention and early intervention – with clear and compelling goals tied to global standards of wellbeing that are centered in equity, diversity, and inclusion.

### Finding 2

Unmet basic human needs and trauma exposure drive mental health risks. These factors will continue to disrupt statewide prevention and early intervention efforts and outcomes unless they are addressed.

### Recommendation

The State's strategic approach to prevention and early intervention must address risk factors – with particular attention on trauma – and enhance resiliency, by addressing basic needs and bolstering the role of environments, cultures, and caregivers in promoting and protecting mental health and wellbeing across the lifespan for individuals, families, and society at large.

### Finding 3

Strategies to increase public awareness and knowledge of mental health often are small and sporadic, while harmful misconceptions surrounding mental health challenges persist. Mass media and social media reinforce these misconceptions.

### Recommendation

The State's strategic approach to prevention and early intervention must promote mental health awareness and combat stigma by ensuring all people have access to information and resources necessary to understand and support their own or another person's mental health needs.

### Finding 4

Strategies that increase early identification and effective care for people with mental health challenges can enhance outcomes. Yet few Californians benefit from such strategies. Too often, the result is suicide, homelessness, incarceration, or other preventable crises.

### Recommendation

As part of its approach to prevention and early intervention, the State must guarantee all residents have access to behavioral health screening and an adjacent system of care that respects and responds to California's diverse communities and their mental health needs.

# PREVENTION AND EARLY INTERVENTION FOR ALL CALIFORNIANS

California's nearly $520 million investment in PEI programs and services represents an important resource for prevention and early intervention in the mental health arena. However, more is needed to create long-lasting transformational change. In developing this report, the Commission identified actionable strategies and opportunities to advance prevention and early intervention within and outside the mental health system. Now is the time to renew and reform our approach. We can build healthy systems, settings, and communities for all Californians for generations to come.

# INTRODUCTION

In a 2019 interview, former National Institute of Mental Health director Dr. Thomas Insel described the state of mental health in California and the U.S. "I've spent 40 years working in this field," said Insel.[1] "We have seen vast improvements in those 40 years in infectious disease, cardiovascular care, many areas of medicine, but not behavioral health. Suicides are up about 33 percent since the turn of the century. Overdose deaths are skyrocketing. People with mental illness die about 23 years early – and we're not closing the gap. "We've got to come up with better solutions now."

***"We've got to come up with better solutions now."***[2]

Since this interview, the state of mental health in California has only worsened – but not at the fault of the many people who work tirelessly to support the mental health needs of Californians. Soon after this interview, the global COVID-19 pandemic threatened the health and wellbeing of billions worldwide,[3] constricted the economy,[4] and forced many to shelter in place, sometimes to isolation.[5] Against this backdrop, long-standing racial divides came into sharp focus after a police officer murdered George Floyd. Escalating reports of police violence among communities of color sparked renewed nationwide protests of police misconduct and racism.[6] The director of the U.S. Centers for Disease Control and Prevention for the first time declared racism a serious public health threat.[7] These unfolding and often compounding community crises and stressors demanded swift action from decision-makers, many of whom were under significant stress themselves.

As these events transpired, many Californians experienced detrimental changes to their mental health and wellbeing.[8] For some, decreased mental wellbeing began to impact their daily lives for the first time.[9] Some experts are pointing to amassing stress associated with the COVID-19 pandemic, political unrest, and systemic racism and inequality as chief contributors to this decline in wellbeing.[10] These and other factors that threaten mental wellbeing are not new, but they are increasing and will continue to increase unless change occurs, leading to challenges for our already overburdened mental health workforce.[11] When asked how the system should be designed, Dr. Insel replied, "The system now is crisis driven. The biggest transformation will come when we can identify problems and intervene earlier. That's when we get the best outcomes in diabetes, heart disease, cancer. It's equally true in behavioral health." [12]

# PREVENTION TO CATALYZE TRANSFORMATIONAL CHANGE

Just like physical health, all people have their mental health to consider. The World Health Organization defines optimal mental health as a state in which a person "realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community." Among many national and international health leaders, mental health is considered a "basic human right" that underpins how individual people, communities, and societies develop and thrive.

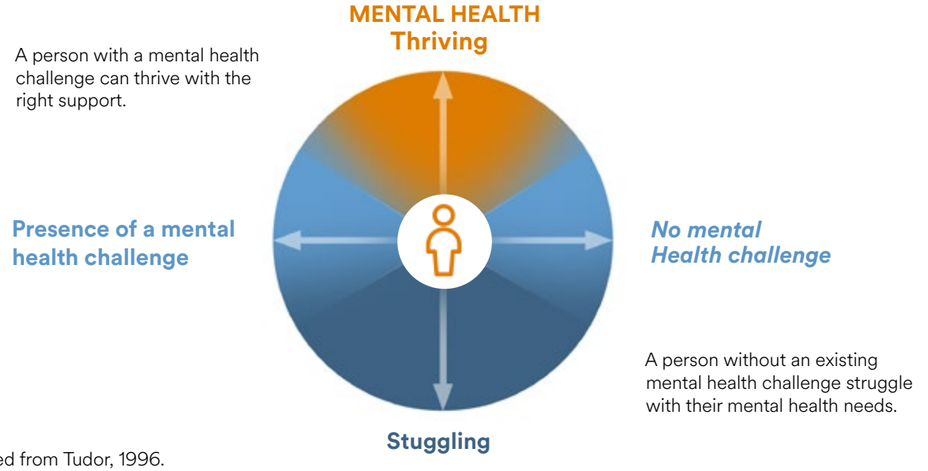
Mental health challenges refer to circumstances in which a person's mental health needs negatively impact their daily life or functioning. These challenges include conditions characterized by uncommon patterns of thoughts and behaviors that cause distress or impair functioning. Substance use disorders, a category of mental disorder, often occur in tandem with other mental health challenges. Throughout this report, references to mental health challenges include substance use disorders.

Optimal mental health is possible for all people, including those experiencing a mental health challenge, if they are given the right tools and support. Basic needs are foundational to mental health. These needs include safe living and working environments, adequate food and housing, connections to community and culture, access to high-quality mental health care, and social support. A person's mental health is at risk when these needs aren't met, even if they have no existing mental health challenge. Other factors like trauma, significant hardship, loss, and other adversities can disrupt a person's mental health. Yet, the outcomes that result can vary from one person to the next depending on the presence of *risk factors* – factors that increase mental health risk, or *protective factors* – factors that buffer against risk and instill resiliency.

## DUAL CONTINUUM MODEL OF MENTAL HEALTH

Mental health is not binary. It is not defined by the presence or absence of a mental health challenge. Rather, mental health is part of a complex and dynamic continuum of positive and negative experiences which can, and often do, change throughout a person's lifetime depending on their environment and experiences.

The dual-continuum model of mental health shown below, illustrates these conditions: the blue horizontal line represents the presence or absence of a mental health challenge; the blue vertical line represents the degree to which a person is thriving or struggling with their mental health state. Prevention and early intervention strategies work across this continuum to keep people thriving as mental health needs emerge and change.




Adapted from Tudor, 1996.



# THE PROMISE OF PREVENTION AND EARLY INTERVENTION

The promise of a prevention and early intervention approach is grounded in decades of research showing that many factors influencing mental health can be modified, often preventing mental health challenges from emerging at all.[19] Research also establishes that early intervention and support lessen suffering, reduce suicide, and improve quality of life.[20]

Prevention and early intervention approaches provide long-lasting benefits that are felt throughout communities and across generations.[21] The approaches also pay for themselves. The National Academies of Sciences, Engineering, and Medicine in 2009 calculated that for every dollar invested in prevention and early intervention, society saves $2 to $10 in health care costs, criminal justice expenses, and the avoidance of lost productivity.[22] Savings also result from a reduced need for emergency services or long-term care.[23] When prevention programs begin in early childhood, the returns are even higher – up to almost $13 per dollar invested.[24]

## Prevention and Early Intervention Strategies

Prevention and early intervention strategies work along the mental health continuum and include promotion, prevention, early detection and intervention, and recovery. Such strategies can, and often do, overlap. Prevention and early intervention strategies are most effective when provided simultaneously across individuals, families, communities, and societies in ways that respond to their unique and fluid needs.[25]

Mental health *promotion* strives to improve the wellbeing of whole communities through[26] such strategies as raising public awareness, reducing stigma, and ensuring access to activities and resources that support wellbeing.[27]

Prevention in the context of mental health seeks to reduce the incidence, prevalence, and recurrence of mental health challenges. It also focuses on minimizing the time spent with symptoms and decreasing the impact of illness on families and communities.[28]

Prevention strategies in mental health generally fall into three broad types. The first, *primary prevention*, targets an entire population, not just those at risk, as well as members of groups who are at higher-than-average risk. *Secondary prevention* aims to reduce the impact or progression of mental health challenges through early detection and connection to services and supports. The third type, *tertiary prevention*, seeks to prevent relapse and improve the quality of life for people with existing mental health challenges. Secondary and tertiary prevention include early intervention and recovery-focused strategies.

*Early Intervention* describes mental health services and supports that promote recovery and prevent mental health needs from becoming severe and disabling. Effective early intervention can ensure optimal outcomes even for those with the greatest challenges.

*Recovery* is the process through which people improve their health and wellbeing, become better able to live self-directed lives, and set the stage to reach their full potential. Recovery is different for everyone. It may include learning to make healthy choices to support wellbeing, establishing a safe and secure place to live, or building or rebuilding relationships and social networks. Recovery often is not linear or timebound, and many people experience cycles of relapse and recovery. Such strategies may include learning new coping tools, developing relapse or crisis contingency plans, and putting in place graduated levels of supports that can be selected if mental health challenges change or reemerge.

# WHOLE COMMUNITY APPROACHES

Increasingly, national[35] and international[36] health and mental health leaders advocate for approaches to promote the mental health and wellbeing of everyone; not one person at a time. Such approaches recognize that prevention and early intervention programs and services must occur in tandem with policies and practices to ease risk factors, such as economic deprivation, social isolation, racial injustice, and trauma, with an emphasis on reducing disparities in these domains.

In the wake of the COVID-19 pandemic, the American Psychological Association in 2020 called for a population health approach to tackle the nation's emerging public mental health crisis.[38] This approach does not replace individualized intervention. Rather, it emphasizes the potential for those within and outside the mental health field to address the harms of society-wide risk factors like systemic racism and a faltering economy. The need is greatest for marginalized populations.[39]

A population health approach builds on traditional public health practices by employing policies and interventions that improve the mental health of a whole population.[40] This requires examining a broad range of factors that influence wellbeing. Such factors include geography, socioeconomic conditions, the political climate, and sources of mental health services and supports.[41] A population health approach works across various systems to promote health equity in each of these areas.[42]

The population mental health approach draws upon strategies for prevention and early intervention to support groups who may be at risk in addition to those already experiencing mental health challenges.[43] Large-scale initiatives often are required to tackle structural barriers to wellbeing, access to services and supports, and social determinants of health, defined as the conditions in which people live, learn, play, work, and age.[44] At the same time, strategies are used to ensure equitable access to effective services and supports, acknowledging that such responses will vary necessarily across a continuum of needs, within different settings, and at each life stage.[45] An understanding of how culture, beliefs, attitudes, and behaviors influence wellbeing is foundational to any effective population health approach.[46]

### CHARACTERISTICS OF EFFECTIVE PREVENTION AND EARLY INTERVENTION STRATEGIES

*Effective prevention and early intervention strategies are tailored to the unique risks, strengths, needs, cultures, and languages of individuals, families, and communities.[47] Such strategies target the root causes of disrupted wellbeing in communities. Continuous community engagement plays a critical role.[49]*

*Environmental, social, and other factors vary as a person grows, lives, and ages, with each life stage providing opportunities to prevent and address mental health challenges. Effective prevention and early intervention strategies consider a "life course perspective," taking into account how conditions and events across the lifespan shape one's wellbeing.*

*Effective prevention and early intervention strategies are nimble enough to adapt to changing risk factors, needs, and emerging events.[50] They respond to and mitigate the harmful impacts of unexpected stressful or traumatic events in communities,[51] such as mass shootings, terrorist attacks, natural disasters,[52] and political or social turmoil. [53]*

*Finally, successful prevention and early intervention strategies are offered where people spend most of their time, such as in their community, at school, work, home, places of worship, or health care settings.[56]*



# PREVENTION ESTABLISHED IN THE MENTAL HEALTH SERVICES ACT

Californians in 2004 voted to pass Proposition 63, which was later enacted as the Mental Health Services Act (MHSA).[57] The first of its kind in the U.S., the MHSA outlines a vision for transformational change of California's mental health system. Funded by a 1 percent tax on personal incomes over $1 million, MHSA funds are allocated to 59 local mental health departments across California's 58 counties.[58] For each county, approximately 20 percent of MHSA annual revenues are earmarked to support prevention and early intervention (PEI) programs and services.[59] According to the latest revenue data, the PEI component of the MHSA generated nearly $520 million for programs and services during fiscal year 2020-21.[60] Local departments use the funds to deliver an array of programs and services focused on prevention, outreach, stigma reduction, screening and timely access to services, suicide prevention, and early intervention.[61] Accounting for only a fraction of California's $8–10 billion public mental health budget, PEI represents a rare instance in mental health policy where funds are specifically set aside for prevention and early intervention.

## Senate Bill 1004

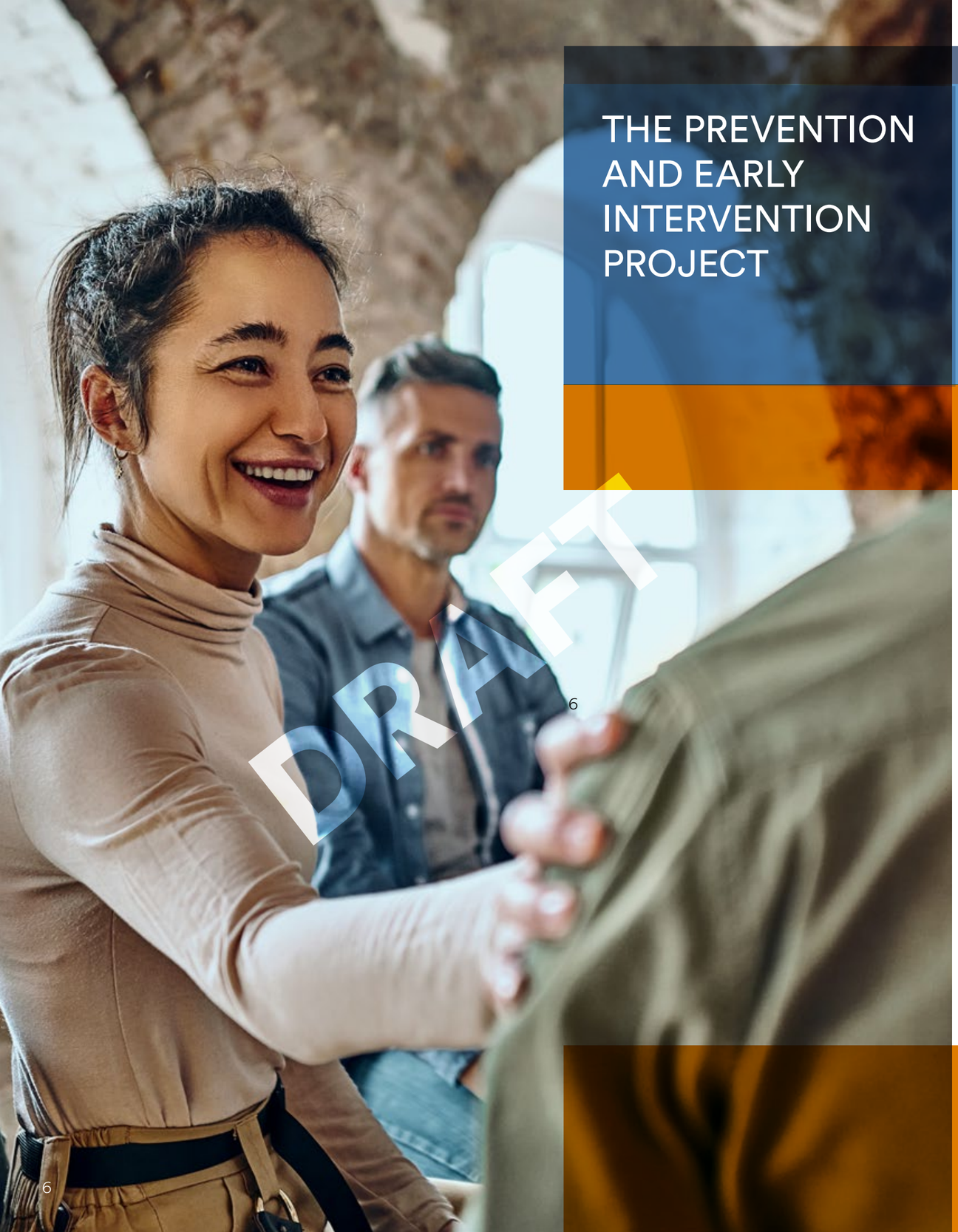
SB 1004 was enacted in 2018 to advance the MHSA vision by creating additional focus and structure for PEI-funded programs. The bill authorizes the Commission to establish additional priorities and develop a strategy for monitoring and supporting PEI programs and services.[62] This bill and its funding priorities are grounded in the same concepts, opportunities, and best practices described in this report. The bill promotes a life-course approach as reflected in its focus on childhood trauma and strategies to support the mental health needs of youth and older adults.[63] It emphasizes the importance of early detection and support to achieve the best outcomes for people with mental health challenges by prioritizing early intervention for psychosis or mood disorders.[64] Current PEI priority areas also encompass practices that are community-centered and culturally responsive and that strive to advance mental health equity.[65]

Through SB 1004, the Governor and the Legislature identified the following priorities for local PEI program development and delivery:[66]

- Programs that target children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events to prevent or address the early origins of mental health challenges and prevent negative outcomes.
- Evidence-based approaches and services to support recovery for people experiencing first, or early, symptoms of psychosis or mood disorders, such as by identifying and supporting early signs and symptoms, keeping people engaged in school or at work, and supporting them on a path to better health and wellness.
- Strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs that educate and engage college age youth and provide either on-campus, off-campus, or linkages to mental health services.
- Strategies to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.
- Strategies targeting the mental health needs of older adults, including screening and early identification of mental health challenges, suicide prevention, and outreach and engagement with caregivers, victims of elder abuse, and individuals who live alone or are isolated.

The bill also authorizes the Commission to identify additional priorities, with community input, that are proven effective in achieving the bill's goals. The next section of this report outlines the Commission's process for exploring how the bill's goals and others could be achieved to lay a foundation for effective and sustained prevention and early intervention programs and services.

Through its process, the Commission heard from community members and other experts that California has yet to establish a strategic approach to prevention and early intervention. There are many needs, funding sources, partners, and assets, yet they have not been connected or coordinated. Meanwhile, communities have been pummeled by crisis after crisis, leaving deepened deficits in basic human needs, such as housing and healthcare. Exposure to trauma has become the norm for many of California's communities. These factors, and others, create the context in which California's PEI initiatives are delivered and often outweighed by the scale of community needs.



# THE PREVENTION AND EARLY INTERVENTION PROJECT





Catalyzed by SB 1004, the Commission launched a policy research project in early 2019 to explore statewide opportunities for prevention and early intervention (PEI) in mental health.[67] The Commission also began to investigate options for bolstering PEI programs through data monitoring, evaluation, and technical support. To lead the project, the Commission formed a Prevention and Early Intervention Subcommittee chaired by Commission Chair Mara Madrigal-Weiss and Vice Chair Mayra E. Alvarez.[68]

## ENGAGEMENT WITH COMMUNITY MEMBERS AND OTHER EXPERTS

The Subcommittee held meetings in Sacramento and Monterey counties in 2019 to hear presentations that identified areas of need. The presentations explored challenges and opportunities surrounding PEI in such areas as health inequities, outreach efforts, workforce development, effective program evaluation, cultural relevancy, and program flexibility.

The Subcommittee also convened 10 virtual listening sessions targeting specific communities and regions across California beginning in 2020. The sessions explored risk and protective factors and identified unique approaches to meeting the needs of African American, Asian American and Pacific Islander, Latinx, Native, and LGBTQ+ communities. Commission staff partnered with cultural brokers to host sessions, recruit participants, and facilitate conversations. These sessions were small, each including seven to 12 participants.

The Subcommittee held five virtual listening sessions in early 2021 for California's Northern, Bay Area, Southern, Los Angeles, and Central regions. Together these sessions attracted over 500 community members who, with the help of peer and family member facilitators, provided their thoughts and perspectives regarding how PEI could be advanced to improve outcomes, reduce disparities, and increase timely access to services and supports.

In March and April 2021, the Subcommittee held three statewide virtual public forums to explore ways to leverage state and local data, evaluation methodologies, and opportunities for technical support to advance prevention and early intervention. Approximately 300 participants attended these technology forums, including community members, advocates, providers, evaluation professionals, subject matter experts, and local behavioral health department staff. Each forum included presentations by subject matter experts, videos to highlight key prevention and early intervention concepts, and group discussions.

The Commission held two virtual public hearings during regularly scheduled Commission meetings in February and April 2021. The hearings included presentations by subject matter experts that explored key concepts in prevention and early intervention and opportunities across the lifespan.

In September 2021, in partnership with the California Alliance of Child and Family Services and The Children's Partnership, the Commission co-hosted a virtual panel conversation on prevention and early intervention and school and community partnerships. A panel of community providers who serve California's children and youth highlighted opportunities to promote mental health and wellbeing among youth, especially those currently and historically marginalized.

In addition to PEI-specific activities, Commission staff also gathered information during other Commission-hosted events held in 2020 and 2021. These included Innovation Idea Labs hosted by the Youth Innovation Committee, events to support the Workplace Mental Health Project, and an Immigrant and Refugee listening session.[69]

At its December 8, 2021, meeting, the Commission's Cultural and Linguistic Competency Committee approved several recommendations related to the Commission's prevention and early intervention project.[70] Those recommendations are:

1. Emphasize transition age youth generally under the identified priorities in Senate Bill 1004 (Wiener, 2018). Prioritizing just college-age transition age youth disadvantages transition age youth of color.
2. Add language under the identified priorities in Senate Bill 1004 (Wiener, 2018) to specifically reference "community defined evidence-based practices" as programs that can be funded under PEI, such as "culturally-competent and linguistically-appropriate prevention and intervention, including culturally-defined evidence-based practices."
3. Include the establishment of hiring preferences for applicants with backgrounds in ethnic studies and related academic disciplines in systems-change efforts.
4. Establish mechanisms to incentivize behavioral health employees to take courses in ethnic studies and related academic disciplines to create robust personnel development opportunities to build capacity within existing behavioral health care departments to serve historically marginalized communities.





Commission staff, meanwhile, conducted interviews with subject matter experts and other local and national leaders working to advance mental health prevention and promotion. Interviewees included representatives from the World Health Organization, RAND Corporation, the American Public Health Association, and the National Academies of Sciences, Engineering, and Medicine. Also interviewed were mental health researchers from Columbia University, Harvard University, the University of California, Davis, and the University of California, Los Angeles. The Commission consulted with representatives in other state agencies as well, including the California Department of Public Health's Office of Health Equity, the California Department of Social Services, and First 5 California.

## PROGRAM DATA ANALYSIS

Commission staff conducted a content analysis of nearly 850 program descriptions from 59 local MHSA Three-Year Program and Expenditure Reports.[71] Commission staff also compiled data and information from Annual PEI Reports submitted by local behavioral health departments. [72] These reports should document data and information required by regulation and include basic participant data, such as:

- Participant demographics,
- Number of individuals served by PEI services,
- Number and type of potential responders reached in outreach activities,
- Number of individuals referred to county and noncounty mental health services,
- Number of individuals referred to different types of services, and
- Descriptive statistics related to referral timing for outreach programs and activities to improve timely access to services.

Missing data and information in both program descriptions and participant data limited the use of such programmatic data in the Commission's findings. For example, upwards of 70 percent of program descriptions did not specify the setting in which services took place, and over 68 percent of program descriptions did not specify who staffed each program. Similarly, most reports did not contain information on referrals, outreach activities, and timing of activities. To support improved data quality, Commission staff designed a draft, optional template for the Annual PEI Report and held several meetings from June 2021 to December 2021 with local department representatives to hear feedback on the draft.

## PUBLIC AWARENESS STRATEGIES

Commission staff produced short videos with subject matter experts. These videos highlight key concepts related to mental health promotion and prevention and early intervention. In 10 minutes or less, the videos deliver key messages that describe contemporary challenges and opportunities to help advance health equity and maximize mental health awareness using technology.[73]

## PUBLIC COMMENT

A draft of this report was first released for public comment on August 24, 2022. The Subcommittee will review written and verbal comments and consider revisions to the document prior to approval by the Subcommittee. The Subcommittee will meet as many times as needed to hear comments. Once approved, the Subcommittee will submit the revised draft to the Commission for consideration of adoption. An implementation plan will be developed following adoption of the final report.

*Note: Quotes from community members and other experts documented below include identifying information about the speaker when such information is available. Commission staff received permission to publish statements made by speakers during project events whenever possible.*

# FINDINGS AND RECOMMENDATIONS

Broad, multidisciplinary, statewide initiatives are needed to combat California's growing mental health crisis. These initiatives must be grounded in a strategic approach to prevention and early intervention. The Commission has identified four key findings and recommendations to guide this work. Each finding combines public input with scientific evidence and is accompanied by a summary of relevant best practices and promising solutions. These opportunities for prevention and early intervention will demand significant time, leadership, and investment of fiscal and human resources. The result will be a stronger foundation for prevention and early intervention that will benefit Californians now and for generations to come.

### Finding 1

California does not have a strategic approach in place to address the socioeconomic and structural conditions that underpin mental health inequities or to advance statewide prevention and early intervention.

### Recommendation

The Governor and Legislature should establish a state leader for prevention and early intervention, charged with establishing a statewide strategic plan for prevention and early intervention – with clear and compelling goals tied to global standards of wellbeing that are centered in equity, diversity, and inclusion.

### Finding 2

Unmet basic human needs and trauma exposure drive mental health risks. These factors will continue to disrupt statewide prevention and early intervention efforts and outcomes unless they are addressed.

### Recommendation

The State's strategic approach to prevention and early intervention must address risk factors – with particular attention on trauma – and enhance resiliency, by addressing basic needs and bolstering the role of environments, cultures, and caregivers in promoting and protecting mental health and wellbeing across the lifespan for individuals, families, and society at large.

### Finding 3

Strategies to increase public awareness and knowledge of mental health often are small and sporadic, while harmful misconceptions surrounding mental health challenges persist. Mass media and social media reinforce these misconceptions.

### Recommendation

The State's strategic approach to prevention and early intervention must promote mental health awareness and combat stigma by ensuring all people have access to information and resources necessary to understand and support their own or another person's mental health needs.

### Finding 4

Strategies that increase early identification and effective care for people with mental health challenges can enhance outcomes. Yet few Californians benefit from such strategies. Too often, the result is suicide, homelessness, incarceration, or other preventable crises.

### Recommendation

As part of its approach to prevention and early intervention, the State must guarantee all residents have access to behavioral health screening and an adjacent system of care that respects and responds to Californians' diverse mental health needs.





# FINDING ONE

**California does not have a strategic approach in place to address the socioeconomic and structural conditions that underpin mental health inequities or to advance statewide prevention and early intervention.**

The MHSA and its funding for prevention and early intervention account for a small fraction of California's $8–$10 billion public mental health system. This fraction is even smaller when considered against the many billions of dollars that the state spends to support the health and wellbeing of its residents through subsidized housing, public education, employment support, and other services.

Despite these collective efforts and an unprecedented increase in public spending, innovation, and ingenuity, mental health outcomes in California are worsening, constituting what many experts consider a public health emergency. Entrenched social, economic, and systemic challenges continue to drive inequities in mental health risk, awareness, and access to effective care.[74] No single department or funding source can address these broader societal challenges, nor can the state's mental health community on its own, from administrators and advocates to policymakers and providers.[75] Promoting and protecting the mental health of all communities will demand multisector collaboration within the mental health system and among partners outside the mental health community.[76] Absent is a strategic approach to bring these partners together in a systematic effort to optimize resources, improve systems, and advance prevention and early intervention. Only by coordinating and building capacity among a broad range of providers, administrators, educators, caregivers, advocates, peers, and others can we reduce unnecessary suffering and loss of life due to unsupported mental health needs.

### *Determinants that impact wellbeing include:*

- **Discrimination, racism, and social exclusion**
- **Immigration status**
- **Adverse early life experiences and other significant adult traumas**
- **Poor education**
- **Neighborhood and domestic violence**
- **Unemployment, underemployment, and job insecurity**
- **Poverty and income inequality**
- **Food insecurity**
- **Poor housing quality and housing instability**
- **Lack of health care**

The COVID-19 pandemic laid bare many of the social and structural inequities that for so long have contributed to health disparities among marginalized communities. Groups with lower median incomes, poor housing quality, lower educational attainment, and inadequate internet access have suffered higher rates of infection throughout the pandemic.[84] Two out of every three Californians who have died of COVID-19 had a high school degree or less.[85] Blacks, Latinx individuals,[86] immigrants and refugees[87] all experienced higher COVID-19 death rates than the population as a whole. Mental health also was threatened by COVID-19. Prolonged isolation to protect high risk groups from infection increased risk of depression and suicide, especially for older adults.[88] Suicide deaths among California youth increased significantly in the wake of the pandemic, with the sharpest rise among African American youth. Nationally, Black, Latinx, and immigrant communities reported a higher incidence of depression and anxiety. LGBTQ+ communities, especially LGBTQ+ youth, also reported more depression, anxiety, and substance use.[89]

Throughout the pandemic, public heath efforts understandably focused on protecting individuals with medical or age-related vulnerabilities to the virus. Yet not all racial, ethnic, and socioeconomic disparities in COVID-19 impacts were attributed to health status or age. COVID-19 provided a tragic example of how stressors experienced by marginalized groups can complicate and compound risks.

*"Health inequities are the result of more than individual choice or random occurrence. They are the result of the historic and ongoing interplay of inequitable structures, policies, and norms that shape lives."*

*– Finding from the "Pathways to Health Equity" report from the National Academy of Sciences, Engineering, and Medicine, Committee on Community-Based Solutions to Promote Health Equity (United States, 2017)*[90]

## Structural Racism and Discrimination

Many of the conditions that drive health inequities stem from structural factors such as laws, rules, or official policies that favor some groups and harm others.[91] These factors, referred to as structural racism and discrimination, unjustly treat groups based on race, sexual orientation, gender or gender identity, physical or intellectual differences or disabilities, age, immigration status, or income.[92] Examples of structural racism include "redlining," in which loans or insurance are denied to individuals or businesses in disadvantaged neighborhoods;[93] covenants, codes, and restrictions, which bar people from buying homes in neighborhoods based on race or religion;[94] and gerrymandering, in which voting boundaries are manipulated to favor or exclude certain racial and ethnic groups, socioeconomic classes, or political parties.[95] The lack of infrastructure, investments, and political power that results from such policies unfairly disadvantage segregated communities.[96] For example, hospitals, schools, grocery stores, and job opportunities are exceedingly scarce in redlined communities, impacting the social determinants of poor mental health including unemployment, food insecurity, and poverty.[97] Although residential segregation has been outlawed in the U.S., its impacts on health endure.[98]

Structural barriers can perpetuate poverty and other factors that increase mental health risk.[99] For example, poor communities experience greater shortages in mental health providers.[100] Structural barriers also can exacerbate the stigma, prejudice, and trauma that members of marginalized groups,[101] including those with mental health challenges, often experience.[102] During Commission events to gather community insights and guidance as part of this project, members of the public highlighted the power of structural inequities. Event participants repeatedly emphasized that cultural and racial discrimination passed down from previous generations takes a toll on the mental and physical health of those communities that are most harmed by socioeconomic hardship and trauma.

*"Much of the mental health challenges people experience are either caused by or exacerbated by minority stressors that people of color and LGBTQ and other marginalized populations suffer from [...] systemic racism and bias is inherent in so many of the things that people face, whether it's their health care, their housing, their income, their access to such care. And we know that people do have disparities by mere zip code."*

*– Participant during a March 3, 2021, virtual prevention and early intervention listening session with residents from Los Angeles*

Public agency leaders also have begun to acknowledge the impact of structural racism and discrimination. Organizations representing California county health agencies in March 2021 issued a powerful, unified public statement declaring structural racism a public health crisis.[103]

"Our members understand that the experience of racism is itself a social determinant of health and is associated with negative mental health impacts for members of Black, Indigenous, Latinx, and Asian and Pacific Islander communities," said Michelle Cabrera, Executive Director of the California Behavioral Health Directors Association.[104] She added: "At the same time, [these] communities all too often face barriers, rooted in systemic racism, in accessing life-saving behavioral health treatment." [105]

## Structural Barriers in Mental Health Systems

Structural factors are driving inequities across mental health care systems. For example, high health care costs disproportionately harm rural, Latinx, Native,[106] and undocumented[107] Californians who are less likely to have insurance due to their increased likelihood of being un- or underemployed – itself a reflection of systemic racism and discrimination.[108] LGBTQ+ community members are similarly affected by lower insurance availability due to policies that may reflect systemic discrimination against non-conforming or non-binary sexual orientation or gender identity.[109]

In addition to inequities in access to care, discriminatory policies and practices shape the way mental health challenges are defined, detected, and supported in California's health care systems. Community members participating in the Commission's 2021 public engagement events asserted that program and funding priorities do not always reflect their communities' cultural and linguistic needs. At its December 8, 2021, meeting, the Commission's Cultural and Linguistic Competency Committee discussed areas of potential discrimination within the priorities for PEI funding articulated in Senate Bill 1004 (Wiener, 2018). For example, many committee members and members of the public argue that the emphasis on college partnerships in priorities for youth outreach and engagement disadvantage the broader population of youth, many of whom are youth of color. According to community members, part of the problem is a lack of inclusive and equitable community representation in the planning and development of mental health programs and services. One youth representative said during a public hearing that young people often are completely excluded from decisions regarding their wellbeing.

## Biases in Data

Data systems are a critical tool to advance broad systems change and promote equity in mental health. Unfortunately, limitations in data infrastructure continue to impede data-informed practices in California.[110]

Unequal representation of certain populations in existing data reinforces discriminatory decision making and policy.[111] Large-scale health surveys used to inform health policy, for example, generally exclude smaller geographic areas or certain marginalized groups.[112] Another issue is data aggregation, or the grouping of people together into sometimes arbitrary categories based on their race, ethnicity, gender or sexual identity, and other characteristics.[113] Grouping such individuals together makes it difficult to understand disparities within the group and can also lead to false assumptions that reinforce stereotypes and bias.[114] This is assuming such data is even reported, which is often not the case. For example, in national COVID-19 data reported in 2021, race and ethnicity were missing for 34 percent of cases.[115] Also, many health data collection efforts are conducted only in English, thereby excluding those with limited English proficiency who are already underserved.[116]

Public health data often lack consistency in the topics they capture over time as well, making it difficult to assess the impact of upstream prevention initiatives that by their nature can take several years, even decades, to demonstrate a measurable effect. Cost is a foremost limitation. Capturing data at the community and population level is expensive. Moreover, data infrastructure used by government agencies often is siloed, outdated, and underutilized in decision making.

Program and service data similarly lack consistency, reliability, and coordination. For example, in a review of MHSA PEI program data reported by local behavioral health departments, upwards of 70 percent of 850 program descriptions assessed did not specify a setting, and over 68 percent did not include information on staffing. Similarly, most reports did not contain information on referrals, outreach activities, and timing of activities, even though such information is required by State regulations. During one event, several behavioral health department representatives said they sometimes feel the need to choose between satisfying reporting requirements and providing actual services. The challenge is more difficult in smaller counties with fewer resources and staff dedicated to data collection, analysis, and reporting. Complicating matters is that current State requirements are not explicit in the ways counties should define, measure, and report outcomes for MHSA PEI programs and services. Such challenges result in program data that is missing, incomplete, or inconsistent.

Ultimately, relying on limited data systems weakens program evaluation and quality assurance. Incomplete data also misleads priorities for funding, policy making, and resource allocation. As a result, underserved communities continue to be overlooked and underfunded.





# BEST PRACTICES AND PROMISING SOLUTIONS

The World Health Organization, National Institute of Medicine, U.S. Surgeon General, and other leading health experts agree that no single program, partner, or funding source can adequately support a population's mental health needs.[122] Instead, prevention and early intervention programs and services must be part of broader initiatives that address the systemic and structural inequities that fuel mental health risk.[123]

Leadership is needed to catalyze momentum and leverage resources for change.[124] A strategic plan is needed to guide priorities for planning, collaboration, policies, and funding.[125] Investments in data and technical assistance are needed to evaluate and improve initiatives over time. The need for a broad, systems level approach has been recognized at the federal level, such as in Congress' 2021 *Improving Social Determinants of Health Act*, an initiative to promote interagency partnerships to improve social determinants of health.

> *"We continue to work in silos that are holding us back from something greater. If we could start converging our silos through the connection of agencies, we would have all the pieces of the puzzle. Different perspectives could come together to develop innovative ideas and solutions to problems that were previously too massive for one agency to solve."*
>
> – *Hillary Konrad, Prevention Network Development Manager in California's Office of Child Abuse Prevention, during a March 17, 2021, Commission public engagement event*

## Establish a Foundation for Prevention

Achieving health equity requires broad, upstream initiatives to address the systemic and structural conditions that underlie risk and enhance the conditions that promote wellbeing.[127] Such large-scale change cannot be achieved without participation from multiple partners from various sectors, with alliances at the private, public, state, and local levels, including community-based organizations and tribal governments.[128] Leadership at all levels is necessary to activate change agents and support collaboration.[129]

### Leadership

Developing strong and effective leadership is necessary to activate change agents and bridge effective alliances.[131] Such leadership must be visionary and capable of braiding systems and resources to effect bold, innovative, and lasting change.[132]

Establishing leadership is a strategy used often by governments to drive high priority initiatives. In 2021, California's Governor appointed a Senior Advisor on Aging, Disability, and Alzheimer's to lead cross agency initiatives as part of the State's Master Plan for Aging. In 2022, the Governor's executive order established California's first Racial Equity Commission with the responsibility of providing a framework and guidance to support California's commitment to equity, diversity, and inclusion in all State agencies and their practices. Similar leadership is needed to drive equity, innovation, and partnerships so that California can realize its vision for prevention and early intervention in mental health. This need for leadership was emphasized repeatedly by community members and local behavioral health partners during Commission public engagement events.



### OPPORTUNITY SPOTLIGHT: Leadership to Drive Broad Solutions

**California has done more than perhaps any other state to meet the mental health needs of its people. Noteworthy efforts in the past two years alone include the State's Children and Youth Behavioral Health Initiative, Community Schools Partnership Program, and its Master Plan for Kids' Mental Health. Other endeavors include the California's ACEs Aware initiative launched in 2020 to combat childhood trauma, the Family First Prevention Services Act (FFPSA) Five-Year Prevention Plan to reduce child maltreatment, California's public health care system (Medi-Cal) Cal-AIM Population Health Management Strategy, and the State's Behavioral Health Prevention Plan currently under development. Yet, as substantial as these and other efforts are, they are but a fraction of the State's many systems and initiatives impacting Californian's mental health and wellbeing. A state-level leadership position to coordinate and integrate such resources is needed to achieve these broad goals.**

**2019, Governor Gavin Newsom appointed California's first Surgeon General to lead the State in addressing some of its most pernicious and incessant public health challenges, many of which are too large for any one agency to address. In addition to health equity and addressing Adverse Childhood Experiences, improving mental health, particularly among youth, is a top priority of the current Surgeon General, Dr. Diana Ramos, who is herself a self-proclaimed person with lived experience and a champion of mental health. This commitment in addition to acting her role as top advisor to the Governor and key public health spokesperson make the Surgeon General well positioned to develop and lead a statewide strategy for mental health prevention.**

## Interagency Approaches

Partners outside the mental health system play a critical role in mental health prevention. These partners include people with mental health challenges and their families, advocates, researchers, community-based service providers, business representatives, public health officials, faith-based communities, first responders, health care workers, tribal leaders, traditional healers, and representatives from the education, justice system, social services sectors, among others.

Public health has a long history of leveraging multisector partnerships for disease prevention and health promotion. For example, the U.S. Centers for Disease Control and Prevention (CDC) has been leading interagency partnerships focused specifically on improving social determinants of health, such as collaborations with the federal Department of Housing and Urban Development and Department of Transportation. The collaborations promote better health by improving both living conditions and access to transportation for low-income individuals, older adults, and people with disabilities.

In another project, the CDC's National Center for Chronic Disease Prevention evaluated 42 multi-sector community partnerships across the country that address social determinants of health. Such partnerships generated health-promoting improvements such as new walking trails, bike lanes, and playgrounds, community and school gardens, and tobacco-free policies. More than half of the initiatives yielded immediate positive health outcomes, including improved health behaviors and decreased health care costs. although though most initiatives were designed to produce long-term outcomes through changes in policy, systems, and the environment. When forecasting the long term impacts, evaluators estimated that 29 partnerships alone could prevent as many as 2,140 coronary heart disease events, 1,650 strokes, and 850 deaths over 20 years, resulting in $566 million in savings due to averted medical and productivity costs.

Despite the need and promise for interagency approaches, opportunities continue to be lost as a result of collaboration challenges among partners within and outside the mental health system. During the Commission's prevention and early intervention events, partners from child welfare and criminal justice agencies said they feel unable or unprepared to play a role in mental health. They described feeling siloed from their mental health partners, with limited infrastructure and data that would permit collaboration toward common goals.

### OPPORTUNITY SPOTLIGHT: Interagency Prevention in Foster Care

California has taken an interagency approach to better serve children and youth in the foster care system and beyond through Assembly Bill 2083.[147] Established in 2018, this bill promotes a "local systems of care" framework by requiring counties across the state to identify and coordinate the roles and responsibilities of the various local entities that serve children and youth in foster care such as behavioral health departments, regional centers, education departments, social services, etc.[148] The legislation also calls for the establishment of a Joint Interagency Resolution team, to provide guidance, support, and technical assistance to counties.[149] The Interagency Resolution Team's mission includes:

1. Promote collaboration and communication across systems to meet the needs of children, youth, and families;
2. Support timely access to trauma-informed services for children and youth; and
3. Resolve technical assistance requests by counties and partner agencies, as requested, to meet the needs of children and youth.

Since its implementation, many counites have constructed Interagency Leadership Teams that are primed to collectively administer broader prevention frameworks at the systems and community level.[150] Scaling this and similar interagency approaches to reach more communities could greatly enhance California's capacity to implement upstream, comprehensive prevention.[151]

## Create and Implement a Strategic Plan

Developing a strategic plan to tackle a complex public health challenge is a common best practice. In fact, a strategic plan often is required for public funding. For instance, an approved plan is required for applicants receiving Substance Abuse Prevention Treatment Block Grants from U.S. Department of Health and Human Services.[152] Examples of strategic plans in the public health arena include the California Department of Public Health's integrated plan to address human immunodeficiency virus (HIV), hepatitis C virus, and sexually transmitted infections.[153] as well as its strategic plan for suicide prevention. The California Office of Traffic Safety created a highway safety plan to guide a strategic approach to ensure street safety, especially for bicyclist and pedestrians.[154]

In 2019, California developed a statewide Master Plan for Aging that provides a "blueprint" for state and local government, the private sector, and other partners to aging adults and people with disabilities, now and in the future. By 2030, the plan strives to ensure housing for people of all ages, improve access to home and community-based health care services, ensure inclusive and equitable opportunities for community participation and engagement, bolster the caregiving workforce, and increase economic security for Californians over the age of 65. California does not yet have a comparable plan in place to drive a statewide, integrated approach to mental health prevention and early intervention.

### Statewide Prevention Plan

A comprehensive strategic plan can be a powerful tool to help coordinate and map broad upstream, multidisciplinary, and interagency approaches to prevention and early intervention. California Gov. Gavin Newsom recognizes the opportunity and need for strategic planning to prevent mental health challenges and substance use disorders. California's Department of Health Care Services is leading an effort launched in April 2022 to develop the state's first Behavioral Health Prevention Plan. This plan will include guidance for assessment, capacity, planning, implementation, evaluation, sustainability, and cultural competence in the prevention of mental health challenges and substance use disorders.[162] This plan also will map California's various state and federal funding streams and use data to guide implementation of best practices in California's diverse communities.[163] This strategic approach should help guide existing and future investments, including MHSA funding, to improve state and local prevention efforts.

## OPPORTUNITY SPOTLIGHT: Priorities for Funding Earmarked for Prevention And Early Intervention

The Mental Health Services Act (MHSA) outlines a vision for transformational change of the California public mental health system with funding from a 1 percent tax on personal income over $1 million. Most of this funding is allocated to California's 59 local mental health departments. Local departments use MHSA funds specifically earmarked for prevention and early intervention approaches that prevent and lessen the suffering and negative outcomes associated with mental health challenges.[164] These approaches include outreach and engagement, health promotion, stigma reduction, screening and linkage to services, suicide prevention, and early intervention for a variety of mental health challenges.[165] To guide local program development and delivery, the State has identified several priority areas that include:[166]

- Childhood trauma prevention and early intervention to address the origins of mental health challenges
- Early psychosis and mood disorder detection, and mood disorder and suicide prevention cross the lifespan
- Youth outreach and engagement strategies, with an emphasis on partnerships with college mental health programs
- Culturally competent and linguistically appropriate prevention and interventions for diverse communities
- The mental health needs of older adults

Local mental health departments also may identify other priorities in addition to or in lieu of those listed above.[167] In drafting legislation on priorities for prevention and early intervention in mental health, the Governor and Legislature recognized that priorities should evolve based on new knowledge and changing needs. As a result, they authorized the Commission in 2018, through Senate Bill 1004, to explore and establish additional priorities for the use of MHSA prevention and early intervention funding.[168] A statewide strategic approach to prevention and early intervention would guide the identification of additional priorities for this earmarked funding, along with other public investments in strategies to reduce the drivers of mental health risk, such as unmet basic needs, poverty, and trauma. A strategic statewide plan would guide priorities to maximize all public investments intended to reduce mental health risk and build resiliency.

## Planning with Community Experts

To be most effective, prevention and early intervention strategies must be tailored to unique community needs, risks, and strengths. They must prioritize those who are marginalized, underserved, or at greater risk.[169] In California, our communities form a diverse mosaic of cultures, languages, lifestyles, physical environments, and resources. We also differ in terms of what threatens[170] or protects[171] our mental health and wellbeing. However, every community is an expert in its local needs and assets.[172] Community participation therefore is a critical component of strategic planning for prevention and early intervention. Individual communities are in the best position to understand the barriers faced by groups who are unserved or inappropriately served.[173] And devoting space for community representation in decision making promotes transparency, inclusion, and accountability for the way local resources are allocated.[174]



During an April 21, 2021, Commission public engagement event, presenter and youth leader Matthew Diep remarked on the critical need for community voices in mental health decision making, particularly voices of youth. He emphasized the need for community members to "be there" from development through implementation and evaluation. Indeed, people who are closest to the problem often are closest to the solution and should have a place at the decision table.

## OPPORTUNITY SPOTLIGHT: Community Needs Assessment

County behavioral health departments in California are required to assess the mental health needs of residents who qualify for services under the Community Services and Supports (CSS) component of the Mental Health Services Act. This assessment asks about racial and ethnic background, age, and gender identity. Departments use these data and other information to identify priority areas for CSS funding. The information allows partners to align their resources and program priorities in ways that better support a community's mental health needs and reduces disparities.

In practice, mental health needs assessment strategies vary greatly depending on county resources. In many cases, community members have not had the opportunity to communicate their needs. Language and cultural barriers are a key barrier. Some people also may have a mistrust of government or health care agencies due to experienced oppression, others simply cannot participate because of employment or family obligations or other barriers. During Commission public engagement events, participants from all California regions repeatedly mentioned the lack of community inclusion in mental health decision making. One participant in a Los Angeles engagement event urged the State to "hold counties accountable to execute ongoing, robust, diverse stakeholder engagement in the program planning, delivery, revision, and reviewal processes of mental health services."

## Build Capacity with Data and Technical Assistance

Capacity building, the process by which organizations enhance their systems and resources, is a powerful tool for achieving equity in mental health. The process can allow more underserved communities to benefit from critical investments, policies, and direct services to promote mental health. Providing data and evaluation and delivering technical assistance and training are common capacity-building strategies.

## Integrated Data Systems

Integrated data systems are essential to an effective prevention approach, providing information to identify and respond quickly to health risk and needs. In the realm of public health, for example, real-time emergency department data are used to identify disease outbreaks and make quick and accurate predictions to inform prevention decisions. Linking data across agencies across health care and non-health care agencies can help break down systemic silos, allowing agencies to identify and communicate opportunities, coordinate resources, and act jointly toward mutual goals.

Integrated data systems also are a critical tool for promoting health equity by allowing the ongoing monitoring of disparities, including documenting how different communities are impacted by risk and needs. Identifying disparities in service access and utilization can inform priorities for program funding and capacity building. Understanding diverse characteristics of communities also can help policymakers identify specific service needs such as translation services, transportation, or access to culturally responsive providers. Public dissemination of data trends also is a way for systems to practice transparency, improve public awareness, and empower individuals, communities, and advocates.

During the Commission's public engagement events, several participants highlighted the need for a centralized, State-supported data system that would allow mental health data to be disseminated to the public. Community members, providers, and subject-matter experts participating in the public engagement events identified specific data measures to prioritize, including those that capture basic needs such as access to healthy food, housing, and safety, as well as structural factors such as systemic inequities, minority stress, trauma, and poverty. Many participants also stressed the importance of measuring and disseminating information about community strengths and protective factors, including cultural practices, social cohesion, social capital, and local leadership.

### OPPORTUNITY SPOTLIGHT: Leverage Existing Data

Public health partners have been exploring how integrating large data systems could be used to better understand and support a population's mental health.[189] For example, public health survey data can be used to identify the mental health needs of communities and monitor changes in those needs over time. Assessing community trends in mental health diagnoses and risk factors can help guide targeted prevention strategies. Information on community characteristics can be particularly valuable to inform targeted responses to adverse or traumatic events such as wildfires, acts of violence in communities, or the significant challenges resulting from the COVID-19 pandemic.

California possesses many tools for measuring and tracking mental health data, such as the California Health Interview Survey and the Behavioral Risk Factor Surveillance System. Each measures an array of physical and mental health and wellbeing factors, including those related to social determinants of health. State and local agencies, such as school districts, social service agencies, criminal justice systems, and child welfare offices, also capture data relevant to mental health, as do private and public health care and behavioral health institutions. Leveraging and enhancing existing data systems to develop a centralized, integrated data infrastructure that is responsive to community needs and statewide goals could enhance the State's capacity to better understand and support the mental health needs of Californians.

## Evaluation of Prevention and Early Intervention Programs

Evaluating the development, implementation, and outcomes of prevention and early intervention programs is necessary to ensure programs are having their intended impact on the communities they serve. Meaningful evaluation relies on the quality and precision of local program data.

Prevention and early intervention programs and services often differ from region to region, as do the data that are collected and reported. Although necessary to meet the needs and expectations of communities, this variability in programs and data poses significant challenges for assessing the local and statewide impacts of its prevention and early intervention investments.

Throughout the Commission's public engagement activities, participants reiterated the need for more State guidance and resources to support data-driven planning, delivery, and evaluation of prevention and early intervention programs and services. On several occasions, local behavioral health departments have requested that the State offer standardized data reporting and evaluation tools, such as uniform data collection and reporting guidelines and standardized performance metrics for common programs. To support the use of such tools, participants also emphasized the need for resources that include clear and consistent definitions, templates for data collection, and an inventory of standardized tools and measures for evaluation.



### OPPORTUNITY SPOTLIGHT: Standardizing PEI Program Data

California's prevention and early intervention programs, including those delivered through MHSA and other funding streams, have varied widely in the types of services offered and data collected. Lack of standardization is a key challenge.

Collecting standardized program data on these and like programs could guide statewide investments and best practices in prevention and early intervention services.[203] Potential metrics could include needs and risk assessment data, timeliness and quality of care, and data across outpatient, inpatient, and emergency services and the cost associated with these services. Others could include recovery-focused, individual-level outcomes related to employment, housing, and family connectedness.[204]

Standardized data also could enhance local behavioral health department's capacity for better supporting underserved populations such as youth, older adults,[205] and marginalized populations. For example, outcome measures could be used determine the effectiveness of cultural or linguistic adaptations of existing programs or to establish a new evidence base for community-defined practices. These data could be used to transform care through training and technical assistance, facilitate services for individuals in real time, and answer program, county, and State-level questions.[206]

## Training and Technical Assistance

Many of California's prevention partners lack the resources and skills to contribute to a statewide prevention and early intervention strategy. Training and technical assistance are critical steps in addressing these gaps.[207]

Technical assistance is the process of providing an organization or community with focused support that meets resource and development needs. Technical assistance may be delivered in many ways, such as via one-on-one consultation, facilitated small groups, direct technical support, or web-based tools and information. Training, especially when delivered alongside technical assistance, further enhances capacity by helping partners build a knowledge base and technical skillset necessary to implement best practices.

Providing informational resources, such as a clearinghouse of evidence-based practices, together with training can promote effective programs and services. Technical assistance also can enhance program capacity by supporting the sharing and coordination of resources, assets, and information.

Training and technical assistance are critical for strengthening the role of partners in non-mental health systems and settings. For example, trainings and resources on best practices for mental health screening, support, and linkage to services, such as those described in Finding 4, can build capacity among non-mental health care providers to detect and respond to mental health needs early and effectively. Training in trauma-informed practices for emergency first responders can help prevent the escalation of a mental health crisis, while training for law enforcement staff can prevent the unnecessary use of force or incarceration when responding to a person experiencing significant mental health challenges.

Training and technical assistance in organizations also can promote policies and decisions that are mental-health and trauma-informed. One example is the National Center for Child Traumatic Stress (NCCTS) which was created to coordinate and support a network providers, family members, researchers, and national partners to raise the standard of care and increase access to services for children and families who have experienced trauma. Among its many roles, the NCCTS provides training and technical assistance to build capacity across its network of 286 centers from 48 states. Resources include a carefully curated, publicly available online library of information about rigorously evaluated treatments for trauma, as well as promising emerging practices. The NCCTS also offers a series of online and in-person trainings that cover a range of topics for varied audiences, from basic trauma education to assessment and intervention techniques for providers. According to the center's website, the NCCTS has trained more than two million professionals in trauma-informed interventions and benefited hundreds of thousands more through community and website resources. The work of the NCCTS also resulted in over 10,000 local and state partnerships, increasing capacity for integrating trauma-informed services among all child-serving systems including schools.

At the local level, training and technical assistance resources can support data collection and community engagement to assist with local needs assessments, regulatory reporting, and program evaluation.

### OPPORTUNITY SPOTLIGHT: Training and Technical Assistance to Reduce Disparities

In 2016 Solano County Behavioral Health Division (SCBHD), partnered with UC Davis Center for Reducing Health Disparities (CRHD), to launch a multi-phase five-year community-initiated MHSA Innovation project known as the Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM). The aim of this project was to enhance cultural and linguistic competencies required to understand and support the needs of Filipino American, Latino, and LGBTQ+ communities in Solano County. The project combined a comprehensive community-engagement process to assess needs, customized training in Culturally and Linguistically Appropriate Services (CLAS) Standards, and technical assistant to support development and implementation of a Quality Improvement Action Plan to promote sustainability of the project. Evaluators of the project found that overall, the CLAS training program improved participants' cultural responsivity and comfort with community engagement which helped organizations create innovative programs to help reduce mental health disparities in the communities of focus. Expanding collaborative and community-oriented approaches like ICCTM could help counties' better respond to the diverse needs of communities and reduce disparities.



# RECOMMENDATION ONE

**The Governor and Legislature should establish a state leader for prevention and early intervention, charged with establishing a statewide strategic plan for prevention and early intervention – with clear and compelling goals tied to global standards of wellbeing that are centered in equity, diversity, and inclusion. That plan must work to innovate and integrate California's existing efforts to pursue the following:**

**1A.** Form an advisory body that taps into the lived experiences and expertise of a broad coalition of community voices, local, state, and federal government partners, as well as private sector partners all focused on population health opportunities.

**2B.** Assess existing prevention and early intervention investments to identify opportunities for improved integration, new investments, and other forms of attention to achieve global standards of wellbeing with a focus and expanding best practices.

**3C.** Establish prevention and early intervention goals that fortify and align with California's commitment to equity, diversity, and inclusion, through strategies to address historic and contemporary disparities and structural racism, including efforts to bolster the influence and representation of community partners in the planning, review, and approval of local decisions impacting their wellbeing.

**4D.** Develop an array of tools and strategies to support progress and success in achieving prevention and early intervention goals, including: fiscal incentives, training, technical assistance, and other forms of capacity building; research and engagement to improve understanding of opportunities and guide improvement; development of key metrics and data systems to monitor impact.

# FINDING TWO

**Unmet basic human needs and trauma exposure drive the risk associated with many mental health needs. These factors will continue to disrupt statewide prevention and early intervention efforts and outcomes unless they are addressed.**

A wide array of personal, environmental, social, and other factors can positively or negatively impact mental health.[224] Prevention strategies should focus on reducing the factors that carry negative impacts while increasing those that protect and improve mental health.[225] Prevention efforts have the greatest impact when they focus on factors that are shared in common by a community or population.[226] In California, such shared risk factors include insufficient access to basic social, economic, and physical health resources. Trauma is another common and dangerous factor threatening the current and future mental health of Californians. Unlike genetic predispositions to mental health challenges, these factors can be modified and represent factors that are foundational to healthy, thriving communities.

## DRIVERS OF MENTAL HEALTH RISK

A complex set of factors shapes the experiences and outcomes that underlie a person's mental health. These factors, related to biology, environment, society, and behavior, can change dramatically over time.[227] Those that increase risks of developing mental health challenges are called *risk factors*. Those that buffer against risk are called *protective factors*.[228] Depending on these factors, a person may be genetically predisposed to a mental health challenge, yet never develop symptoms – or may be able to manage symptoms with little disruption to their lives. With a different set of factors, the same person may develop significant symptoms and experience severe negative outcomes.

Examples of common mental health risk factors include social isolation,[229] poor attachment to caregivers, child abuse and neglect, poverty, job loss, [230] mental health stigma, access to substances,[231] and exposure to racism, community or domestic violence, and other forms of trauma.[232] Each of these can be sources of stress or barriers to effective coping.

Protective factors can include access to information and resources, stable employment or income, adequate food and housing, education, health care,[233] feeling connected to and supported by another person, or belonging to a social support network.[234] Protective factors strengthen coping and resiliency, facilitate social connections, and provide a feeling of control over one's actions and their consequences, all of which improve physical and mental health outcomes.[235]

Risk and protective factors can be as diverse as California's population. However, research and community input have identified key mental health risk factors that remain common across groups: unmet basic needs and exposure to trauma. These risk factors are discussed in this finding along with opportunities and possible solutions to prevent or mitigate them.

### Unmet Basic Needs

The opportunity to be physically and mentally healthy is considered a fundamental human right.[236] The United Nations Committee on Economic, Social, and Cultural Rights defines the right to health as the right to *basic needs*, including food and nutrition, housing, safe water, adequate sanitation, safe and healthy working conditions, and a healthy environment.[237] Many experts also consider access to transportation, health care, education, and supportive social relationships as basic human needs.[238]

Research repeatedly has shown that a person deprived of basic needs is at greater risk of experiencing mental health challenges including psychosis,[239] severe depression, and anxiety,[240] as well as physical challenges like diabetes and heart disease.[241] Those who lack basic human needs also have a shorter life expectancy than people with greater social and economic opportunities.[242]

California has made significant investments in addressing the basic needs of its residents. Despite these critical changes to policy and practice, however, many people continue to struggle to meet basic social, economic, and health-related needs.[243] Unmet basic needs disproportionately impact Latinx, Black, Native and indigenous, and refugee communities,[244] as well as caregivers and many rural residents.[245]

*"We live in some of the poorest communities in California. Access to jobs, education, just the social determinants of health – air quality is terrible – those very basic needs aren't being met, and so it can be a very hopeless and helpless situation for youth. Some of them can leave their communities for better opportunities, but those who can't can become very desperate and hopeless."*
*– Participant during a March 8, 2021, Commission public engagement event with residents from Central California*

## Income and Affordability

More than one in three California households does not earn sufficient income to meet basic needs, according to a 2021 report by United Ways of California. This number rises to one in two among households with children under age 6. Such deprivation is confounding, given that California has one of the world's largest economies, ranking first in the U.S. Soaring housing costs are the primary driver, with roughly 4.1 million California households spending more than 30 percent of their income on housing. At the same time, the costs of raising young children are rising, with child-care expenses often exceeding the cost of housing for many families.

## Health Care

Many Californians have unmet basic health needs due to lack of access to affordable health care. Access to mental health care is even more limited. In a 2019 statewide poll administered by the Kaiser Family Foundation and the California Health Care Foundation, mental health care access ranked as the top health priority that Californians wanted the Governor and Legislature to address.

Health care access based on ability to pay is an important driver of health care disparities, as approximately 3 million Californians lack health care insurance. Even those with coverage are not getting the care they need, including mental health care. Many with insurance face high out-of-pocket costs for health care, averaging $7,545 annually for California families in 2018. Residents of rural and poor communities face additional challenges in accessing health care, as providers and care facilities are scarcer in these areas.

Mental health is one of the largest drivers of health care costs in the United States. According to a White House report, costs associated with mental health services have more than doubled nationally in the last decade, approaching $280 billion in 2020. At the individual level, people with the most severe mental health challenges shoulder far greater financial burdens than those who are less impacted.

Lack of affordable health coverage takes an enormous toll on a person's mental and physical health and quality of life. Undetected or poorly managed health care needs contribute to higher rates of illness, higher levels of stress, and shorter life expectancy among people without coverage. Being uninsured carries economic consequences as well. Illness not only increases the risk of unemployment. It also contributes to financial debt due to medical bills. Regardless of income, adults in the U.S. cite high health care costs and uncertainty about future coverage as major sources of stress, according to the American Psychological Association.

## Community Disparities

Ongoing socioeconomic and health care disparities disproportionately impact certain communities. For example, uninsured rates are highest among Latinx, Native,[266] and undocumented Californians.[267] In rural communities, which account for roughly 850,000 Californians, incomes are about 25 percent lower than for the state as a whole.[268] Rural areas also experience above-average unemployment rates.[269] In both rural and urban settings, under-resourced communities also experience disparate deprivation in basic needs such as education, safety, green spaces, proximity to grocery stores, public transportation, and affordable housing. [270]

Healthy aging also has become unaffordable in California. With rising living costs increasingly outpacing average retirement income and social security benefits, people over the age of 65 are at risk of poverty, hunger, and homelessness.[271] An estimated 20 percent of Californians over age 65 currently live in poverty, and residents over the age of 50 are now the fastest growing population of homeless people.[272] This is profound given that older adults are expected to represent one quarter of the state's population by 2030.[273]



In all communities, a massive gap remains between the most impoverished and the most resourced Californians,[274] and the potential for upward socioeconomic mobility[275] has not improved for many communities in the past two decades.[276] According to the Public Policy Institute of California, the gap between high-and low-income households in California continues to grow.[277] Families at the top of the income distribution curve today earn up to 11 times more than those at the bottom.[278] Nationally, California ranks among the top five states with the greatest income inequality. Wealth is distributed even more unevenly than income. Two percent of Californians own 20 percent of the state's total net worth.

Unequal distribution of income and wealth is associated with higher disease and mortality risk in both developing and industrialized countries.[279] Research shows that populations with greater income inequality have a higher prevalence of schizophrenia, depression, anxiety, and substance abuse.[280]

Digital technology is a fundamental need in modern society.[281] The internet has become a critical conduit of social and emotional support for many people, especially those who are underserved, isolated,[282] or have disabilities.[283] During the COVID-19 pandemic, internet-based resources became a lifeline for many people cut off from the places and people they previously relied on for employment, education, and social and emotional support.[284] Yet disparities in technology access and digital literacy among Californians continue to limit the reach of online resources, especially for those in rural or under-resourced communities.[285] Community members participating in Commission public engagement events underscored that people who cannot afford high-speed internet or digital devices, or who lack the necessary skills to navigate technologies, are excluded from the quickly evolving digital landscape.[286]

## Trauma Exposure

Trauma can have profound and lifelong effects on a person's physical and mental health.[287] Trauma can be experienced in many forms including violence, abuse, or neglect, perceived discrimination, political persecution (such as that experienced by refugees), environmental disasters, or public heath crises.[288] Cumulative traumatic experiences can initiate a chronic stress response, known as toxic stress, that may disrupt a person's social, emotional, and cognitive functioning long after the events that caused them.[289] The more severe or frequent the trauma, the higher the risk of toxic stress.[290]

### Childhood Trauma

Children's developing immune and nervous systems make them especially vulnerable to trauma. If not properly addressed, childhood trauma can set the stage for a lifetime of physical and mental health challenges.[291] A subset of traumas experienced before the age of 18 – referred to as adverse childhood experiences, or ACEs – have been linked to increased risk of mental health challenges such as depression, anxiety, suicide, and psychosis.[292] Adverse childhood experiences also predict liver disease, heart disease, stroke, smoking, Alzheimer's disease, and dementia.[293] As many as 21 million cases of depression among U.S. adults are attributed to ACEs.[294]

A person with six or more ACEs is expected to die 20 years earlier on average than someone who has none.[295] California's first appointed Surgeon General, Dr. Nadine Burke Harris, identifies adverse childhood experiences as "a root cause of some of the most harmful, persistent, and expensive societal and health challenges facing our world today."[296]

Childhood trauma is exceedingly common in California. At least three out of every five Californian adults have experienced at least one adverse childhood experience,[297] with rates even higher in rural areas.[298] Indeed, the fallout of adverse childhood experiences is estimated to cost California more than $112 billion annually in health care expenses and lost productivity.[299]

*"The saddest way that trauma impacts communities is that it robs the children of [feeling protected] by their parents and robs the confidence in parents to [protect their children]."*
*– Dr. Vilma Reyes, Clinical Supervisor, Director of Training, Associate Director of Community Programs, University of California, San Francisco Department of Psychiatry and Behavioral Sciences, during an April 22, 2021, Commission public engagement event*

### *Costs and Consequences of ACEs*

***Suicide:*** *U.S. estimates suggest that the odds of suicide ideation or serious attempts increase threefold among people with three or more ACEs compared to those with none.[300] In California, the estimated annual medical and work related costs attributed to suicide amounts to roughly $4.9 billion.[301]*

***Removal of children from their homes:*** *According to the U.S. Department of Health and Human Services, children engaged in the child welfare system are on average four times more likely to have experienced four or more ACEs compared to the general population of U.S. youth.[302] In 2016, $29.9 billion in federal, state, and local funds were spent on child welfare services in California alone.[303]*

***Substance use:*** *Having more ACEs increase the likelihood of lifetime drug and alcohol use and addition.[304] strongly linked with substance use disorders during early adulthood.[305] In California, full lifetime costs of alcohol abuse and illicit drug abuse were estimated to be $128.7 billion and $43.9 billion, respectively.[44] This number includes medical costs, public services, property damage, and loss of wages.[44]*

***Health Care:*** *Average annual health care costs are $407 higher among Californians who report one ACE. Health care spending more than doubles for people with four or more ACEs ($818). This amounts to a total of $10.5 billion in ACEs related personal health care spending in California each year.*

## Positive Childhood Experiences

Fortunately, adjacent research has shown that children can be insulated from the harm of trauma when they have access to *positive childhood experiences*. Positive childhood experiences broadly refer to advantageous, usually non-monetary, experiences occurring before the age of 18.[306] Examples include feeling safe, protected, accepted, and supported by parents and family members, the ability to talk openly with parents or caregivers, and healthy household routines.[307] When children don't have access to such experiences in their home, they can still benefit from positive experiences in other settings.[308] Examples include feeling supported by friends or neighbors, having a sense of belonging and connection with a larger group such as in school, church, and clubs, participation in community or cultural traditions, and having at least one positive relationship with a non-parent adult.[309] The extent to which a child has access to any of these experiences is dependent on the health of their household and community.[310] Conditions such as poverty, violence, and deprivation, therefore, can interfere with the protective benefit of positive childhood experiences.

## Poverty

Poverty and trauma are intertwined. Severe poverty on its own can be a form of trauma,[311] impacting a person's body and brain in ways similar to physical abuse and neglect.[312] At the same time, poverty and severe deprivation set the stage for further trauma.[313] People living in poor areas, on average, experience higher rates of crime, violence, and stressors in their communities and homes.[314] Overall, children living in poor households experience more ACEs than their peers.[315] People in poorer communities also may have fewer resources to cope and heal from traumatic experiences, increasing the risk that they will experience long-term effects of trauma.[316]

This reality was shared by a trauma survivor during a Commission engagement event. The survivor described the struggle of meeting her mental health needs as a parent on a limited income. "If I don't have child care [or transportation] to go to my counseling appointment, then I'm not getting counseling," the community member said. "If I'm too busy making sure that I have food in my fridge and the rent is paid [...] I'm going to prioritize feeding my child and making sure my child has somewhere to sleep before I'm going to prioritize a potential mental health [need] that might happen in the future."

Poverty also threatens the mental health of long-term caregivers and those in their care. The estimated 6.7 million Californians who provide long-term care for a friend or family member are foundational to the state's long-term services and supports infrastructure. Women, particularly Black, Native, Latinx, and Asian American women, provide a disproportionate amount of this care – often while simultaneously caring for children. According to a 2018 report by California's Task Force on Family Caregiving, the combined economic value of these unpaid caregiving contributions surpasses the entire Medi-Cal budget. The report also points to the challenges California's caregivers face in balancing employment and caregiving, accessing culturally relevant and competent services, paying for supportive services, and attending to their own health and wellbeing. Together these challenges place caregivers at significantly greater risk of stress, burnout, poverty, and poorer physical and mental health.

## Wildfires and Other Large-Scale Adversities

In addition to individual and generational traumas, trauma can be shared by communities.[322] Community trauma can result from natural disasters, acts of violence such as mass shootings, or systemic adversities that impact populations such as structural racism, discrimination, and socioeconomic disparities.[323] Symptoms of community trauma include severed social networks, a low sense of political efficacy, deteriorating living environments, neighborhood violence, and intergenerational poverty.[324] Decades of research indicates that each incident of large-scale adversity increases mental health risks for exposed individuals, ranging from short-term anxiety to longer-term depression and post-traumatic stress disorder.[325] Cumulatively, large-scale adversity weakens a community, strips its resilience, and threatens the collective pursuit of healing and wellness.[326]

Californians have endured an unprecedented number of community traumas over the last decade. As this report is being written, communities statewide still grapple with the effects of the COVID-19 pandemic while simultaneously confronting national and global political and social unrest, severe drought, massive wildfires, and a possible economic recession.[327]

Thousands of Californians have lost their homes, livelihoods, and communities due to wildfires. Many have lost their lives.[328] As wildfires continue across the state, many health experts are concerned about the mental health impacts of these traumatic events.[329] In one recent study, researchers from the University California San Diego found that six months after the devastating 2018 Camp Fire in Butte County, Northern California residents experienced increased post-traumatic stress disorder, depression, and anxiety.[330] Mental health risk increased with proximity to the fire and was greatest among people with a history of childhood trauma.[331] Resilience was greatest among those with strong social supports and those who engaged in mindfulness coping practices.[332]

Many impacted by wildfire are already on the margins of poverty and deprivation[333] and lack the means to replace lost homes, vehicles, and other basic needs.[334] At the same time, skyrocketing home insurance costs in designated high-risk fire zones are exacerbating disparities in housing affordability.[335] Without immediate and bold interventions, climate researchers expect the incidence and severity of wildfires to increase dramatically over the next few decades.[336] Disparities in exposure and vulnerability to wildfire mean that some Californians are subjected to disproportionate – yet preventable – mental health risk.[337]

# BEST PRACTICES AND PROMISING SOLUTIONS

Prevention is most effective when it includes a combination of strategies to reduce risk and build resilience for individuals, families, and communities.[338] Larger and more sustainable improvements will be achieved when strategies move upstream to target broad, overlapping social, economic, environmental, and systemic barriers to wellbeing.[339]

In addition to broad solutions, direct services and supports are equally important for people who are at greater mental health risk. Vulnerable populations include children in poor households, isolated older adults, and people with disabilities and their caregivers.[340] Many of the strategies coincide. For example, reducing poverty can improve access to basic needs like housing,[341] reduce violence and the risk of child abuse,[342] and improve a community's ability to recover financially and emotionally from acute adversities,[343] such as wildfires. Below are key opportunities for addressing some of California's core drivers of mental health risk, while building its resilience.

> *"[We must] address the economic and social barriers that contribute to poor mental health for young people, families, and caregivers [...] priorities should include reducing child poverty and ensuring access to quality child care, early childhood services, and education; healthy food; affordable health care; stable housing; and safe neighborhoods."*
>
> *– U.S. Surgeon General's 2021 National Advisory Report on youth mental health*

## Meet and Exceed Basic Needs

Reducing disparities in basic needs is critical to upstream, population-based mental health prevention.[344] Access to and affordability of health care for physical and mental health challenges and substance use disorders is a fundamental basic need of all Californians. Reliable, high-quality child care for young children also is a critical need for all communities. Strategies to increase basic needs include ensuring people have access to livable wages, healthy and affordable food, adequate housing, transportation, and internet access, among others. Communities also must be safe and have clean air and water.[345]

### Health Care Without Hardship

Universal health coverage that includes mental health coverage is among the targets set by the World Health Organizations[346] and United Nations[347] to achieve sustainable development around the globe. WHO defines universal health coverage as ensuring that all individuals and communities receive the health services they need without suffering financial hardship.[348] It defines health services as the "full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care, across the life course."[349]

With universal health coverage, all people can access the physical and mental health care services they need, when and where they need them, independent of their housing, employment, or financial status.[350] While there are multiple approaches to achieving universal health coverage, paths generally include some combination of public and private insurance.[351] Because uninsured people are more likely to depend on emergency care rather than preventive or intervention services, providing these individuals with insurance also reduces strains on emergency services and saves money.[352]

### *Unmet Needs in California*

**3 million Californians lack health care insurance**
**1 in 3 households without sufficient income to meet basic needs**
**1 in 2 households with children unable to afford basic needs**
**4.1 million California households spend more than 30% of their income on housing**
**20% of Californians over age 65 currently live in poverty**



### OPPORTUNITY SPOTLIGHT: Universal Health Coverage

**Implementing universal health coverage can incur substantial startup costs, but research suggests money[353] – and lives – would be saved beginning in the first year. Recent analyses suggest California could save up to $500 billion[354] in health care costs in the first decade following rollout. Additional savings could be realized if California were to leverage its substantial power as a buyer of prescription medications, the cost of which are currently a substantial stressor for many Californians, especially older adults. Further, depending on the model of universal health coverage, businesses could benefit financially. The cost of providing health insurance currently represents up to a fifth of payroll costs for businesses.[355]**

**Californians' health also would improve. Worldwide, universal health coverage is associated with reduced mortality.[356] Some estimates suggest that as many as 4,000 Californian lives would be saved each year if universal health coverage were achieved.[357]**

**Universal health coverage would accelerate California's capacity to address some of its greatest mental and physical health disparities and prevent the physical, emotional, and financial toll of physical and mental health crises.[358]**

## Combat Poverty

Reducing poverty will decrease trauma and improve mental health outcomes across the lifespan for current and future generations of Californians.[359] Approaches involving direct financial support for families in poverty, such as child tax credits and guaranteed income programs, show promise for reducing financial stressors, improving caregiver and child mental health, and preventing conditions linked to child maltreatment.[360]

Reducing poverty also can help children develop to their full potential. For example, in a recent large-scale U.S. clinical trial examining the effects of guaranteed income for new mothers, researchers observed improved brain activity in regions critical for cognitive skill development in young children whose mothers received monthly cash stipends of $333 for one year.[361] The effect was not seen in a comparison group of children whose mothers received a nominal $20 monthly payment.[362]

Advocates of income-based programs stress that such approaches are not intended as a panacea for economic disparities. Rather, the approaches should be implemented alongside strategies to improve equity in social and economic domains by helping disadvantaged individuals and communities acquire and retain wealth and achieve economic mobility.[363]

Among California's efforts to address its growing poverty crisis, guaranteed income programs have shown promise not only in reducing economic challenges, but also in improving overall wellbeing.[364] For example, a preliminary evaluation of California's first basic income pilot program in the city of Stockton showed that residents who received $500 per month reported significant reductions in depression and anxiety along with improvements in subjective wellbeing after one year of participation.[365] Though promising, more research is needed to assess the effectiveness and feasibility of large-scale implementation of guaranteed income programs in California.

## OPPORTUNITY SPOTLIGHT: Investments in Child Care

High quality, low-cost child care during the first five years of a child's life shows promise for helping families overcome poverty.[366] By allowing parents to remain in the workforce, child care not only reduces economic stress and risk of child maltreatment. It also buffers against the harmful effects of poverty and trauma by providing nurturing and supportive environments for children.[367] Children from low-income homes who receive high-quality child care before age 5 exhibit better social and cognitive development compared to their peers without child care.[368] To be effective, child care must be high quality, affordable, and available to diverse cultural and linguistic populations.[369]

A recent report by researchers at the University of California, Berkeley, underscores the need for California to increase investments in high-quality child care for the growing number of families in need.[370] The researchers found that licensing and business costs, low wages, and high staff turnover are among the most important capacity barriers for publicly supported child care programs – barriers that could be addressed with increased financial support.[371]

Such investments yield profound dividends. For each dollar invested, the State realizes two dollars in child-care workforce spending and income tax revenue alone, according to the Berkeley report.[372] Further economic benefits derive from increased workforce participation and productivity among parents and higher salaries for women.[373] Such estimates do not include the financial impacts of projected lifetime improvements in outcomes for the 4.2 million California children with working parents.[374]

## Build Healthy and Resilient Communities

While addressing broad disparities in basic social and economic needs is critical for prevention, also needed are investments to build healthy, safe, and supportive communities that promote mental health resilience.[375] Building resilient communities is increasingly important in a state confronting wildfire, drought, pandemic infection, economic swings, and other emerging and ongoing crises that disrupt mental health.[376]

Evidence has shown that resilience is greater in communities that promote physical activity, civic participation, social engagement, and other healthy coping behaviors.[377] Communities as a whole become more resilient when diverse groups and institutions are united by a shared sense of participation, co-operation, and inclusivity.[378]

Research on healthy aging makes clear that being socially and physically active leads to better health and quality of life.[379] These benefits are not just physical, but also have a profound effect on a person's mental and cognitive wellbeing.[380] For example, staying physically[381] and socially[382] active can prevent dementia and depression for older adults.

At any age, being socially engaged plays a critical role in fostering self-confidence and belonging, reduce isolation, and help people access information and resources to sustain their physical and mental health.[383] Supportive relationships in the home, school, and community are especially important for promoting resilience against trauma.

Evidence-informed strategies to increase community resilience include building public green spaces, parks, and safe walkable and bikeable paths that are accessible to people of all ages and abilities.[385] Other important community interventions include investments in recreational and community centers for both young people and older adults, public schools, libraries, and high-quality child care.[386] For these and other approaches, community participation is critical to identify local needs and lead local solutions.[387]

Resilience also is enhanced when people have opportunities to engage in activities that align with their cultures and beliefs. For example, multiple initiatives, such as the California Reducing Disparities Project's piloting of community-defined evidence practices (CDEPs), have developed tools to measure the positive impact of culture on Native/Indigenous communities. That project, along with three large sample studies in two countries (Canada and the United States), showed that Native/Indigenous culture is an important social determinant of health and that connection to culture is an important intervention to contribute to better mental health and wellbeing.

## OPPORTUNITY SPOTLIGHT: California Opportunity Zones

Economic development approaches that show promise for building resilient communities include leveraging investments in "Opportunity Zones" – federally designated, economically distressed census areas where new investments may be eligible for preferential federal tax treatment or preferential consideration for federal grants and programs.[392] California Opportunity Zones, largely facilitated by the Governor's Office of Business and Economic Development, support new investments in local businesses, environmental justice programs, sustainability, climate change mitigation, and affordable housing.[393]

Northern California's Humboldt County is using its Opportunity Zone to revitalize the Port of Humboldt Bay.[394] This area, once a vital local resource, was neglected and underutilized following years of economic downturn and the demise of the local logging industry.[395] Steady increases in poverty, substance use, homelessness, and unaddressed mental health challenges ensued.[396] In partnership with local community members, industries, and Cal Poly Humboldt, the County developed a strategic plan to transform the port and surrounding community into a hub for employment and tourism.[397] Elements of the plan include enhancing green energy infrastructure, increasing affordable housing, fostering small business entrepreneurship, and improving access to health care and child care.[398] These and similar efforts are examples of primary mental prevention as they foster mental health resiliency. They can be leveraged to support other struggling communities across California.[399]

## Place-Based Supports Across the Lifespan

Strategies that support children, older adults, people with disabilities, and others in need of full-time care are critical to prevent trauma, stress, and other physical and mental health challenges.[400] These strategies help to promote resilience across the lifespan for both caregivers and those for whom they care.[401]

*"We have an evidence base for prevention of poor outcomes for young children. It includes nurturing attachment with all adults in the young child's life, providing parents and caregivers knowledge of child development, supporting social connections between families, concrete resources for parents to address the direct impacts of poverty, and supporting social-emotional development for children. The biggest barrier to all of these is a lack of dedicated resources, resources that the Prevention and Early Intervention fund can and should provide."*

*– Participant during a March 3, 2021, Commission public engagement event with residents from Los Angeles*



## Supports for Parents and Primary Caregivers

Parents or caregivers of young children play a critical yet often-underrecognized role in promoting the wellbeing of a population, as do those who provide long-term care for a child or adult with significant disabilities or medical needs.[402] These caregivers can better meet the physical and emotional needs of their loved ones when their own physical and emotional needs are met.[403] When caregivers' physical and mental health needs are met, they become less likely to experience mental health challenges or develop substance use disorders. Importantly, they also become less likely to engage in elder or child abuse or neglect.[404] Addressing the tremendous physical, emotional, and economic challenges that parents and primary caregivers experience therefore can reduce the risk, harm, and transmission of trauma and mental health challenges across generations.[405]

## OPPORTUNITY SPOTLIGHT: Two-Generation, Family-Centered Services for Parents and Caregivers

Two-generation, family-centered services in the home aim to address the needs of parents or caregivers and their children simultaneously. Decades of evidence demonstrates that home visits by a nurse, early childhood educator, or other trained provider during pregnancy and in the first few years of a child's life significantly improve outcomes for children and families alike. Generally, this approach delivers in-home services that teach parenting skills, strengthen adult–child attachment, and improve bonding.[406]

The Parents as Teachers Evidence-Based Home Visiting Model offers an example of a comprehensive home-visiting education approach. Community-based "parent educators" deliver services and supports to families with children from the prenatal period through kindergarten. Parent educators support parent-child interaction, development-centered parenting, and family wellbeing. Outcomes include increased parent knowledge of early childhood development, stronger parenting skills, earlier detection of developmental delays and health challenges, reduced child abuse and neglect, and enhanced school readiness and success.

An additional nationally recognized home-visiting program, the Nurse Family Partnership (NFP), involves regular visits from trained nurses who support first-time parents and their families beginning in pregnancy and extending through a child's second birthday.[407] While most home visiting programs do not rely on clinically trained professionals, NFP utilizes trained nurses to provide in-home services.[8] As a result,caregivers and children who receive in-home services demonstrate improved emotional regulation, lower levels of stress, reduced family conflict, and stronger social bonding, all of which protect against long-term mental health risk.[409]

Children who benefit from these programs grow up less likely to maltreat their own children, engage in intimate partner violence, commit crimes, or develop substance use disorders.[410]

As we consider well-being across the lifespan, adapting home visiting programs to support long-term caregivers, including those caring for people with disabilities or older adults, could improve the wellbeing of caregivers and those they care for, prevent the escalation of needs, and promote wellbeing for generations now and in the future.[413]

## Supports for Providers and Educators

Settings outside the home, such as child-care centers and schools, are foundational for a child's health and development. Teachers, child-care providers, and facility staff play an important role in supporting a child's mental health and development, identifying potential problems, and linking children to care.[414] A child-care provider or teacher's ability to distinguish between what is typical, age-appropriate behavior and what indicates a potential mental health need or developmental delay can make an important difference in initiating early intervention, which is critical for optimal long-term outcomes and cost savings.[415] With the right information and tools, teachers and child-care providers can help to prevent or mitigate challenging behaviors through developmentally appropriate supports and trauma-informed approaches.[416] Programs that use mental health specialists to support providers and educators, such as Early Childhood Mental Health Consultation programs, can improve the care and outcomes for young children.[417]

## OPPORTUNITY SPOTLIGHT: Early Childhood Mental ealth Consultation

Early Childhood Mental Health Consultation (ECMHC) is an evidence-based approach that helps parents, teachers, and child-care providers better support the social and emotional needs of young children.[418] In this model, mental health professionals trained in early childhood development are paired with adults who care for infants and young children in a variety of settings, such as child-care centers, preschools, and the home.[419] Children who benefit from these services experience improved social skills and emotional regulation, healthier relationships, and reductions in challenging behaviors and school expulsions.[420] Staff and providers receiving ECMHC support report improved sensitivity and understanding of children's emotional needs and feel more confident and capable in supporting those needs.[421] The program also reduces staff turnover and enhances a culture of wellbeing in early childhood settings.[422]

California has recently made steps to expand statewide use of infant and early childhood mental health (IECMH) programs. For example, Assembly Bill 2698 (Rubio, 2018)[423] allows subsidized early child-care and education programs to use State funds for staffing and other costs associated with consultation services.[424] Additionally, the 2021–2022 State budget included a $10 million investment in ECMHC over two years.[425] This investment represents an opportunity to apply mental health consultation in more early childhood

## Caregiving to Support Aging in Place

Supporting caregiving for adults, like caregiving for children, is essential for family and community wellbeing. At some point, most Californians will rely on another person for assistance or long-term care as they age. Allowing people to be cared for in their home and/or community of choice promotes optimal health and a higher quality of life. People aging at home also are less likely to experience loneliness and social isolation, and therefore are at lower risk of depression and other mental health challenges that can occur with older age.

According to the California Master Plan for Aging report, paid caregiving, whether from a family member or professional, is essential to older adults' ability to choose where to live. Caregivers provide direct care in many settings – in homes, through community-based services like adult day centers, or in residential care homes, such as assisted living facilities or nursing homes.

## OPPORTUNITY SPOTLIGHT: All-Inclusive Care for the Elderly

The Program for All–Inclusive Care for the Elderly (PACE) is a federally and state funded program that works to maintain independent living for eligible seniors who would otherwise need to be in long term care. To do so, PACE coordinates and provides home visits and transportation to adult day health care centers where participants can receive all-inclusive medical care, rehabilitative therapies, and social services. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment. Throughout California, PACE programs serve over 17,000 participants in 22 counties. According to the California PACE Association (CalPACE), PACE costs up to 40% less than placement in skilled nursing facilities, saving California more than $130 million in 2021 alone. Expanding PACE models to reach more Californians could enhance the State's capacity to support the needs of its growing older adult population.



# RECOMMENDATION TWO

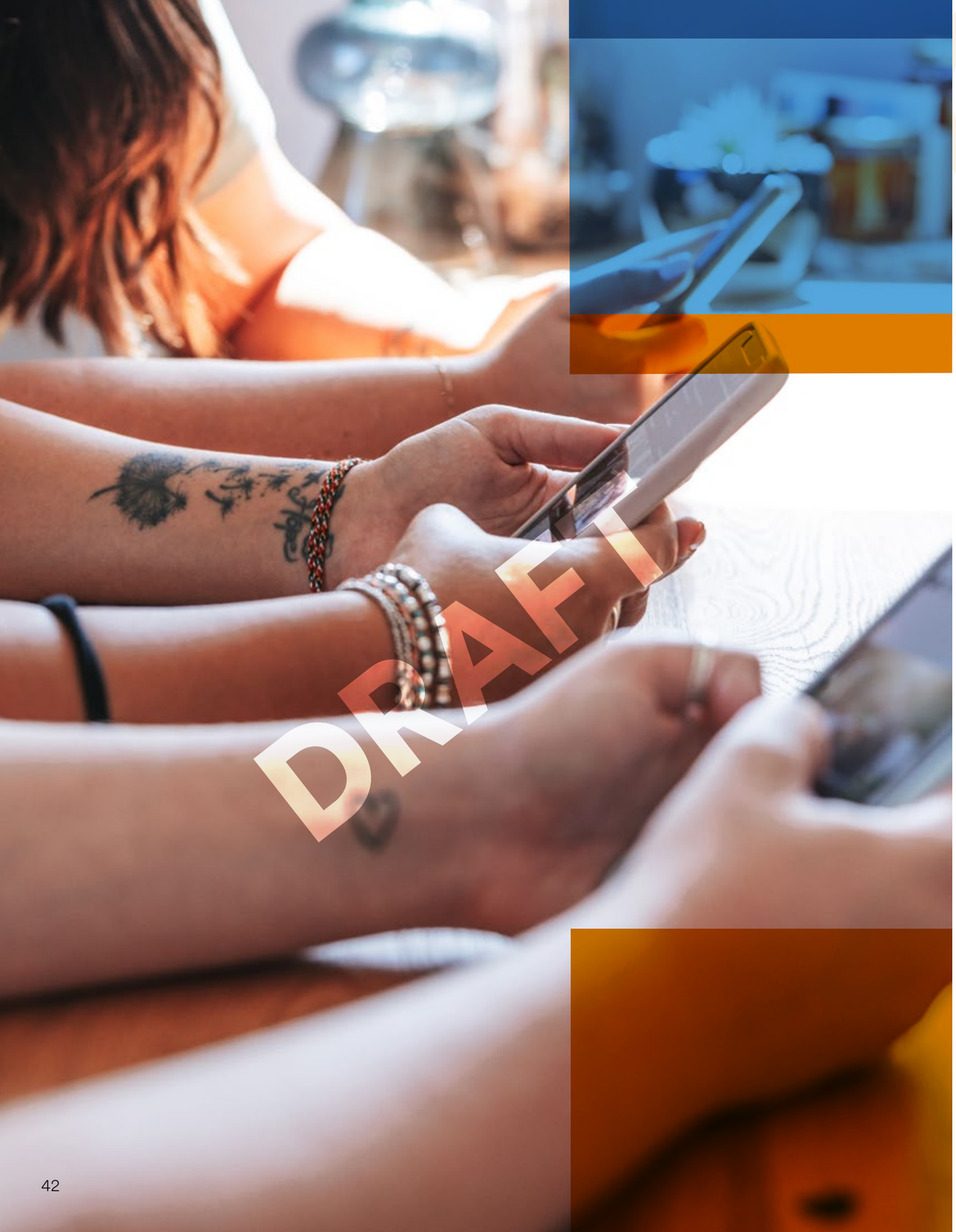
**The State's strategic approach to prevention and early intervention must address risk factors – with particular attention on trauma – and enhance resiliency, by addressing basic needs and bolstering the role of environments, cultures, and caregivers in promoting and protecting mental health and wellbeing across the lifespan for individuals, families, and society at large. Efforts to achieve this goal should include the following:**

**2A.** Consistent with the establishment of wellbeing goals called for in Recommendation 1, assess gaps in existing investments, identify metrics, and document progress in achieving universal basic needs.

**2B.** Support understanding and application of strategies for creating community environments that promote healthy lifestyles, civic participation, and foster a sense of belonging and connection to one's culture.

**2C.** Attention on risk and resiliency should focus on enhancing understanding and response to the mental health impact of natural disasters, extreme climate conditions, pandemics, firearm violence, and other shared community-level traumas.

**2D.** Fortify understanding and response to the needs of California's most vulnerable residents, including the very young, older adults, and others who may need the support of caregivers. Those efforts should ensure that the caregiver economy is robust and inclusive of parents, family-members, and other non-traditional caregivers, and supports a workforce that reflects the people being served.







# FINDING THREE

**Strategies to increase public awareness and knowledge of mental health often are small and sporadic, while harmful misconceptions surrounding mental health challenges persist. Mass media and social media reinforce these misconceptions.**

The World Health Organization defines health promotion as "the process of enabling people to increase control over, and to improve, their health.[427] Enhancing people's basic knowledge and awareness of health is central to this process.[428] Health awareness not only promotes healthy decisions and behaviors among individuals, but also promotes the health of a whole population, as awareness spreads across families, communities, and systems.[429] Public health partners have made significant investments in information and education campaigns to prevent or mitigate many leading threats to physical health, from tobacco use to an unhealthy diet.[430] Yet comparable investments have yet to be made in the mental health arena.[431] Limited understanding and awareness of what constitutes mental health and what is meant by mental illness contribute to stigma, misperceptions, and discrimination.[432] Lack of awareness impedes access to care, and drives negative outcomes that disproportionately impact those in underserved communities.[433]

## BARRIERS TO MENTAL HEALTH AWARENESS

Mental health awareness refers to a person's knowledge and perceptions of what mental health is, why it matters, how mental health challenges are prevented, and when and where individuals can receive support.[434] As with knowledge about physical health, mental health awareness can be strengthened. Doing so can help people manage their own mental health needs and reduce the need for clinical intervention.[435] Improving mental health can be as simple as engaging in healthy behaviors to manage stress, strengthening social connections, and seeking support from those with similar experiences.[436] People also can seek out information to help them understand and manage new and emerging mental health challenges, whether their own of those of another person, including how to navigate complex systems of care.[437]

Improving public awareness is fundamental to mental health promotion. Stigma and lack of knowledge remain significant barriers to improving the mental health of Californians. These challenges are discussed below, followed by promising solutions to enhance statewide mental health awareness.

### Stigma

Negative perceptions and beliefs – or stigma – surrounding mental health challenges can prevent or delay accessing support. Vice Admiral Jerome M. Adams, MD, MPH, who served as U.S. Surgeon General from 2017-2021, is among the many experts who regard stigma as a leading obstacle to acknowledging and supporting the mental health needs of Americans.[438]

"I advocate daily to eradicate stigma, whether related to a physical or mental health condition, substance misuse, socioeconomic status or other causes," Dr. Adams said in his 2020 commentary on mental health promotion, "I encourage everyone to do the same. Stigma keeps people in the shadows. It keeps people from getting help. But by opening up and sharing our stories, and by seeking support when we need it, we can shatter stigma and all that it represents. The single most important thing we can do to promote mental health, is to talk openly and often about it, and encourage those with mental health symptoms to seek care!" [439]

Fear, denial, and shame affect not just those who experience mental health challenges. Too often they also shape the attitudes of health care providers, teachers, employers, and others.[440] Stigma can delay or prevent the early identification of mental health needs. [441] It also can impede appropriate management of mental health crises, resulting in delayed care, increased fear, and excessive use of force or restraint.[442]

Mental health stigma is a primary concern among many California communities. In a 2015 survey of more than 1,000 California adults with a probable mental health challenge, 81 percent of those surveyed said they believed people with mental health needs are likely to experience prejudice and discrimination, and two-thirds said they felt the need to hide their mental health challenges from peers and family members.[443]

*"Mental health is something that everyone has as an inner and interpersonal experience with. The stigma that 'mental illness' is a negative thing and something to be ashamed about is a consistent barrier and obstacle."*
*– Participant during the Commission's February 22, 2021, public engagement event with Bay Area residents*

Stigma arose frequently during project public events. As one participant from the Bay Area stated during the Commission's February 22, 2021, event, "the stigma that 'mental illness' is a negative thing and something to be ashamed about is a consistent barrier and obstacle." Stigma and discrimination directed against those with mental health challenges in the workplace surfaced as a top concern among the almost 300 employee and employer representatives who participated in the Commission's May 27, 2020, event to support its Workplace Mental Health intiative.[444] Especially harmful are implicit biases that manifest in hiring practices, paid leave decisions, or job protection policies.[445]

Stigma-related barriers disproportionally impact certain communities in California. In the 2013-14 California Health Interview survey conducted by the UCLA Center for Health Policy Research, Latinx and Asian American adults reported more negative beliefs about mental health challenges compared with non-Hispanic white adults.[446] At the same time, they were less likely to have received mental health services during the previous year.[447]

Members of diverse communities reinforced the harm of stigma during the Commission's 2020 public engagement events.[448] Participants described how fear of experiencing discrimination based on their mental health challenges, amplified by the discrimination they already experienced because of their race or identity, deterred them from seeking mental health support. The issue is particularly acute in communities with a strong mistrust of health care systems or whose cultures, languages, or health practices contrast with Western models of mental health care.[449]

## Information and Education

Limited mental health information and education[450] prevent many Californians from supporting their own mental health needs or the needs of someone for whom they care.[451] Misconceptions and lack of knowledge regarding early signs and symptoms of a new or worsening mental health challenge are especially problematic, contributing to unnecessary delays in accessing care and increased risks of negative and sometimes dangerous outcomes.[452] For example, exaggerated depictions of mental illness in the media may lead people to overlook subtle changes in mood, behavior, or sleep patterns that can signal a potentially serious problem.[453]

*"When I had my 'break,' I knew that there was something going on, [...] but had no idea what mental health was. And the only concept I had of mental illness was how it was portrayed in the media. I had no idea how to connect the dots until it was too late. [...] Had I known where to go, it would have saved years of my life."*
– *Participant during the Commission's March 3, 2021, public engagement event with residents from Los Angeles*

Media also skews perceptions related to mental health and age. For example, a common myth suggests mental health challenges do not occur in youth, however, evidence proves otherwise. Symptoms of anxiety can emerge as early as age 6, behavior disorders by age 11, mood disorders by age 13, and substance use disorders by age 15. Other mental health challenges such as personality disorders and psychosis also can emerge during youth through early adulthood. Like youth, public awareness of mental health challenges among older adults also is lacking. Contrary to common beliefs, mental health challenges can and do emerge after the age of 65, even if a person has had no prior mental health diagnosis. Yet despite such evidence, mental health challenges among youth and older adults are frequently under-identified by health-care professionals, family members, and peers who are ill-informed, and the stigma surrounding these conditions makes people reluctant to seek help.

Culture, like age, also plays a key role in mental health awareness. The way symptoms are labeled, interpreted, and even experienced can vary significantly among different cultures, sometimes in ways that don't align with clinical diagnostic norms. Likewise, the degree of cultural and linguistic competency among providers themselves impacts the effectiveness of services they provide to diverse communities.

Community members participating in the Commission's public engagement events described how the absence of culturally and linguistically responsive mental health information and resources disproportionately impacts many Californians. For example, members of certain immigrant populations and LGBTQ+ individuals often lack knowledge about available services, how to access them, and what rights they have regarding nondiscriminatory care.[459] They also may be less able to identify and communicate their mental health needs, especially if they are non-English speakers or hold misperceptions of mental illness.[460] One participant from Californian's Central Region talked about the refugee experience during a Commission public engagement event. "Refugees ... escaping war ... may not have the language or the tools or the resources to understand the ways in which their behaviors are related to post-traumatic stress disorder," the participant said. "Normalizing those conversations, giving them the resources, is key."



# BEST PRACTICES AND PROMISING SOLUTIONS

Improving mental health knowledge and awareness requires multifaceted approaches. Providing the right information and resources can empower Californians to play a more active role in supporting their own mental health and that of others in their care.[462] Key opportunities to improve mental health awareness include broad dissemination of public information[463] and resources, alongside mental health training[464] and education.[465] Such strategies should include improving knowledge of mental health disparities and the structures and systems that reinforce such disparities.[466]

Mental health awareness initiatives also help to reduce stigma, normalize help-seeking behavior, and provide tools for managing emotional health.[467] Done effectively, these approaches can empower people to make healthy decisions and take positive actions to promote their mental wellbeing. Such decisions may include deciding to seek out professional help when it is needed. Positive actions may include successfully navigating service systems.[468] Enhancing public awareness also informs policy decisions[469] that impact the mental health of people in communities and in organizations.[470]

Regardless of the intended audience, strategies to improve awareness are most effective when they are developmentally, culturally, and linguistically responsive and when they are informed by people with similar backgrounds or experiences.[471]

*"What seems to be needed is a lot more education for the public so that we can learn how to spot mental health needs and how to handle those needs. Our communities need more mental health awareness"*
– *Participant during the Commission's April 5, 2021, public engagement event*

## Enhancing Public Awareness

Broad public awareness strategies are common in public health promotion and should be used on a similar scale to promote mental health awareness.[472] Large-scale public campaigns,[473] community outreach,[474] and technology-based resources[475] are effective tools for disseminating facts, changing perceptions, and giving people the tools they need to be healthy. The COVID-19 pandemic provides a recent example of the critical role that public information plays in empowering people to safeguard their health.[476] Multiple mediums were used to disseminate and reinforce information about vaccination and other protective measures, and to combat misinformation.[477]

Public health awareness strategies are most effective when they are designed for diverse audiences across age groups, cultures, languages, and geographic areas.[478] They also must adapt over time to incorporate emerging media technology and changes in social norms.[479]

## Public Campaigns

Public health campaigns can have a significant impact on health knowledge and perceptions.[480] Successful previous campaigns have helped to combat stigma and raise awareness of AIDs,[481] promote breast self-exams and mammograms, and encourage tobacco cessation. Such campaigns provide a template for reaching both the general population as well as specific communities.

For example, the National Institute of Child Health and Human Development (NICHD) in 1994 launched the Back to Sleep campaign, later renamed Safe to Sleep.[482] The campaign sought to reduce deaths from Sudden Infant Death Syndrome (SIDS) by encouraging parents and caregivers to put infants to sleep on their backs.[483] It followed research in the late 1980s and early 1990s that linked SIDS with stomach sleeping.[484] Nationwide public awareness campaigns ranged from public service announcements to partnerships with large companies to include messaging on infant-related product packaging.[485] Respected public figures, including then- second lady Tipper Gore, helped to raise the campaign's visibility.[486] Experts credit the effort with preventing thousands of infant deaths,[487] even as work continues to reach the highest-risk infants with adapted messaging and updated science.[488]

Public information campaigns also can promote mental health. A 2019 study by the RAND Corporation demonstrated the potential of comprehensive social marketing strategies to enhance mental health awareness and services use.[489] In the study, California residents with a probable mental health challenge were assessed following exposure to a statewide stigma reduction campaign.[490] The researchers found that people exposed to the campaign reported feeling less stigma and making greater use of mental health services compared to those who were not exposed.[491] The researchers also found that people were more likely to access mental health services if they believed that recovery was possible and felt capable of interpreting symptoms.[492] Despite such potential, however, mental health campaigns often are short-lived and may fail to reach diverse audiences.[493]

Community members participating in Commission public engagement events repeatedly emphasized the need to improve mental health awareness to equip people and providers with information to identify the early signs of mental health challenges.

### OPPORTUNITY SPOTLIGHT: Mental Health Awareness Saves Lives

A lack of awareness of warning signs and symptoms and the importance of early intervention is causing unnecessary, and sometimes dangerous, delays in the detection and care of mental health challenges. Fear, stigma, and misperceptions among peers, family members and providers further increase the likelihood that critical early signs will be overlooked or unaddressed. The consequences of such oversight can be dire, even fatal, as a person living with an unaddressed mental health challenge is expected to die 10 to 20 years sooner than the general population. Increased risk of suicide is one factor.

Young people and older adults are uniquely impacted by this risk, as mental health challenges are more likely to go undetected among these age groups. According to a 2019 public health survey, nearly one in five U.S. high school students has seriously considered suicide, and nearly one in 10 has made a suicide attempt. Indeed, suicide is the second-leading cause of death among people between the ages of 10 and 24.

While suicide attempts are more frequent among youth, the rate of deaths by suicide increases starting at the age of 60, Californians over the age of 85 have the highest rate of death by suicide than any other age group, in some cases quadrupling the national suicide rate.

Public awareness strategies focused on early signs and symptoms of mental health challenges across the life span have the potential to save lives. Such strategies arm people with the information they need to quickly and accurately identify and act on their own mental health needs or those of someone they know or for whom they care. In fact, recognizing subtle changes in behavior or functioning can prevent a mental health relapse or crisis from occurring, or prevent their negative consequences.

Needed are investments in strategies to enhance public knowledge of when, how, and why mental health challenges emerge during a person's lifetime. Such knowledge can enhance early detection and access to life-saving intervention for people experiencing mental health challenges.[504]



## Community Outreach

Because mental health information and supports are sometimes best received from trusted community sources,[505] outreach and engagement strategies are key mechanisms for enhancing public awareness and combatting stigma.[506] Participants in the Commission's public engagement events frequently praised local community-based organizations working in their neighborhoods for delivering culturally and linguistically responsive mental health information. Through a Khmer translator, one participant expressed her gratitude for workshops offered in Khmer by a community-based organization in Orange County. The woman said she was able to take the information she learned at the workshops back to others in her community. During a Commission-facilitated virtual Immigrant and Refugee Listening Session on October 21, 2021, other participants reinforced the value of culturally responsive community resources. Promotores de Salud, for example, has gained national recognition for its ability to bridge cultural and linguistic gaps in mental health information, stigma, and service navigation.[507] In this program, community health workers serve as cultural brokers, offering translation, service navigation assistance, and advocacy for underrepresented populations in health care settings.[508]

### OPPORTUNITY SPOTLIGHT: Community-Based Mental Health Awareness

Communities are critical conduits for sharing information and influencing perceptions and health behavior. Youth-based community programs can be effective not only at enhancing youth mental health awareness but also at shifting social norms, since youth are often the vehicle of innovation and change. For example, the Napa County's CLARO/A Prevention Program works with Latinx youth to address cultural barriers and stigma. The program seeks to help youth understand their mental health needs and know when and how to ask for help. When needed, it also connects participants to mental health services and sources of support through friends, family, school, and community.

## Online Strategies

The internet has become a critical conduit of mental health resources for many people, especially those from underserved and isolated communities. It was a lifeline for many Californians during the COVID-19 pandemic.[510] With the click of a button, people today can access more mental health information than at any other time in history.[511]

Yet despite the potential to enhance mental health promotion in the digital era, people cannot always trust the information they consume online.[512] Some websites post inaccurate or biased information, while others are not up to date, leaving consumers lost or discouraged.[513]

As people and communities become more reliant on remote and web-based platforms to support their mental health and wellbeing, addressing disparities in technology access becomes more urgent. Public investments in high-speed internet and digital devices can address access barriers but must be supplemented with efforts to improve digital literacy, especially in non-English speaking and underserved communities.

The opportunities for internet technology in the mental health space are virtually endless,[514] as is the potential for harm caused by its misuse.[515] Effectively harnessing the power of online platforms to promote mental health will require investments and oversight to ensure information and resources are credible, affordable, and accessible to every Californian while protecting confidential health information.[516]

## OPPORTUNITY SPOTLIGHT: Online Self-Help

Within the last several years, California has expanded online self-help tools at the local and statewide levels. For example, Live Well Madera County launched CredibleMind in 2020 to promote population-based mental health with trustworthy and easily accessible resources, information, and self-assessments.[517] Together for Wellness, another recent website, was created by public and private partners across the state. It offers a wealth of digital resources to support mental health.[518] Investments to expand these or similar models could help shift Californian's understanding and perceptions of mental health and give people the tools they need to support their wellbeing.

Another example is the California Department of Health Care Services' CalHOPE initiative, an online information and resource hub funded by the Federal Emergency management Agency to support mental health needs during or following a crisis. Among its many features, CalHOPE provides no-cost information, video tools, exercises, and trainings to reduce stigma around mental health challenges, build supportive environments, and expand the skills of youth and adults to identify and cope with their mental health needs or support others in need of help. Direct and immediate access to culturally and linguistically appropriate emotional and/or crisis support also is available through a variety of remote, digital, and video-based platforms. What largely began as a response to the mental health impact of the COVID-19 crisis, CalHOPE serves as a model of mental health promotion in the digital era.

# Delivering Mental Health Training and Education

Settings such as schools, child-care facilities, workplaces, and law enforcement agencies, as well as primary care and emergency medical departments, are important gateways for identifying and supporting mental health needs in a community.[519] The staff employed in these settings must be well informed.[520] Throughout the Commission's public engagement events, community members and subject matter experts alike emphasized the need for increased mental health training and education for staff in non-mental health settings. Such training can help to reduce systemic and institutional biases and stigma surrounding mental health challenges. Training and education can also equip providers and peers with the information they need to recognize and support the mental health needs of the people they serve.[521]

## Mental Health Training in the Workplace

The potential of workplaces to promote mental health cannot be overstated, as the majority of Californians over the age of 16 spend at least part of their day at work.[522] The values, learning, and practices adopted by an organization impact not only employees, but become infused into their outside lives, families, and communities. Research has shown that employees' health and productivity improve when organizations promote open communication,[523] encourage healthy behaviors such as work breaks and physical activity,[524] and provide opportunities for employees to participate in decisions impacting their workload and schedule. At the same time, unsupportive or unsafe work environments, including workplaces that tolerate or foster toxic power dynamics, bullying and harassment, or excessive workloads, can threaten employee wellbeing.[525] Stigma and discrimination directed at an employee's mental health challenges also can cause significant harm both to individuals and the organization.

During the Commission's April 22, 2021, public engagement event, speakers discussed opportunities for employees to learn how to identify colleagues at risk and help them access services. Community partners attending other Commission engagement events highlighted the need for training to reduce stigma and increase mental health awareness and best practices in the workplace.

Community voices complement research demonstrating the effectiveness of training to improve mental health knowledge and attitudes in the workplace.[527] Evidence-based strategies include providing mental health literacy training to staff and leadership, incorporating[528] mental health education in staff induction and professional development activities, and offering access to mental health information and resources to reinforce training content.[529] Training can be universal or designed with specific professions or populations in mind.[530] Like all other strategies to enhance mental health awareness, training is most effective when it addresses nuances in mental health perceptions and experiences related to age, culture, and language.[531]

*"Mental health is a collective responsibility. It's not just the responsibility of individuals to do things around self-care. It's definitely not a matter of just a health care system. It's about where people live, how they interact with one another, and it's very much about the workplace experience."*
*– Paula Allen, Global Leader and SVP, Research and Total Wellbeing, presenting during the Commission's April 22, 2021 hearing on prevention and early intervention*

## OPPORTUNITY SPOTLIGHT: Employee Mental Health Awareness Training

Private and public agencies increasingly recognize the value of mental health training for their employees.[532] Such training can improve the quality of products and services an agency offers its customers. At the same time, it can promote staff wellbeing and productivity.[533]

Kaiser Permanente, for example, has developed a free online Mental Health Awareness training program designed for people in the workplace.[534] The program helps employees and organizations understand the impact of mental health and wellness, recognize common mental health challenges, and support practices that promote emotional wellbeing. It also gives employees tools to talk more openly about mental health.[535]

## Mental Health Education in Schools

School is a setting in which children, adolescents, and young adults spend a large part of their time, and thus plays a central role in promoting mental health awareness.[536] When given the proper funding and resources, schools not only aid in early screening, detection, and linkage to services, but can also provide mental health education.[537]

Community partners emphasized the importance of education-focused strategies during Commission public engagement events. A participant in a February 22, 2021, virtual listening session with residents from the Bay Area, for example, urged the State to better "incorporat[e] mental health topics into school curriculums to stop cycles of stigma, shame, and failure."

Just as learning curriculums increase academic literacy, education also is a tool to foster mental health "literacy."[538] Mental health literacy encompasses five key components: understanding of how to obtain and maintain positive mental health, knowledge and recognition of mental health challenges, reducing stigma, promoting help-seeking efficacy, and improving attitudes about seeking mental health support.[539]

### MENTAL HEALTH LITERACY

**Mental health literacy encompasses five key components:**[540]

1. *Understanding of how to obtain and maintain positive mental health*
2. *Knowledge and recognition of mental health challenges*
3. *Attitudes and stigma related to mental health challenges*
4. *Ability to seek help and navigate systems of care effectively*
5. *Attitudes about seeking mental health support.*

*Literacy in these areas may vary depending on a person's age, culture, and other factors.*



Mental health education in schools shows promise for improving mental health literacy. Examples include the incorporation of age-appropriate mental health curricula for students in primary,[541] secondary,[542] and higher education settings,[543] including licensure certification and other programs for health care practitioners.[544] School-based programs also can promote mental health literacy among educators and school staff.[545]

School-based approaches that are developed and led by youth themselves are especially effective.[546] Examples include peer-led outreach and curricula in classes,[547] mentorship for between-grades support, youth wellness centers and zones, and student voice committees.[548] In addition, students benefit from access to information and resources that affirm their cultures, languages, and identities.[549]

## OPPORTUNITY SPOTLIGHT: Mental Health in the Classroom

**California is exploring opportunities to increase mental health education in the classroom. One such opportunity is outlined in Senate Bill 224 (Portantino, 2021).[550] This bill will require middle and high schools that provide health classes to also provide mental health education.[551] Another newly approved bill, Senate Bill 14 (Portantino, 2021), directs the Department of Education to identify a mental health training program for school staff and students in grades 7 through 12.[552] Such programs could be expanded to enhance mental health literacy throughout California.[553]**

# RECOMMENDATION THREE

**The State's strategic approach to prevention and early intervention must promote mental health awareness and combat stigma by ensuring all people have access to information and resources necessary to understand and support their own or another person's mental health needs. The State's approach should:**

**3A.** Expand upon the State's investment in CalHope and the digital portal strategy under its Child and Youth Behavioral Health Initiative to promote broad dissemination of information related to mental health and wellbeing across the lifespan.

**3B.** In addition to broad awareness, the State should invest in strategies to reinforce stigma reduction and mental health awareness in key settings where people learn, work, and receive services. Those strategies should include training and education in the workplace, schools, public safety, health care, and other high value settings and industries.

**3C.** Consistent with the State's broader equity goal described in Recommendation 1.b., the State's mental health awareness initiatives should address disparities through two priorities: promote awareness of how disparities are created and share information that results in reduction of disparities.

## MENTAL HEALTH FACT OR FICTION?

Despite improvements in mental health awareness, false beliefs persist. Discerning mental health "facts" from "fiction" can helppeople get the support they need.

***Fiction:*** *Mental health challenges are rare.*
***Fact:*** 1 in 2 people in the U.S. will experience at least one mental health challenge in their lifetime; 1 in 5 in the past year.

***Fiction:*** Young people do not experience mental health challenges.
***Fact:*** 50% of mental health challenges in the U.S. begin by age 14; 75% by age 24.

***Fiction:*** Mental health challenges don't affect older people.
***Fact:*** 6.6% of all disability among people over the age of 60 worldwide are attributed to mental health and neuroglial challenges.

***Fiction:*** There is no hope for people with mental health challenges.
***Fact:*** With the right tools and support, people with mental health challenges are able to live, work, learn, and participate fully in their communities.







# FINDING FOUR

**Strategies that increase early identification and effective care for people with mental health challenges can enhance outcomes. Yet few Californians benefit from such strategies. Too often, the result is suicide, homelessness, incarceration, or other preventable crises.**

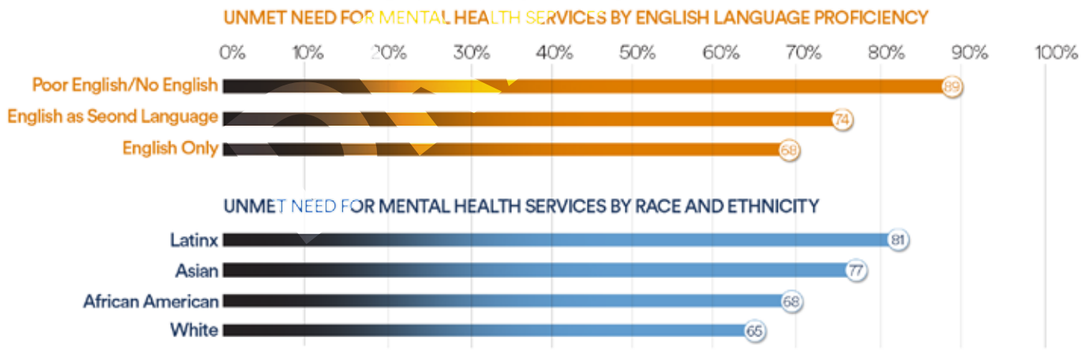
Mental health challenges are common, affecting nearly one in two U.S. adults and one in six youth each year.[554] In California, recent estimates suggest that more than 80 percent of people aged 18 and older report some type of disruption to their mental health.[555] Survey data indicate that the prevalence of mental health challenges among California adults has increased by at least 41 percent since 2014.[556] During 2018 and 2019, one in five adults and nearly one in two adolescents in California reported at least one significant disruption in their mental health.[557]

People with mental health challenges can live full and meaningful lives when they receive appropriate care and support.[558] In almost all cases, the earlier a person's mental health needs are identified and supported the better the outcome.[559] Yet California's systems of care are limited in their capacity to deliver high quality, coordinated, and timely services that accommodate the diverse needs of Californians.[560] Together, the consequences of unmet mental health needs are costly not only for individuals but for the families, communities, and the systems that support these individuals.[561]

## CHALLENGES TO STATEWIDE EARLY INTERVENTION

Early intervention refers to mental health services and supports provided early to promote recovery and prevent mental health challenges from becoming severe and debilitating.[562] Early intervention includes services and supports for both newly emerging and reoccurring mental health challenges.[563]

Findings from a 2018 California Health Interview Survey (CHIS) showed that almost half – 44 percent – of the 1.4 million adults who reported experiencing severe mental health challenges said that they had received no mental health services in the previous year.[564] Among the 2 million who reported moderate challenges, almost 70 percent reported receiving no services in the previous year.[565]




Without appropriate support, mental health challenges can worsen over time, often requiring more intensive and costly forms of care that may be less effective as symptoms progress.[566] The longer a person goes without mental health support, the more likely that individual is to experience challenges in other areas of life such as education, employment, family relationships, and housing. Criminal justice involvement and suicide risk also increase.[567]

Despite the promise of early intervention, programs and services to address early signs of psychosis and mood disorders are largely unavailable to most Californians. Even when services are available, those who need them confront unnecessary delays. Hurdles include lack of access to mental health screening,[568] narrow eligibility criteria,[539] and inadequate crisis responses. Overly complex, disconnected, and under-resourced service delivery systems create further barriers. Too often the obstacles are insurmountable, forcing Californians to face substantial delays in receiving services as their needs worsen.[570] These challenges are discussed below, followed by promising solutions to advance statewide early intervention in mental health.

# Delays in Care

In both physical and mental health care, early and accurate identification of needs and timely connections to the appropriate level and type of care are critical to achieve the best possible outcomes. This is true for both newly emerging and existing mental health needs. An overall lack of screening and rigid eligibility policies that limit access to services cause many people to experience unnecessarily delays in receiving much-needed care.

## Inconsistent Mental Health Screening

Mental health needs can occur at any age, yet there are critical periods during a person's lifetime when mental health challenges are more likely to emerge. Youth and early adulthood is, for example, one period when half to three-fourths of people report experiencing their first mental health symptoms.

A person's mental health needs also increase during or after experiencing significant life events such as losing a loved one, divorce, trauma, injury, or becoming a parent. At least one third of people experience mental health challenges during or following the birth of a child. Mental health needs also change as people get older. Coinciding health challenges, loss of autonomy, loss of peers, and increased isolation are just some of the conditions that can cause or exacerbate mental health challenges. In the U.S., as many as 20 percent of people over the age of 55 experience at least one mental health challenge, depression is the most prevalent.

Unfortunately, a lack of routine mental health screening is causing delays in detection and support for many people. According to a 2019 report by the California State Auditor, millions of eligible children fail to receive preventive mental health screenings despite federal guidelines.

*"I have a child with autism. When he was 18 months old, I took him in for his well-child appointment. He had a pediatrician who was trained to recognize the signs of autism. And she was on top of it. I didn't even notice it in my own child. Since she had the training, we were able to identify my son's needs early and have additional assessments done. It put us on a whole different track. It is my understanding that this isn't typically the experience of many parents of kids expressing mental health needs. There aren't always early screenings and follow-up assessments."* - *Brenda Grealish, Executive Officer, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation and parent of a 14 year old boy with autism, speaking at an April 5, 2021, Commission public engagement event.*

For adults, routine mental health screening guidelines and practices are nearly nonexistent. Also, screenings that are administered are not always interpreted or responded to correctly, or may not be linguistically, culturally, or age appropriate.

Community members who participated in Commission public engagement events highlighted the lack of linguistically and culturally responsive screening approaches. One Native American participant whose mother died by suicide described the harm that results when providers lack awareness of cultural nuances in perceptions of mental health. "We come into the doctor's office with somatic feelings, instead of knowing these words of 'depression' or 'anxiety,'" the participant said at a December 2020 event. "When (my mother) talked about (her suffering), it was in her body."

## Service Eligibility

People may get worse before they get mental health care due to strict eligibility and reimbursement policies. During the Commission's public engagement events, community partners from all regions of the state expressed frustration with insurance restrictions that prevent access to early intervention services. One participant at a March 1, 2021, engagement event with residents from Southern California put it this way: "A lot of times I hear from folks that they aren't 'bad enough' to receive services, and that they've been told that they don't qualify for services so many times."

In California most health plans will cover health care services, including preventive screenings, only if such services are deemed "medically necessary." This designation often excludes people at risk for developing a mental health challenge, as well as those who have mild or moderate mental health needs that do not meet the criteria for diagnosis of a mental disorder. For example, someone may experience frequent feelings of hopelessness and helplessness, but these symptoms alone do not meet the criteria for a diagnosis of major depressive disorder. As a result, many people who could benefit from early intervention are forced to forgo services until their mental health challenges become more severe and disabling.

## Crisis Supports

Delays in care greatly impact those who are experiencing a mental health crisis or are at high risk of crisis. The delays can lead to preventable emergency room visits and hospitalizations, as well as poorer outcomes. According to some estimates, up to 70 percent of people seen in emergency rooms for a psychiatric crisis could be appropriately cared for in less intensive settings. In general, emergency staff and settings are ill-equipped to provide appropriate mental health crisis care. One costly consequence can be an overreliance on law enforcement personnel to monitor people in crisis in emergency departments until more appropriate settings can be found.

Californians need consistent access to appropriate, recovery-focused services when experiencing a frightening mental health crisis. Properly addressing such crises will reduce costs, prevent suffering, and save lives.

# Limited Services

Many Californians feel neglected or ignored by the state's current fragmented and complex mental health care systems and find them burdensome to navigate. Californians who have experienced mental health challenges, whether personally or among their families or friends, consistently report that mental health services are unavailable, unaffordable, or inappropriate. The problems are especially acute for members of marginalized communities. ,

## Fragmented Systems

Navigating services can feel like a full-time job for individuals with mental health needs, as well as for their loved ones. Those who lack time or resources must go without support for their mental health challenges. During a March 8, 2021, Commission public engagement event with residents from Central California, the parent of a child with mental health needs voiced a common frustration: "Who do I call when I first uncover some concern? There seems to be a lack of understanding or a lack of knowing, when I'm faced with a particular crisis with my child, who is it that I call to help me navigate what is obviously a very complex system?"

*"As someone who has been working in the field for over a decade and has had to navigate the system for myself [...] I have struggles and challenges just trying to access care. So, for someone who just got discharged and is completely confused about what to do, having someone provide support and help navigate, step by step, is essential."*
*– Participant during the Commission's March 3, 2021, public engagement event with residents from Los Angeles*

A health care system that separates physical and mental health care services creates unnecessary barriers to care. Fragmented services also represent a missed opportunity, as non-mental health care partners play a critical role in identifying and supporting mental health needs. For example, an expert in child development said during one Commission public engagement event that for children, medical providers are the "first points of contact" and "a point of access where [there is] a lot of power to make a difference." When service systems are fragmented, continuity of care is much harder to achieve.

During a February 25, 2021, Commission public engagement event, Dr. Deryk Van Brunt, an associate clinical professor in the UC Berkeley School of Public Health, expressed his frustration with fragmented care. "In the communities I work with around the country, I have been surprised by how rarely public health and behavioral health work together," he said.

Community members who spoke at the Commission's public engagement events also pointed to barriers, including incongruent administrative policies that impede coordination among service systems, an absence of secure tools for sharing health information, and a scarcity of providers in some geographic areas. During an April 5, 2021, engagement event, Dr. Tara Niendam, director of Early Psychosis Programs at the University of California, Davis, highlighted capacity barriers that impede intervention for early psychosis. "Systems aren't ready to support widespread early identification and treatment," Niendam said.

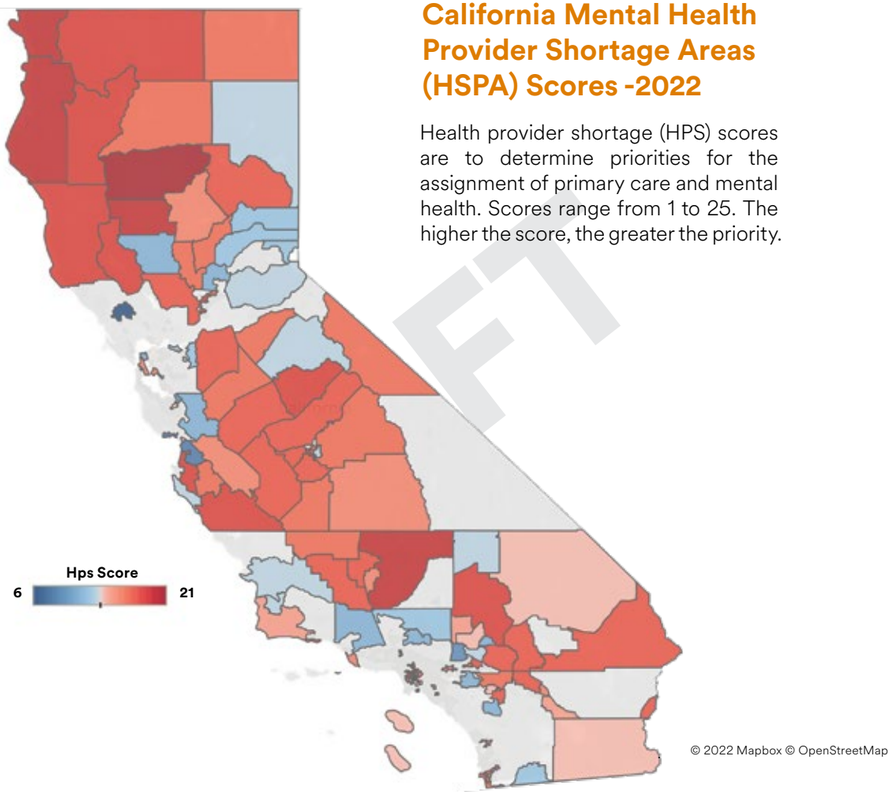
## Access to Providers

The lack of mental health providers is exacerbating systemic barriers to care. A 2018 report by the University of California, San Francisco, predicted a 40% increase in the demand for mental health providers in California. This estimate is modest given the dramatic increase in needs following COVID-19.

The federal agency, Health Resources and Services Administration (HRSA) uses Health Professional Shortage Areas (HPSA) to designate areas and population groups that are experiencing a shortage of health professionals. For mental health, HPSA includes areas where the population to provider ratio exceeds 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community). In California, all but 5 of its 58 counties are at least partially experiencing mental health provider shortages, almost half of these counties (25) are whole shortage areas.

### California Mental Health Provider Shortage Areas (HSPA) Scores -2022

Health provider shortage (HPS) scores are to determine priorities for the assignment of primary care and mental health. Scores range from 1 to 25. The higher the score, the greater the priority.




California's mental health providers are not evenly distributed nor are they equally compensated, resulting in provider ratio disparities across regions. In some cases, providers are simply underutilized due to insurance restrictions. For example, marriage and family therapists currently are not permitted to care for people who rely on Medicare. High caseloads, administrative hurdles, and burnout are becoming more common among mental health providers, especially during the pandemic.

Shortage of specialty providers is a key concern. As it stands, close to one third of counties have zero child and adolescent psychiatrist. Mental health providers specializing in maternal mental health, geriatric mental health, substance abuse, and crisis intervention also are in short supply across the state. Even more scarce are non-English speaking providers and/or providers from diverse racial, ethnic, and socioeconomic backgrounds.



## Social and Cultural Barriers to Care

A lack of cultural and linguistic representation among services and providers poses a further barrier to accessing mental health care, a theme that community members frequently returned to during Commission public engagement events. Research backs up the concerns: More than 75 percent of California's psychologists are white, for example, while people of color make up more than 50 percent of the state's population.

Participants at Commission public engagement events also emphasized the need for services and providers trained to assist the LGBTQ+ community. Others called for greater funding and respect for nontraditional approaches to mental health. Some suggested the use of cultural brokers to help diverse communities navigate the health care system.

"What I'd like to see the State doing, is supporting cultural and community-based mental health and not just the medical Western way of addressing mental health." – Participant at a March 17, 2021, public engagement event

A person"s age can be another social barrier to care. A 2019 UCLA study, for example, identified significant gaps in programs, services, providers, and data focused on the unique mental health needs of adults over age 60. According to the report, a major barrier was a lack of state guidance to build out a system of care to support the complex, overlapping mental and physical health needs of older adults. The COVID-19 pandemic only exacerbated these challenges. Older adults not only faced a greater risk of infection and hospitalization, but also were more likely to experience prolonged isolation and loss of agency as a result of shelter-in-place orders. Such conditions increase mental health risk for any age group, particularly older people.

# BEST PRACTICES AND PROMISING SOLUTIONS

Prevention strategies to address the drivers of mental health risk and promote awareness are essential. Just as important are early intervention strategies to prevent the escalation or reoccurrence of mental health challenges, support recovery, and help people achieve healthy and fulfilling lives. Community members who participated in Commission public engagement events emphasized the urgency of this need, calling on the State to improve both access to and quality of care for people experiencing mental health challenges. Making early intervention services available to all Californians who need them will require bringing to scale strategies that deliver accessible, high-quality services tailored to diverse social and cultural needs.

The need to fortify California's behavioral health care system is reflected its 2021 Youth Behavioral Health Initiative (CYBHI). Catalyzed by a onetime $ 4.4 billion public investment, this 5-year initiative is focused on delivering equitable, appropriate, timely, and accessible services and supports from prevention to treatment to recovery for ALL children with an emerging or existing mental health challenge. Such a commitment will undoubtedly promote a healthier future for California's youth, yet for the State to achieve wellbeing for ALL, such efforts must be paralleled for Californians of all ages to support their behavioral health needs.

## Increase Early Access to Care

Timely access to care can greatly improve outcomes for people experiencing mental health challenges. Universal screening is necessary to enhance early detection and linkage to mental health supports, as are reforms to make care more accessible, including for people at risk or experiencing a crisis.

### Mental Health Screening

Screening is an indispensable health care practice that helps millions of people live longer and healthier lives despite health challenges. Mental health is no exception. Screening relies on validated instruments to identify health risks and conditions. Routine screening, for example, has been used to assess developmental delays in infants and children, detect cancer, and diagnose diabetes and other chronic illnesses. Universal screening also has been instrumental in preventing transmission of infectious diseases such as tuberculosis.

National health leaders, including the American Academy of Pediatrics and the U.S. Preventive Services Task Force, endorse universal mental health screening in the same settings where physical health screenings occur. Mental health screening tools can identify signs and symptoms of depression, anxiety, psychosis, suicide, and impending relapses. Screening also can identify mental health risk factors, and, when used among high-risk or underserved populations, help to reduce mental health disparities. At Commission public engagement events, justice and child welfare agency representatives underscored the need for mental health and substance use disorder screenings in high-risk and high-need settings.

Like other health screenings, mental health screenings should be standardized and follow routine schedules based on age- and situation-specific best practices. Standardized screening should be accompanied by protocols that document how to respond in the event of a positive screen. Mental health screening tools and practices also must be appropriate for use across diverse settings and adapted for unique cultures and languages.

### OPPORTUNITY SPOTLIGHT: Routine Screening Across the Lifespan

The American Academy of Pediatrics recommends that physicians provide behavioral and mental health screening for children from birth through age 21. In addition, the federal government mandates mental health screening for children who receive Medicaid (Medi-Cal in California).

Health care guidelines, however, have yet to endorse mental health screening for adults, particularly those over the age of 65. This represents a missed opportunity for identifying and supporting mental health needs as they interact with the physical, cognitive, and social changes unique to older age.

Enhancing the mental health of California will require expanding mental health screening across the lifespan with practices that are age-specific and routinely administered. Screening must look for mental health risk factors, such as socioeconomic distress and trauma, as well as clinical symptoms. Providers also need better tools and support so that they can act quickly and confidently to address mental health needs identified through screening.

## Risk-Informed Care

Advancing prevention and early intervention requires a shift in the way systems fund and deliver services. Historically, mental health systems have relied on "illness-centered" approaches, where programs and services benefit only people with severe mental health challenges. However, care based on risk, with or without a formal diagnosis, is equally important to prevent unmet mental health needs and the negative consequences that follow.

Care financing models to incentivize quality health care are key strategies for addressing broader non-medical risk factors, such as the social determinants of health, in care delivery systems and promoting health equity. The public health sector has the opportunity to help achieve this.

While some mental health screening can be self-administered, screening by a trained professional may result in a timelier referral or, in the event of a crisis, immediate intervention. Health care settings present ideal opportunities for routine mental health screening.

California's Health and Human Services Agency recently expanded eligibility for behavioral health services, such as child and family therapy, to children who lack a formal mental health diagnosis but have at least one risk factor for developing a mental health challenge. Starting in 2023, through its California Advancing and Innovating Medi-Cal (CalAIM) reforms, the State will require all managed care plans to conduct data-informed risk assessments for enrollees. The risk assessments will guide care management, coordination, and transition plans. Managed care plans also will be required to provide preventive and wellness services for all Medi-Cal enrollees. Similar reforms in the private health care sector would further move California's mental health care system toward risk-informed care and prevention.

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### OPPORTUNITY SPOTLIGHT: Incentives for Risk-Based Services

Historically, providers have not been reimbursed for delivering benefits such as mental health therapy to individuals who do not have a formal mental health diagnosis. Such restrictions represent a lost opportunity, because strategies that address risk beyond traditional diagnostic criteria can improve both the efficacy and cost of services.

Some health care systems are exploring ways to promote risk-informed services. Insurance agencies in some states are beginning to factor in clients' social determinants of health when determining provider reimbursement rates. In these models, providers caring for clients with greater risk receive higher reimbursements. Such risks may include unstable housing, food insecurity, or history of trauma. Other models reward providers when their clients' outcomes exceed expectations based on risk. Such strategies avoid penalizing providers who care for people with complex, non-medical needs. These approaches hold promise for promoting preventive practices that address social and economic risk factors as part of standard health and behavioral health care.

## Crisis Services

Crisis response can include a variety of crisis services, ranging from "warm lines" and crisis hotlines to crisis stabilization support and short-term crisis residential care. Best-practice approaches for systematic crisis response include centralized call centers that use real-time coordination across systems, coordinated mobile crisis outreach and support, and crisis residential and stabilization services. California has a complex web of crisis services, funded through various mechanisms with little standardization or uniformity of care. Most crisis services are tailored to connect people with local resources, but the degree to which help is available, accessible, or affordable varies county by county.

Recent federal legislation has taken a step toward an integrated crisis response system. As of July 16, 2022, the National Suicide Prevention & Mental Health Crisis Lifeline has transitioned to a three-digit dialing code, 988. Providers of 988 services offer confidential emotional support to people in emotional crisis or distress across the United States, 24 hours a day, seven days a week. In California, the 988 system is operated by 13 crisis centers staffed by trained counselors who respond to calls, texts, and chats in keeping with national standards and best practices. The 988 services do not replace 911 services, which are delivered through local emergency medical and public safety systems. In many cases, all that is needed to support someone in a time of emotional crisis is offered through 988 lifeline services.

Transformation of California's crisis response system will take time. California is exploring how to strengthen and expand its crisis response infrastructure and capacity through policy and practice changes. For example, Assembly Bill 988 (Bauer-Kahan, 2021), would connect and expand mobile crisis teams, crisis stabilization services, and crisis counseling. Locally, California counties are exploring opportunities to connect their crisis services using a best-practice approach called the Crisis Now model. Crisis Now connects three core elements of a comprehensive crisis response system: High-tech crisis centers that coordinate all aspects of an immediate crisis response, community mobile crisis teams, and crisis stabilization facilities. Connecting these elements ensures continuity of care for people in crisis. Crisis Now also supports local assessments of community crisis care needs. The Commission is supporting a multi-county collaborative to use the Crisis Now Model to identify local needs for crisis services and supports, eliminate barriers, form partnerships, and design optimized crisis systems.

## OPPORTUNITY SPOTLIGHT: Investment in Mental Health Wellness Act

California's Investment in Mental Health Wellness Act provides funds to improve California's response to mental health crisis services. Recently changes to the act allow those funds to be used for crisis prevention and early intervention in addition to crisis response. This Act and related funding is intended to reduce reliance on hospitalization, improve access to care, and enhance outcomes. Such funds can be used to strengthen upstream responses to mental health needs that can reduce the need for crisis response services.

# Deliver High-Quality Services

In addition to improving timely access, California needs to increase its capacity for delivering high-quality mental health services. Doing so will require restructuring the State's patchwork model of care into an integrated network of comprehensive medical, behavioral, and substance abuse services that consumers can easily navigate. Building a robust network of services, provided in multiple settings by a diverse workforce, will help ensure that all Californians have access to effective care when they need it.

## Integrated Service Delivery System

During the Commission's public engagement events, participants recommended better coordination among, and increased co-location of, mental health and non-mental health services as strategies to reduce delays in care. Participants argued that collaboration across health care and behavioral health systems would strengthen mental health screening and linkage to services. Use of integrated care models can achieve these goals.

Integrated care broadly refers to models in which mental health and substance use are embedded within primary care services in one care delivery system. This approach includes a variety of strategies to unify systems and providers, including the use of consultation, sharing of resources and client information, team-based collaborative care models, and co-locating mental health and substance use disorder services in primary care clinics or through virtual platforms. Integrated care models promote a wraparound approach for people and their families, so that effectiveness is dependent not on one service provider but on a network of professional and personal supports. The use of integrated care delivery models is especially effective at improving timeliness of care for traditionally marginalized and underserved populations. Integrated care models also benefit those experiencing concurrent physical and mental health needs or disabilities related to aging.

A key barrier to integrated care is a general lack of infrastructure among care delivery systems that would permit easy exchange of client health information, coordinated care, and seamless billing and reimbursement. To address these challenges, California's public health care system, Medi-Cal, has begun an initiative to coordinate and integrate its systems and services. California Advancing and Innovating Medi-Cal (CalAIM) broadens eligibility for overlapping and prevention-oriented services and includes infrastructure and billing reforms. The reforms will enable primary care, mental health, and substance use providers and systems to better communicate and share client information. Unfortunately, most of CalAIM's benefits apply only to those with "clinically significant" challenges or needs. Further, CalAIM is not available to people in the private health care sector. Expanding CalAIM benefits to those with a broader range of mental health needs and extending integrated service delivery to private health care systems would enhance mental health prevention and early intervention for all Californians.



## OPORTUNITY SPOTLIGHT: Collaborative Care

Before the COVID-19 pandemic, scientist-clinicians at Seattle's Pediatrics Northwest noticed that few of the children they referred for mental health services were able to receive those services in a timely manner, if at all. They discovered that, on average, it took parents 26 phone calls before they were able to connect with a service, and that only a small number of parents were successful in getting care. To address this issue, Pediatrics Northwest partnered with HopeSparks, a local children and youth services agency, to create a team-centered collaborative-care model. In this partnership, children and youth ages four through 21 are screened using validated tools during their regular checkups. Children and youth with early signs of concern are connected to an in-house Behavioral Health Care Manager within an average of less than two days. Collaborative care billing codes and a shared electronic health record support the provision of evidence-based early interventions, which reach an average of 72 percent of the referred children and youth. Outcomes of these interventions have included clinically significant reductions in behavioral, depressive, and anxiety symptoms. Further, none of the children and youth sought emergency department care for mental health crises after the collaborative-care model began. Integrated models like the one in operation at Pediatrics Northwest can make mental health care timely and

## Diverse Workforce

During the Commission's April 22, 2021, public engagement event, presenter Dr. Andreea Seritan, professor of clinical psychiatry at the University of California, San Francisco, stated: "We need more bilingual, language-concordant, culturally responsive services." Her call to action reflects research showing that the cultural and linguistic competence of providers can have a profound effect on access to and quality of mental health services for ethnic and racial minorities. Vital for the delivery of such services is building a culturally and linguistically diverse workforce. This workforce should include language interpreters adequately trained in mental health best practices in addition to providers trained to work effectively with interpreters and clients from diverse backgrounds. The best way to achieve these goals is through employing providers of similar linguistic and cultural backgrounds as the communities they serve.

*"Investing more in training and hiring of people of color, especially people within that community, is so important because if you come from the community, you understand the community – if you're from the community, you're more relatable to that patient. Providing more resources towards training as well as recruiting, and providing incentives to hire, train, and educate more people within that specific community, will really help with the de-stigmatization of mental health."*

*– Participant at a March 3, 2021, Commission public engagement event with residents from Los Angeles*

UnitedHealth Group is collaborating with the University of California San Diego and University of California San Francisco to grow and diversify the mental health workforce. The goal of the collaboration is to address a projected critical shortage of psychiatrists, psychologists, social workers, and counselors in California. Strategies include creating new public psychiatric fellowships, recruiting diverse students for psychiatric-mental health nurse practitioner programs, and providing financial support for underrepresented medical and nursing students pursuing child-and-adolescent mental health careers. Expanding approaches like this to promote diversity in mental health and medical career pipelines could help California address its shortage of culturally and linguistically diverse providers.

Research shows that mental health programs and supports are more effective when they tap the experience and influence of mental health peers. Broadly defined, peers refer to people with common challenges who can help one another based on shared experience. Peers can be especially powerful in engaging community members from marginalized groups, such as people of color and LGBTQ+ communities. Peers can promote mental health awareness and resources, lead support groups, and link those with mental health needs to appropriate services.

Peer-supported programs have proved effective at preventing relapse and suicide risk for people following a mental health intervention. In these programs, individuals who are recovering from mental health or substance use challenges draw upon their first-hand experiences to support others. Research confirms that such programs improve participants' life satisfaction and functioning and reduce homelessness and hospitalization.

## OPPORTUNITY SPOTLIGHT: Peer Certification

To help address California's growing mental health needs, the State is establishing a certification process for mental health peer providers. The law defines peers as individuals who have recovered from a mental disorder, substance use disorder, or both. Certified peer providers will be eligible for Medi-Cal reimbursement for such services as coaching and skill-building.

Increasing the number and diversity of peer providers represents a unique opportunity for addressing gaps in mental health services and supports for underserved racial, ethnic, and linguistic populations. One example is The Ripple Effect Respite Program. This program provides planned mental health respite care for transitional age youth (age 18 and over), adults, and older adults. The emphasis is on people of color who may identify as LGBTQ+. The program uses a peer-run structure to increase social connectedness. Program services, including a daily support group, aim to prevent acute mental health crisis and suicide.

Partnering with schools to promote peer-based supports also is critical to supporting the mental health of young people who are more inclined to turn to informal sources of support, including similar-aged peers, for issues around their mental health and wellbeing. Peer-to-peer (P2P) programs are one example of a school-based approach that acknowledges the importance of social influence and peer attachments during the adolescent years to reframe mental health as part of healthy development rather than a response to pathology. Increased investments are needed to ensuring more young people can benefit from peer-based supports. Fortunately, California's 2022-2023 budget includes a historic investment of $10 million to be allocated to eight high schools to pilot additional P2P programming for students.

Broadening certification to cover peers with other life experiences related to mental health risks could further strengthen community-based prevention and early intervention services and supports. Such experiences could include pregnancy and parenting, caregiving for a person with a mental health or substance use challenge, trauma survival, and navigating the child protective services system, among others.

## Community-Based Supports

Strategies to achieve mental health and wellbeing must be nimble as they respond to the diverse and fluctuating needs of communities. Not all mental health needs or challenges require clinical services. In fact, community-based supports can be equally or more effective, easier to access, and less expensive. Community-based programs can ensure that people have access to basic needs. They are especially important for promoting early detection and intervention and for supporting a person through recovery. Community-based supports are most effective when they promote connectedness and belonging by engaging peers and respecting the perspectives of diverse cultures.

Community-based programs also involve mobilizing agencies, institutions, and groups to work together to improve the wellbeing of a community. In addition to mental health information and supports, community-based programs can offer a variety of social, informational, and tangible resources. They can be especially successful in meeting the needs of local underserved populations. Examples of community-based programs include native cultural centers, youth mental health drop-in centers, LGBTQ+ community centers, senior centers, and community-based health navigators.

Community-based programs are unique in their ability to promote social inclusion and cohesion, which are among the most potent predictors of positive physical and mental health outcomes. For example, the Tuolumne Me-Wuk Indian Health Clinic provides outreach and engagement services for Native American youth and their families. The program seeks to engage individuals who are receiving little or no mental health services and to provide needed support in locations other than traditional mental health service sites. The focus is on identifying needs, assisting with linkages to services, reducing barriers to services, and providing culturally competent responses to behavioral health problems.

Community-based programs are unique in their ability to promote social inclusion and cohesion, which are among the most potent predictors of positive physical and mental health outcomes. For example, the Tuolumne Me-Wuk Indian Health Clinic provides outreach and engagement services for Native American youth and their families. The program seeks to engage individuals who are receiving little or no mental health services and to provide needed support in locations other than traditional mental health service sites. The focus is on identifying needs, assisting with linkages to services, reducing barriers to services, and providing culturally competent responses to behavioral health problems.

Community-based programs have proved effective in providing high-quality mental health services and supports for youth. An example is California's allcove™ program, which offers quick access to evidence-based mental health supports for youth between the ages of 12 and 25. This model is designed to serve youth of ALL backgrounds, including those not attending college, homeless youth, LGBTQ+ youth, and those of diverse cultural and linguistic backgrounds. In addition to direct services, allcove™ centers include youth-led outreach and education and peer-support activities aimed at reducing stigma, increasing community connection and empowering youth.

"One-stop-shop" community-based models like allcove™ also can address the needs of older adults. SF Village, for example, provides a model for supporting the physical, social, and cognitive needs of older adults. This nonprofit organization connects older people living in San Francisco to the activities, resources, and expertise they need to feel connected and live independently in the places they call home. Among its many programs and services, SF Village provides free assistance for people transitioning from the hospital to home, including navigating doctor visits, accessing community services, and taking care of basic needs such as grocery shopping and housework. The program facilitates social connectedness through regular phone calls, home visits, and warm relationships with providers. As stated in the SF Village mission statement, "these connections provide a powerful antidote to the isolation and loneliness that often besiege adults in our society, no matter their age." By 2050, one in five people in the United States will be aged 65 years or older. Enhancing support for aging adults and their unique physical and mental health risks must be a public health priority. Expanding models like SF Village to other communities could greatly enhance the State's capacity to promote and preserve the wellbeing of Californians growing population of

## OPPORTUNITY SPOTLIGHT: Community-Defined Evidence Practices

Community-defined evidence practices (CDEPs) have been gaining attention in the public health community as a strategy to address the unmet needs of historically underserved and diverse racial, ethnic, and LGBTQ+ populations. Although definitions vary, CDEPs broadly refer to a set of health promoting practices which may or may not have been measured empirically but have reached a level of acceptance by the community. Such practices are commonly developed and evaluated alongside community members and incorporate cultural activities to supplement or complement more traditional therapeutic services.

Butte County's Zoosiab "Happy Program" is one example of a CDEP that works to support the mental health needs of Hmong elders by blending Western mental health approaches with traditional cultural practices and beliefs. Housed within the Hmong Cultural Center, this program supports individuals in recovery as well as those who are at risk due to trauma, stress, anxiety, isolation, stigmatization, or depression.

California Reducing Disparities Project (CRDP) recently funded the development and evaluation of 35 CDEP pilot projects focused on providing culturally and linguistically competent mental health services from California's African American, Asian and Pacific Islander, Latinx, LGBTQ+, and Native communities. The CDRP has yet to release the result of its statewide evaluation of CDEPs. In the meantime, other State partners, such as the Department of Health Care Service's Child and Youth Behavioral Health Initiative, are exploring opportunities to expand the use of CDEPs to better serve the mental health needs of California's diverse communities.

# RECOMMENDATION FOUR

**As part of its approach to prevention and early intervention, the State must guarantee all residents have access to behavioral health screening and an adjacent system of care that respects and responds to California's diverse communities and their mental health needs. In pursuit of this goal, the State should:**

**4A.** Establish a goal to achieve universal behavioral health screening and, consistent with Recommendation 1, appoint a lead, develop a strategy, and identify metrics to support progress towards that goal.

**4B.** Establish a goal and strategy to achieve universal behavioral health care. Strategies should build on California's current initiatives to incorporate outcomes-based financing, enhanced integration of physical, behavioral health, and community-based services, and workforce development with an emphasis on peer providers.

**4C.** Develop a strategy to ensure behavioral health screening and services are culturally and linguistically responsive and do not discriminate based on a person's age, race, gender, sexual orientation, or socioeconomic circumstances. Efforts should include the adoption of the U.S. Health and Human Services' cultural and linguistic competency (CLAS) standards and strengthening the provision of community-defined evidence practices (CDEPs) and other strategies to reduce disparities.

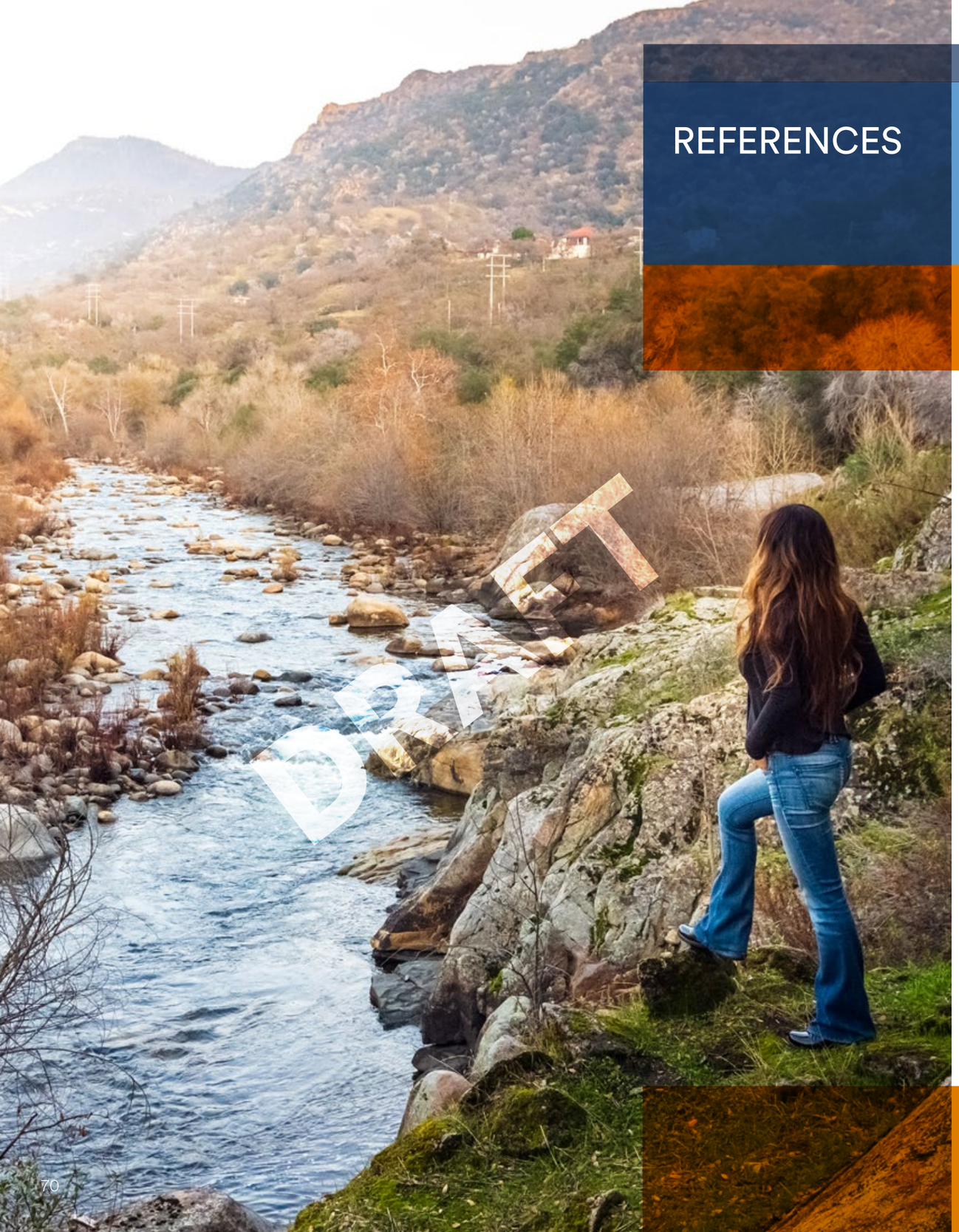
# CONCLUSION

Since the passage of the Mental Health Services Act (MHSA) in 2004, California's mental health system has grown in innovation and ingenuity, fueled by passionate and dedicated providers, administrators, researchers, and advocates. Despite the tremendous reforms launched by the MHSA, however, many Californians continue to experience unmet mental health challenges and the negative outcomes that may ensue, including suicide, incarceration, and homelessness. Decades of evidence affirms that transformational change is possible when prevention and early intervention strategies operate in tandem – not in competition – with high-quality services and supports. Dr. Thomas Insel, a psychiatrist, neuroscientist, and former director of the National Institute of Mental Health, is one of the most respected champions of prevention and early intervention. "The biggest transformation will come when we can identify problems and intervene earlier," he said in a recent interview with California Healthline, a daily news service of the California Health Care Foundation. "We have to manage crisis better, keep people out of the criminal justice system, provide more continuity of care. But we also have to move upstream and capture people much earlier in their journey."

***"We have to manage crisis better, keep people out of the criminal justice system, provide more continuity of care. But we also have to move upstream and capture people much earlier in their journey."***

The findings and recommendations in this report began with a Commission investigation to explore how MHSA prevention and early intervention funds should best be utilized to promote positive outcomes and reduce mental health disparities, particularly among unserved communities. Through a robust public engagement and review process, the Commission found that California does not have in place a strategic approach to prevention and early intervention. Such an approach could address persistent inequities, deficits in basic needs, and exposure to trauma, all of which are too common throughout California. It also could promote mental health awareness and reduce stigma, advance early detection and intervention of mental health challenges, and ensure high-quality mental health care and support that is culturally and linguistically responsive to the needs of California's diverse population. This strategic approach could guide funding decisions, ensuring that all public investments are maximized to truly meet the needs of all Californians.

Developing and implementing a strategic approach to prevention and early intervention will take time. The Commission has identified steps to take now, specifically to promote more community inclusion in the planning and implementation of programs and services, and to strengthen the use of data, training, and technical support to guide best practices in prevention and early intervention. With these strategic actions and strong partnerships, we can shift the course and promote opportunities for all Californians to be well and thrive.



# REFERENCES


1. Waters, R. (2019, August 28). *Spotlight: Governor's 'mental health czar' seeks new blueprint for care in California*. California Healthline. https://californiahealthline.org/news/governors-mental-health-czar-seeks-new-blueprint-for-care-in-california/.
2. Ibid.
3. Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry*, *66*(4), 317-320. https://dx.doi.org/10.1177/0020764020915212
4. Bagchi, B., Chatterjee, S., Ghosh, R., Dandapat, D. (2020). Impact of COVID-19 on global economy. In B. Bagchi, S. Chatterjee, R. Ghosh, & D. Dandapat (Eds.), *Coronavirus outbreak and the great lockdown*. SpringerBriefs in Economics. https://doi.org/10.1007/978-981-15-7782-6_3
5. Joseph, C. A., O'Shea, B. Q., Eastman, M.R., Finlay, J. M., & Kobayashi, L.C. (2022). Physical isolation and mental health among older US adults during the COVID-19 pandemic: Longitudinal findings from the COVID-19 Coping Study. *Social Psychiatry and Psychiatric Epidemiology, 57*(6), 1273–1282. https://doi.org/10.1007/s00127-022-02248-4
6. Wu, H. H., Gallagher, R. J., Alshaabi, T., Adams, J. L., Minot, J. R., Arnold, M. V., ... & Danforth, C. M. (2021). Say Their Names: Resurgence in the collective attention toward Black victims of fatal police violence following the death of George Floyd. *arXiv preprint arXiv:2106.10281*.
7. Centers for Disease Control and Prevention (2021, April 8). Media Statement from CDC Director Rochelle P. Walensky, MD, MPH, on Racism and Health. https://www.cdc.gov/media/releases/2021/s0408-racism-health.html
8. Twenge, J. M., & Joiner, T. E. (2020). Mental distress among US adults during the COVID-19 pandemic. *Journal of Clinical Psychology*, *76*(12), 2170-2182. https://dx.doi.org/10.1002/jclp.23064
9. Hay, J. W., Gong, C. L., Jiao, X., Zawadzki, N. K., Zawadzki, R. S., Pickard, A. S., Xie, F., Crawford, S. A., & Gu, N. Y. (2021). A US Population Health Survey on the impact of COVID-19 using the EQ-5D-5L. *Journal of General Internal Medicine, 36*(5), 1292–1301. https://doi.org/10.1007/s11606-021-06674-z
10. Krieger, N. (2020). ENOUGH: COVID-19, structural racism, police brutality, plutocracy, climate change—and time for health justice, democratic governance, and an equitable, sustainable future. *American Journal of Public Health*, *110*(11), 1620-1623. https://dx.doi.org/10.2105/AJPH.2020.305886
11. Boden, M., Zimmerman, L., Azevedo, K. J., Ruzek, J. I., Gala, S., Magid, H. S. A., Cohen, N., Walser, R., Mahtani, N.D., Joggatt, L.J., & McLean, C. P. (2021). Addressing the mental health impact of COVID-19 through population health. *Clinical Psychology Review*, *85*, 102006. https://doi.org/10.1016/j.cpr.2021.102006
12. Waters, R. (2019, August 28). *Spotlight: Governor's 'mental health czar' seeks new blueprint for care in California*. California Healthline. https://californiahealthline.org/news/governors-mental-health-czar-seeks-new-blueprint-for-care-in-california/.
13. World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, and practice. Summary report*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42940/9241591595.pdf
14. Ibid.
15. Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. https://dx.doi.org/10.3109/09540261.2014.928270
16. Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*, *30*(4), 259-292. https://scielo.isciii.es/scielo.php?pid=S0213-61632016000400004&script=sci_arttext&tlng=en
17. APA. (n.d.). Mental disorder. In *APA dictionary of psychology*. https://dictionary.apa.org/mental-disorder
18. Hasin, D. S., O'Brien, C. P., Auriacombe, M., Borges, G., Bucholz, K., Budney, A., Compton, W. M., Crowley, T., Ling, W., Petry, N. M., Schuckit, M., & Grant, B. F. (2013). DSM-5 criteria for substance use disorders: Recommendations and rationale. *The American Journal of Psychiatry, 170*(8), 834-51. https://dx.doi.org/10.1176/appi.ajp.2013.12060782.
19. Institute of Medicine (US) Committee on Prevention of Mental Disorders. (1994) In. Mrazek, P. J., & Haggerty, R. J. (Eds.). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. The National Academies Press. https://dx.doi.org/10.17226/2139

20. Mei, C., Killackey, E., Chanen, A., & McGorry, P. D. (2021). Early intervention and youth mental health: Synergistic paradigms to transform mental health outcomes. In *Innovations in Global Mental Health* (pp. 929-939). Cham: Springer International Publishing.
21. Le, L. K., Esturas, A. C., Mihalopoulos, C., Chiotelis, O., Bucholc, J., Chatterton, M. L., & Engel, L. (2021). Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. *PLoS Medicine*, *18*(5), e1003606. https://doi.org/10.1371/journal.pmed.1003606
22. National Research Council and Institute of Medicine Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. The National Academies Press. https://doi.org/10.17226/12480
23. John-Baptiste, A. A., Li, L., Isaranuwatchai, W., Osuch, E., & Anderson, K. K. (2019). Healthcare utilization costs of emerging adults with mood and anxiety disorders in an early intervention treatment program compared to a matched cohort. *Early Intervention in Psychiatry, 13*(6), 1439-1446. https://dx.doi.org/10.1111/eip.12790
24. Nores, M., Belfield, C. R., Barnett, W. S., & Schweinhart, L. (2005). Updating the economic impacts of the High/Scope Perry Preschool Program. *Educational Evaluation and Policy Analysis, 27*(3), 245–61. https://dx.doi.org/10.3102/01623737027003245
25. Ibid.
26. World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, and practice. Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
27. Ibid.
28. Institute of Medicine (US) Committee on Prevention of Mental Disorders. (1994) In. Mrazek, P. J., & Haggerty, R. J. (Eds.). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. The National Academies Press. https://dx.doi.org/10.17226/2139
29. Ibid.
30. Ibid.
31. Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's Working Definition of Recovery.* https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf
32. Llewellyn-Beardsley, J., Rennick-Egglestone, S., Callard, F., Crawford, P., Farkas, M., Hui, A., Manley, D., MCGranahan, R., Pollock, K., Ramsay, A., Sælør, K.T., Wright, N., & Slade, M. (2019). Characteristics of mental health recovery narratives: Systematic review and narrative synthesis. *PloS One*, *14*(3), e0214678. https://doi.org/10.1371/journal.pone.0214678
33. Ibid.
34. Segal, Z. V., Pearson, J. L., & Thase, M. E. (2003). Challenges in preventing relapse in major depression: Report of a National Institute of Mental Health Workshop on state of the science of relapse prevention in major depression. *Journal of Affective Disorders, 77*(2), 97–108. https://doi.org/10.1016/S0165-0327(02)00112-X
35. Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Social determinants of health*. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
36. World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, and practice. Summary report*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42940/9241591595.pdf
37. Friedli, L., & World Health Organization. (2009). *Mental health, resilience and inequalities* (No. EU/08/5087203). Copenhagen: WHO Regional Office for Europe. https://apps.who.int/iris/handle/10665/107925
38. Sun, S., Lin, D., & Operario, D. (2020). Need for a population health approach to understand and address psychosocial consequences of COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S25–S27. https://dx.doi.org/10.1037/tra0000618
39. Canady, V. A. (2020). APA adopts new resolution to address pandemic challenges. *Mental Health Weekly, 30*(32), 5-6. https://dx.doi.org/10.1002/mhw.32477
40. Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-based approaches to mental health: History, strategies, and evidence. *Annual Review of Public Health, 41,* 201–221. https://doi.org/10.1146/annurev-publhealth-040119-094247
41. Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet, 372*(9650), 1661–1669. https://doi.org/10.1016/S0140-6736(08)61690-6
42. Astho, National Association of Medicaid Directors, and de Beaumont Foundation. (n.d.). Medicaid and public health partnership learning series: Public health and population health 101. https://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/Learning-Series/Public-Health-and-Population-Health-101/
43. Young, T. K. (2004). *Population health: Concepts and methods*. Oxford University Press. https://dx.doi.org/10.1093/acprof:oso/9780195158540.001.0001
44. Marmot, M., & Wilkinson, R. (Eds.). (2005). *Social determinants of health*. Oxford University Press. https://dx.doi.org/10.1093/acprof:oso/9780198565895.001.0001
45. American Psychological Association (2020). Psychology's understanding of the challenges related to the COVID-19 global pandemic in the United States. https://www.apa.org/about/policy/covid-statement.pdf
46. Evans, A. C., & Bufka, L. F. (2020). The critical need for a population health approach: Addressing the nation's behavioral health during the COVID-19 pandemic and beyond. *Preventing Chronic Disease*, *17*, E79. https://doi.org/10.5888/pcd17.200261
47. World Health Organization. (2002). *Prevention and promotion in mental health*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf
48. Ibid.
49. Ibid.
50. Ibid.
51. Boden, M., Zimmerman, L., Azevedo, K. J., Ruzek, J. I., Gala, S., Magid, H. S. A., Cohen, N., Walser, R., Mahtani, N.D., Joggatt, L.J., & McLean, C. P. (2021). Addressing the mental health impact of COVID-19 through population health. *Clinical Psychology Review*, *85*, 102006. https://doi.org/10.1016/j.cpr.2021.102006
52. Palinkas, L. A., & Wong, M. (2020). Global climate change and mental health. *Current Opinion in Psychology*, *32*, 12-16. https://dx.doi.org/10.1016/j.copsyc.2019.06.023
53. Pinderhughes, H. Davis, R., & Williams, M. (2015). Adverse community experiences and resilience: A framework for addressing and preventing community trauma. *Justice Research and Statistics Association*. Retrieved November 12, 2020, from http://hdl.handle.net/20.500.11990/988
54. World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
55. Jacob, C., Baird, J., Barker, M., Cooper, C., & Hanson, M. (2017). The importance of a life course approach to health: Chronic disease risk from preconception through adolescence and adulthood. World Health Organization. https://eprints.soton.ac.uk/436656/
56. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing Mental Health Promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
57. Mental Health Services Oversight and Accountability Commission. (2021). *The Mental Health Services Act*. https://mhsoac.ca.gov/the-act-mhsa/.

58. Ibid.
59. California Code of Regulations, Title 9, Section 5840.
60. Mental Health Services Oversight and Accountability Commission. (2022). *Transparency Suite: Fiscal Transparency Dashboard*. https://mhsoac.ca.gov/transparency-suite/fiscal-transparency-dashboard/.
61. Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA
62. Chaptered by the Secretary of State. Chapter 843, Statutes of 2018.
63. Ibid.
64. Ibid.
65. Ibid.
66. Ibid.
67. Mental Health Services Oversight and Accountability Commission. (2021). *Prevention and early intervention*. https://mhsoac.ca.gov/initiatives/prevention-early-intervention/
68. Ibid.
69. Mental Health Services Oversight and Accountability Commission. (2021). *MHSOAC Initiatives.* https://mhsoac.ca.gov/initiatives/
70. Mental Health Services Oversight and Accountability Commission. (2021). *Cultural and linguistic committee meeting – December 8, 2021.* Meeting material available at https://mhsoac.ca.gov/connect/committees/cultural-and-linguistic-competency-committee-meeting-december-8-2021/
71. California Code of Regulations, Title 9, Section 3755
72. California Code of Regulations, Title 9, Section 3510 – 3560.
73. Mental Health Services Oversight and Accountability Commission. (2021). *Upstream university*. https://mhsoac.ca.gov/upstream-university/
74. Lake, J., & Turner, M. S. (2017). Urgent need for improved mental health care and a more collaborative model of care. *The Permanente Journal, 21*, 17–024. https://dx.doi.org/10.7812/TPP/17-024
75. World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
76. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
77. Petek, G. (2021, August). *The 2021-22 budget: Overview of the spending plan.* Legislative Analyst's Office. https://lao.ca.gov/Publications/Report/4448#Budget_Overview
78. Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. https://dx.doi.org/10.3109/09540261.2014.928270
79. Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet, 372*(9650), 1661–1669. https://doi.org/10.1016/S0140-6736(08)61690-6
80. Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. https://dx.doi.org/10.3109/09540261.2014.928270
81. Ibid.
82. Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*, *30*(4), 259-292. https://scielo.isciii.es/scielo.php?pid=S0213-61632016000400004&script=sci_arttext&tlng=en
83. Thienhaus, O., Halpin, L., Sobowale, K., & Trestman, R. (2020). Resource document on social determinants of health. American Psychiatric Association. https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/Resource-Document-2020-Social-Determinants-of-Health.pdf
84. Lin, Q., Paykin, S., Halpern, D., Martinez-Cardoso, A., & Kolak, M. (2022). Assessment of structural barriers and racial group disparities of COVID-19 mortality with spatial analysis. *JAMA Network Open, 5*(3), e220984. https://dx.doi.org/10.1001/jamanetworkopen.2022.0984
85. Garcia, E., Eckel, S. P., Chen, Z., Li, K., & Gilliland, F. D. (2021). COVID-19 mortality in California based on death certificates: Disproportionate impacts across racial/ethnic groups and nativity. *Annals of Epidemiology, 58*, 69–75. https://dx.doi.org/10.1016/j.annepidem.2021.03.006
86. Chen, Y. H., Glymour, M. M., Catalano, R., Fernandez, A., Nguyen, T., Kushel, M., & Bibbins-Domingo, K. (2021). Excess mortality in California during the coronavirus disease 2019 pandemic, March to August 2020. *JAMA Internal Medicine, 181*(5), 705–707. https://dx.doi.org/10.1001/jamainternmed.2020.7578
87. Garcia, E., Eckel, S. P., Chen, Z., Li, K., & Gilliland, F. D. (2021). COVID-19 mortality in California based on death certificates: Disproportionate impacts across racial/ethnic groups and nativity. *Annals of Epidemiology, 58*, 69–75. https://dx.doi.org/10.1016/j.annepidem.2021.03.006
88. Troutman-Jordan, M., & Kazemi, D. M. (2020). COVID-19's impact on the mental health of older adults: Increase in isolation, depression, and suicide risk. An urgent call for action. Public Health Nursing. http://dx.doi.org/10.1111/phn.12774
89. Hawke, L. D., Hayes, E., Darnay, K., & Henderson, J. (2021). Mental health among transgender and gender diverse youth: An exploration of effects during the COVID-19 pandemic. *Psychology of Sexual Orientation and Gender Diversity*, *8,*(2). http://dx.doi.org/10.1037/sgd0000467
90. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
91. Ibid.
92. Ibid.
93. Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old issues, new directions. *Du Bois Review: Social Science Research on Race, 8*(1), 115–132. https://dx.doi.org/10.1017/S1742058X11000130
94. Charles, C. Z. (2003). The dynamics of racial residential segregation. *Annual Review of Sociology, 29*(1), 167–207. https://dx.doi.org/10.1146/annurev.soc.29.010202.100002
95. Bailey, Z. D., Feldman, J. M., & Bassett, M. T. (2021). How structural racism works—Racist policies as a root cause of US racial health inequities. *New England Journal of Medicine, 384*, 768-773. https://dx.doi.org/10.1056/NEJMms2025396
96. Ibid.
97. Ibid.
98. Lynch, E. E., Malcoe, L. H., Laurent, S. E., Richardson, J., Mitchell, B. C., & Meier, H. C. (2021). The legacy of structural racism: Associations between historic redlining, current mortgage lending, and health. *SSM-Population Health*, *14*, 100793. https://doi.org/10.1016/j.ssmph.2021.100793
99. Johnson, T. J. (2020). Intersection of bias, structural racism, and social determinants with health care inequities. *Pediatrics, 146*(2), e2020003657. https://dx.doi.org/10.1542/peds.2020-003657
100. Cummings, J.R, Allen, L., Clennon, J. Ji, Xo, & Druss, B.G. (2017). Geographic access to specialty mental health care across high- and low-income US communities. *JAMA Psychiatry* 74, 476 – 484. https://doi.org/10.1001/jamapsychiatry.2017.0303

101. Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2*( 3), 209–213. https://dx.doi.org/10.1037/sgd0000132
102. Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-based approaches to mental health: History, strategies, and evidence. *Annual Review of Public Health, 41,* 201–221. https://doi.org/10.1146/annurev-publhealth-040119-094247
103. California Association of Public Hospitals and Health Systems. (2021, March 16). *County leaders declare racism a public health crisis.* CAPH news. https://caph.org/2021/03/16/county-leaders-statement-on-racism-as-a-public-health-crisis/
104. Ibid.
105. Ibid.
106. Artiga, S., Orgera, K., & Pham, O. (2020). Disparities in health and health care: Five key questions and answers (Issue Brief). *Kaiser Family Foundation*. https://files.kff.org/attachment/Issue-Brief-Disparities-in-Health-and-Health-Care-Five-Key-Questions-and-Answers
107. Ortega, A. N., McKenna, R. M., Pintor, J. K., Langellier, B. A., Roby, D. H., Pourat, N., Bustamente, A. V., & Wallace, S. P. (2018). Health care access and physical and behavioral health among undocumented Latinos in California. *Medical Care, 56*(11), 919. https://dx.doi.org/10.1097/MLR.0000000000000985
108. Yearby, R. (2018). Racial disparities in health status and access to health care: The continuation of inequality in the United States due to structural racism. *American Journal of Economics and Sociology, 77*(3-4), 1113-1152. https://dx.doi.org/10.1111/ajes.12230
109. Connors, J., Cásares, C., Honigberg, M. C., & Davis, J. A. (2020). LGBTQ health disparities. In J. R. Lehman, K. Diaz, H. Ng., E. M. Petty, M. Thatikunta, & K. Eckstrand (Eds.) *The equal curriculum: The student and educator guide to LGBTQ health* (pp. 13-31). Springer. https://dx.doi.org/10.1007/978-3-030-24025-7_2
110. Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-based approaches to mental health: History, strategies, and evidence. *Annual Review of Public Health, 41,* 201–221. https://doi.org/10.1146/annurev-publhealth-040119-094247
111. Yi., S.S., Kwon, S.C., Suss, R., Doan, L.N., John, I., Islam, N.S., & Trinh-Shevrin, C. (2022). The mutually reinforcing cycle of poor data quality and racialized stereotypes that shapes Asian American health. *Health Affairs, 41*(2). https://doi.org/10.1377/hlthaff.2021.01417
112. Zhang, X., Holt. J. B., Yun, S., Lu., H., Greenlund, K. J., & Croft, J. B. (2015). Validation of multilevel regression and poststratification methodology for small area estimation of health indicators from the Behavioral Risk Factor Surveillance System. *American Journal of Epidemiology, 182*(2), 127–37. https://doi.org/10.1093/aje/kwv002
113. Islam NS, Khan S, Kwon S, Jang D, Ro M, Trinh-Shevrin C. (2010). Methodological issues in the collection, analysis, and reporting of granular data in Asian American populations: Historical challenges and potential solutions. *Journal of Health Care for the Poor and Underserved, 21*(4):1354–81. https://doi.org/10.1353%2Fhpu.2010.0939
114. Yi., S.S., Kwon, S.C., Suss, R., Doan, L.N., John, I., Islam, N.S., & Trinh-Shevrin, C. (2022). The mutually reinforcing cycle of poor data quality and racialized stereotypes that shapes Asian American health. *Health Affairs, 41*(2). https://doi.org/10.1377/hlthaff.2021.01417
115. Centers for Disease Control and Prevention. (2021). *COVID data tracker: Demographic trends of COVID-19 cases and deaths in the US reported to CDC.* https://covid.cdc.gov/covid-data-tracker/#demographics
116. Islam NS, Khan S, Kwon S, Jang D, Ro M, Trinh-Shevrin C. (2010). Methodological issues in the collection, analysis, and reporting of granular data in Asian American populations: Historical challenges and potential solutions. *Journal of Health Care for the Poor and Underserved, 21*(4):1354–81. https://doi.org/10.1353%2Fhpu.2010.0939
117. Freeman, E. J., Colpe, L. J., Strine, T. W., Dhingra, S., McGuire, L. C., Elam-Evans, L. D., & Perry, G. S. (2010). Peer reviewed: Public health surveillance for mental health. *Preventing Chronic Disease, 7*(1). http://www.cdc.gov/pcd/issues/2010/jan/09_0126.htm
118. Iyamu, I., Gómez-Ramírez, O., Xu, A. X. T., Chang, H., Watt, S., Mckee, G., & Gilbert, M. (2022). Challenges in the development of digital public health interventions and mapped solutions: Findings from a scoping review. *Digital Health*, *8*. https://doi.org/10.1177/20552076221102255
119. Watkins, K. E., Burnam, M. A., Okeke, E. N., & Setodji, C. M. (2013). Evaluating the impact of prevention and early intervention activities on the mental health of California's population. *Rand Health Quarterly*, *2*(4), 1. https://dx.doi.org/10.7249/TR1316
120. California Code of Regulations, Title 9, Section 3755
121. Yi., S.S., Kwon, S.C., Suss, R., Doan, L.N., John, I., Islam, N.S., & Trinh-Shevrin, C. (2022). The mutually reinforcing cycle of poor data quality and racialized stereotypes that shapes Asian American health. *Health Affairs, 41*(2). https://doi.org/10.1377/hlthaff.2021.01417
122. Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-based approaches to mental health: History, strategies, and evidence. *Annual Review of Public Health, 41,* 201–221. https://doi.org/10.1146/annurev-publhealth-040119-094247
123. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
124. Bigland, C., Evans, D., Bolden, R., & Rae, M. (2020). Systems leadership in practice: Thematic insights from three public health case studies. *BMC Public Health, 20*(1), 1735. https://doi.org/10.1186/s12889-020-09641-1
125. National Technical Assistance and Evaluation Center for Systems of Care. (2008). A closer look: Interagency collaboration. *Child Welfare Information Gateway, U.S. Children's Bureau*. https://www.childwelfare.gov/pubPDFs/interagency.pdf
126. Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-based approaches to mental health: History, strategies, and evidence. *Annual Review of Public Health, 41*, 201–221. https://doi.org/10.1146/annurev-publhealth-040119-094247
127. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
128. Ibid.
129. Ibid.
130. H.R.379 - Improving Social Determinants of Health Act of 2021 117th Congress (2021-2022). https://www.congress.gov/bill/117th-congress/house-bill/379/text
131. Ibid.
132. Bigland, C., Evans, D., Bolden, R., & Rae, M. (2020). Systems leadership in practice: Thematic insights from three public health case studies. *BMC Public Health, 20*(1), 1735. https://doi.org/10.1186/s12889-020-09641-1
133. California Department of Aging (n.d.). *Master plan for aging.* Retrieved September 12, 2022, from https://mpa.aging.ca.gov/
134. California Department of Aging (n.d.). *Master plan for aging.* Retrieved September 12, 2022, from https://mpa.aging.ca.gov/
135. California Department of Aging (n.d.). *Master plan for aging.* Retrieved September 12, 2022, from https://mpa.aging.ca.gov/
136. Office of Governor Gavin Newsom. (2021, October 04). *Governor Newsom announces appointments on 10.4.21.* State of California. https://www.gov.ca.gov/2021/10/04/governor-newsom-announces-appointments-10-4-21/#:~:text=Kimberly%20McCoy%20Wade%2C%2050%2C%20of,Department%20of%20Aging%20since%202019.
137. Ibid.
138. Ibid.

139. Ibid.
140. Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts. https://www.aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf
141. Ibid.
142. Bayer, E., Weiss, S., Hacker, K., & Glasgow, L. (2021, October). Improving social determinants of health-getting further faster. In *APHA 2021 Annual Meeting and Expo*. APHA. https://www.cdc.gov/chronicdisease/programs-impact/sdoh/pdf/GFF-eval-brief-508.pdf
143. Ibid.
144. Ibid.
145. Ibid.
146. Ibid.
147. Chaptered by the Secretary of State. Chapter 815, Statutes of 2018.
148. California Health and Human Services. (2022). *System of care for children and youth.* Retrieved September 16, 2022, from https://www.chhs.ca.gov/home/system-of-care/#:~:text=AB%202083%20Implementation,-Our%20System%20of&text=The%20legislation%20calls%20for%20the,to%20foster%20children%20and%20youth.
149. California Health and Human Services. (2022). *System of care for children and youth.* Retrieved September 16, 2022, from https://www.chhs.ca.gov/home/system-of-care/#:~:text=AB%202083%20Implementation,-Our%20System%20of&text=The%20legislation%20calls%20for%20the,to%20foster%20children%20and%20youth.
150. California Health and Human Services. (2022). *System of care for children and youth.* Retrieved September 16, 2022, from https://www.chhs.ca.gov/home/system-of-care/#:~:text=AB%202083%20Implementation,-Our%20System%20of&text=The%20legislation%20calls%20for%20the,to%20foster%20children%20and%20youth.
151. Ibid.
152. Substance Abuse and Mental Health Services Administration. (2022, April 14). *Substance abuse prevention and treatment block grant.* https://www.samhsa.gov/grants/block-grants/sabg
153. California Department of Public Health. (2021, October 22). *Ending the epidemics strategic plan*. Office of AIDS. https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_div_EtE.aspx
154. California Office of Traffic Safety. (2020). *2020-2023 strategic management plan.* https://www.ots.ca.gov/wp-content/uploads/sites/67/2021/02/2020-2023-OTS-Strategic-Plan-FINAL.pdf
155. Mental Health Services Oversight and Accountability Commission. (2019, December 19). Striving for zero: California's strategic plan for suicide prevention 2020-2025. https://mhsoac.ca.gov/newsroom/announcements/striving-for-zero-californias-strategic-plan-for-suicide-prevention-2020-2025/
156. National Technical Assistance and Evaluation Center for Systems of Care. (2008). A closer look: Interagency collaboration. *Child Welfare Information Gateway, U.S. Children's Bureau*. https://www.childwelfare.gov/pubPDFs/interagency.pdf
157. Saxena, S., Jané-Llopis, E., & Hosman, C. (2006). Prevention of mental and behavioural disorders: implications for policy and practice. *World psychiatry : official journal of the World Psychiatric Association (WPA), 5(1)*, 5–14.
158. Ibid.
159. Ibid.
160. Ibid.
161. California Department of Health Care Services. (2022, June 06). *Behavioral health prevention plan.* https://www.dhcs.ca.gov/services/Pages/BHPP.aspx
162. Ibid.
163. Ibid.
164. Mental Health Services Oversight and Accountability Commission. (2021). *The Mental Health Services Act*. https://mhsoac.ca.gov/the-act-mhsa/
165. Ibid.
166. Senate Bill 1004 (Weiner). Chaptered by the Secretary of State. Chapter 843, Statutes of 2018.
167. Ibid.
168. Ibid.
169. Shonkoff, J. P., & Fisher, P. A. (2013). Rethinking evidence-based practice and two-generation programs to create the future of early childhood policy. *Development and Psychopathology, 25*(40 2), 1635–1653. https://dx.doi.org/10.1017%2FS0954579413000813
170. Agency for Toxic Substances and Disease Registry. (2018). CDC's social vulnerability index (SVI). [Interactive Map]. U.S. Department of Health and Human Services. Retrieved July 21, 2022, from https://svi.cdc.gov/map.html
171. Public Health Alliance of Southern California. (2019). California healthy places index. [Interactive Map]. Retrieved July 21, 2022, from https://map.healthyplacesindex.org/?redirect=false
172. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
173. Ibid.
174. Lavery, S. H., Smith, M. L., Esparza, A. A., Hrushow, A., Moore, M., & Reed, D. F. (2005). The community action model: A community-driven model designed to address disparities in health. *American Journal of Public Health*, *95*(4), 611–616. https://doi.org/10.2105/AJPH.2004.047704
175. Ibid.
176. Geekiyanage, D., Fernando, T., & Keraminiyage, K. (2020). Assessing the state of the art in community engagement for participatory decision-making in disaster risk-sensitive urban development. *International Journal of Disaster Risk Reduction, 51*, 101847. https://doi.org/10.1016/j.ijdrr.2020.101847
177. California Code of Regulations. Title 9, § 3650 – Community Services and Supports Component of the Three-Year Program and Expenditure Plan.
178. California Code of Regulations. Title 9, § 3650 – Community Services and Supports Component of the Three-Year Program and Expenditure Plan.
179. California Code of Regulations. Title 9, § 3650 – Community Services and Supports Component of the Three-Year Program and Expenditure Plan.
180. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
181. Ibid.
182. Fagan, A.A., Bumbarger, B.K., Barth, R.P., Bradshaw, C.P., Cooper, B.R., Supplee, L.H., & Walker, D.K. (2019). Scaling up evidence-based interventions in US public systems to prevent behavioral health problems: Challenges and opportunities. *Prevention Science 20,* 1147–1168. https://doi.org/10.1007/s11121-019-01048-8
183. Bayer, E., Weiss, S., Hacker, K., & Glasgow, L. (2021, October). Improving social determinants of health-getting further faster. In *APHA 2021 Annual Meeting and Expo*. APHA. https://www.cdc.gov/chronicdisease/programs-impact/sdoh/pdf/GFF-eval-brief-508.pdf
184. Chretien, J. P., Tomich, N. E., Gaydos, J. C., & Kelley, P. W. (2009). Real-time public health surveillance for emergency preparedness. *American Journal of Public Health*, *99*(8), 1360–1363. https://doi.org/10.2105/AJPH.2008.133926

185. Freeman, E. J., Colpe, L. J., Strine, T. W., Dhingra, S., McGuire, L. C., Elam-Evans, L. D., & Perry, G. S. (2010). Peer reviewed: Public health surveillance for mental health. *Preventing Chronic Disease, 7*(1). http://www.cdc.gov/pcd/issues/2010/jan/09_0126.htm
186. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
187. Davidson, A. J., Xu, S., Oronce, C. I. A., Durfee, M. J., McCormick, E. V., Steiner, J. F., Havranek, E., & Beck, A. (2018). Monitoring depression rates in an urban community: Use of electronic health records. *Journal of Public Health Management and Practice, 24*(6), E6–E14. https://doi.org/10.1097/PHH.0000000000000751
188. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
189. Goldman-Mellor, S., Jia, Y., Kwan, K., & Rutledge, J. (2017). Syndromic surveillance of mental and substance use disorders: A validation study using emergency department chief complaints. *Psychiatric Services, 69*(1), 55–60. https://doi.org/10.1176/appi.ps.201700028
190. Nguyen A-M, Malig BJ, Basu R (2021) The association between ozone and fine particles and mental health-related emergency department visits in California, 2005–2013. PLoS ONE 16(4): e0249675. https://doi.org/10.1371/journal.pone.0249675
191. Ibid.
192. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
193. Ibid.
194. Ibid.
195. National Technical Assistance and Evaluation Center for Systems of Care. (2008). A closer look: Interagency collaboration. *Child Welfare Information Gateway, U.S. Children's Bureau*. https://www.childwelfare.gov/pubPDFs/interagency.pdf
196. UCLA Center for Health Policy Research. (2021). *About CHIS*. Retrieved December 3, 2021, from https://healthpolicy.ucla.edu/chis/about/Pages/about.aspx
197. Centers for Disease Control and Prevention. (2022). Behavioral risk factor surveillance system. https://www.cdc.gov/brfss/
198. Lyerla, R., & Stroup, D. F. (2018). Toward a public health surveillance system for behavioral health. *Public Health Reports, 133*(4), 360–365. https://doi.org/10.1177/0033354918772547
199. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in Action: Pathways to Health Equity*. National Academies Press (US).
200. California Welfare and Institutions Code, Section 5848(a).
201. Eberhart, N. K., Cerully, J. L., Shearer, A. L., Berry, S. H., Burnam, M. A., & Ebener, P. A. (2017). *Evaluation approaches for mental health prevention and early intervention programs*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR1882.html
202. Niendam, T. A., Sardo, A., Savill, M., Patel, P., Xing, G., Loewy, R. L., Dewa, C. S., & Melnikow, J. (2019). The rise of early psychosis care in California: An overview of community and university-based services. *Psychiatr Services, 70*(6), 480-487. https://dx.doi.org/10.1176/appi.ps.201800394
203. Addington, D., Birchwood, M., Jones, P., Killackey, E., McDaid, D., Melau, M., Mizuno, M., Mueser, K., & Nordentoft, M. (2018). Fidelity scales and performance measures to support implementation and quality assurance for first episode psychosis services. *Early Intervention in Psychiatry*, *12*(6), 1235–1242. https://dx.doi.org/10.1111/eip.12684
204. Öngür, D., Carter, C. S., Gur, R. E., Perkins, D., Sawa, A., Seidman, L. J., Tamminga, C., Huggins, W., & Hamilton, C. (2020). Common data elements for National Institute of Mental Health-funded translational early psychosis research. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging*, *5*(1), 10–22. https://dx.doi.org/10.1016/j.bpsc.2019.06.009
205. Frank JC, McNeill A, Wilson N, Dupuy D, Damron-Rodriguez J, Palimaru A, Kietzman K. (2018). Mental health services for older adults: Creating a system that tells the story. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2018/creatingsystem-brief-jan2018.pdf
206. Canady, V. A. (2021). National learning health care system to advance early psychosis care, research. *Mental Health Weekly*, *31*(7), 1-3. https://dx.doi.org/10.1002/mhw.32681
207. California Strategic Growth Council. (2020). *Technical Assistance Guidelines for State Agencies*. Retrieved August 12, 2020 from https://sgc.ca.gov/meetings/council/2020/docs/20200826-TA_Guidelines.pdf.
208. Ibid.
209. Ibid.
210. Ibid.
211. Ibid.
212. DeCorby-Watson, K., Mensah, G., Bergeron, K., Abdi, S., Rempel, B., & Manson, H. (2018). Effectiveness of capacity building interventions relevant to public health practice: A systematic review. *BMC Public Health*, *18*(1), 1-15. https://dx.doi.org/10.1186/s12889-018-5591-6
213. Caulfield, A., Vatansever, D., Lambert, G., & Van Bortel, T. (2019). WHO guidance on mental health training: A systematic review of the progress for non-specialist health workers. *British Medical Journal Open*, *9*(1), e024059. https://doi.org/10.1136/bmjopen-2018-024059
214. Giles, L., Shepard, L., Asarnow, J., & Keeshin, B. R. (2021). Implementation of a trauma-informed suicide prevention intervention for youth presenting to the emergency department in crisis. *Evidence-Based Practice in Child and Adolescent Mental Health*, *6*(3), 343-353. https://dx.doi.org/10.1080/23794925.2021.1961643
215. Thomas, S., & Watson, A. (2017). A focus for mental health training for police. *Journal of Criminological Research, Policy and Practice, 3*(2), 93-104. https://dx.doi.org/10.1108/JCRPP-01-2017-0005
216. Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, *39*(4), 396. https://dx.doi.org/10.1037/0735-7028.39.4.396
217. The National Child Traumatic Stress Network. (n.d.). *About us.* Retrieved July 22, 2022, from https://www.nctsn.org/about-us
218. Ibid.
219. Ibid.
220. Ibid.
221. Ibid.
222. Ibid.
223. Ibid.
224. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
225. World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
226. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
227. Institute of Medicine (US) Committee on Prevention of Mental Disorders. (1994) In. Mrazek, P. J., & Haggerty, R. J. (Eds.). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. The National Academies Press. https://dx.doi.org/10.17226/2139

228. Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. https://dx.doi.org/10.3109/09540261.2014.928270
229. Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10(2)*, 227-237. https://doi.org/10.1177%2F1745691614568352
230. Paul, K. I., & Moser, K. (2009). Unemployment impairs mental health: Meta-analyses. *Journal of Vocational Behavior, 74*(3), 264–282. https://dx.doi.org/10.1016/j.jvb.2009.01.001
231. Buckley, P. F. (2006). Prevalence and consequences of the dual diagnosis of substance abuse and severe mental illness. *The Journal of Clinical Psychiatry, 67*(7), 5-9.
232. Chen, W. Y., Corvo, K., Lee, Y., & Hahm, H. C. (2017). Longitudinal trajectory of adolescent exposure to community violence and depressive symptoms among adolescents and young adults: Understanding the effect of mental health service usage. *Community Mental Health Journal, 53(*1), 39–52. https://dx.doi.org/10.1007/s10597-016-0031-5
233. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
234. Umberson, D., & Karas Montez, J. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior, 51*(1_suppl), S54-S66. https://doi.org/10.1177/0022146510383501
235. Institute of Medicine (US) Committee on Prevention of Mental Disorders. (1994) In. Mrazek, P. J., & Haggerty, R. J. (Eds.). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. The National Academies Press. https://dx.doi.org/10.17226/2139
236. Braveman, P., & Gruskin, S. (2003). Poverty, equity, human rights and health. *Bulletin of the World Health Organization, 81*(7), 539-45.
237. Office of the High Commissioner for Human Rights. (2000). CESCR general comment No. 14: The right to the highest attainable standard of health (Art. 12). *Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights.* https://www.refworld.org/pdfid/4538838d0.pdf
238. Narvaez, D. (Ed.). (2018). *Basic needs, wellbeing and morality: Fulfilling human potential*. Springer. https://dx.doi.org/10.1007/978-3-319-97734-8
239. Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*, *30*(4), 259-292. https://scielo.isciii.es/scielo.php?pid=S0213-61632016000400004&script=sci_arttext&tlng=en
240. Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., & Alvarez, K. (2018). Social determinants of mental health: Where we are and where we need to go. *Current Psychiatry Reports, 20*(11), 95. https://doi.org/10.1007/s11920-018-0969-9
241. Link, B.G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, 35*, 80-94. https://dx.doi.org/10.2307/2626958
242. Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. https://dx.doi.org/10.3109/09540261.2014.928270
243. Bohn, S., Thorman, T., & Herrera, J. (2022, July). Fact sheet: Income inequality in California. Public Policy Institute of California. https://www.ppic.org/publication/income-inequality-in-california/
244. Manzo, P., Gascon, H., Baum Block, B., & Beeby, D. (2021). *Struggling to move up: The real cost measure in California 2021*. United Ways of California. https://www.unitedwaysca.org/images/RealCostMeasure2021/The-Real-Cost-Measure-in-California-2021-Executive-Summary.pdf
245. California State Office of Rural Health. (2022, March 16). California. *Rural Health Information Hub.* https://www.ruralhealthinfo.org/states/california
246. Manzo, P., Gascon, H., Baum Block, B., & Beeby, D. (2021). *Struggling to move up: The real cost measure in California 2021*. United Ways of California. https://www.unitedwaysca.org/images/RealCostMeasure2021/The-Real-Cost-Measure-in-California-2021-Executive-Summary.pdf



247. Ibid.
248. The World Bank. (2022). *GDP (Current US$)*[infographic]. Retrieved August 16, 2022, from https://data.worldbank.org/indicator/NY.GDP.MKTP.CD
249. Manzo, P., Gascon, H., Baum Block, B., & Beeby, D. (2021). *Struggling to move up: The real cost measure in California 2021*. United Ways of California. https://www.unitedwaysca.org/images/RealCostMeasure2021/The-Real-Cost-Measure-in-California-2021-Executive-Summary.pdf
250. Ibid.
251. Churchwell, K., Elkind, M. S. V., Benjamin, R. M., Carson, A. P., Chang, E. K., Lawrence, W., Mills, A., Odom, T. M., Rodriguez, C. J., Rodriguez, F., Sanchez, E., Sharrief, A. Z., Sims, M., Williams, O., & American Heart Association. (2020). Call to action: Structural racism as a fundamental driver of health disparities: A presidential advisory from the American Heart Association. *Circulation, 142*(24), e454-e468. https://dx.doi.org/10.1161/CIR.0000000000000936.
252. U. S. Department of Health and Human Services. (2019). Reimbursement of mental health services in primary care settings. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma08-4324.pdf
253. Hamel, L., Wu, B., Brodie, M., & Kaiser Family Foundation. (2019). The health care priorities and experiences of California residents: Findings from the Kaiser Family Foundation/California Health Care Foundation California Health Policy Survey.
254. https://www.chcf.org/publication/2019-california-health-policy-survey/
255. Yearby, R. (2018). Racial disparities in health status and access to health care health care: The continuation of inequality in the United States due to structural racism. *American Journal of Economics and Sociology, 77*(3-4), 1113-1152. https://dx.doi.org/10.1111/ajes.12230
256. American Community Survey. (2021). *Health insurance coverage status and type of coverage by state and age for all persons: 2019.* (HI-05_ACS) [Survey Data Table]. United States Census Bureau. https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html
257. Let's Get Healthy California. (n.d.). Americans are paying more out-of-pocket for health care now than they did in the past decade. https://letsgethealthy.ca.gov/goals/lowering-the-cost-of-care/reducing-out-of-pocket-cost-for-health-carehealth-carehealth-care/
258. Bailey, Z. D., Feldman, J. M., & Bassett, M. T. (2021). How structural racism works—Racist policies as a root cause of US racial health inequities. *New England Journal of Medicine, 384*, 768-773. https://dx.doi.org/10.1056/NEJMms2025396
259. Kessler, R. C., Heeringa, S., Lakoma, M. D., Petukhova, M., Rupp, A. E., Schoenbaum, M., Wang, P. S., & Zaslavsky, A. M. (2008). Individual and societal effects of mental disorders on earnings in the United States: Results from the national comorbidity survey replication. *American Journal of Psychiatry, 165*(6), 703-711. https://doi.org/10.1176/appi.ajp.2008.08010126
260. Open Minds. (2020). The U.S. mental health market: $225.1 billion in spending in 2019: An OPEN MINDS market intelligence report. https://openminds.com/intelligence-report/the-u-s-mental-health-market-225-1-billion-in-spending-in-2019-an-open-minds-market-intelligence-report/
261. The White House. (2022, May 31). Reducing the economic burden of unmet mental health needs [Issue Brief]. https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/
262. Bloom, D. E., Cafiero, E., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., Feigl, A. B., Gaziano, T., Hamandi, A., Mowafi, M., O'Farrell, D., Ozaltin, E., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. Z., Weinstein, C., & Weiss, J. (2011). The global economic burden of noncommunicable diseases. *World Economic Forum.* https://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf
263. Davis, K. (2003). In the literature: The costs and consequences of being uninsured. *The Commonwealth Fund.* https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_in_the_literature_2003_jun_the_costs_and_consequences_of_being_uninsured_davis_consequences_itl_663_pdf.pdf

264. Ibid.
265. Ibid.
266. American Psychological Association. (2018). *Stress in America: Uncertainty about health care.* https://www.apa.org/news/press/releases/stress/2017/uncertainty-health-care.pdf
267. American Community Survey. (2021). *Health insurance coverage status and type of coverage by state and age for all persons: 2019.* (HI-05_ACS) [Survey Data Table]. United States Census Bureau. https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html
268. Dietz, M., Lucia, L., Kadiyala, S., Challenor, T., Rak, A., Roby, D.H., & Kominski, G.F. (2021, April 13). *Undocumented projected to remain California's largest group of uninsured in 2022*. California Health Care Foundation. https://www.chcf.org/blog/undocumented-projected-remain-californias-largest-group-uninsured-2022/
269. California State Office of Rural Health. (2022, March 16). California. *Rural health information hub.* https://www.ruralhealthinfo.org/states/california
270. Ibid.
271. https://wellbeingindex.sharecare.com/interactive-map/?defaultState=CA
272. California Department of Aging (n.d.). *Master plan for aging.* Retrieved September 12, 2022, from https://mpa.aging.ca.gov/
273. United States Census Bureau. (2022, September 13). Supplemental poverty measure. Retrieved September 14, 2022, from https://www.census.gov/topics/income-poverty/supplemental-poverty-measure.html
274. California Department of Aging (n.d.). *Master plan for aging.* Retrieved September 12, 2022, from https://mpa.aging.ca.gov/
275. Bohn, S., Bonner, D., Lafortune, J., & Thorman, T. (2020). Income inequality and economic opportunity in California. *Public Policy Institute.* https://www.ppic.org/wp-content/uploads/incoming-inequality-and-economic-opportunity-in-california-december-2020.pdf
276. Baldassare, M., Bonner, D., Lawler, R., & Thomas, D. (2021). PPIC Statewide Survey: California and their economic wellbeing. Public Policy Institute of California. https://www.ppic.org/publication/ppic-statewide-survey-californians-and-their-economic-well-being-november-2021/
277. California Forward. (2021). *California Dream Index.* Retrieved December 18, 2021, from https://www.cadreamindex.org/
278. Baldassare, M., Bonner, D., Lawler, R., & Thomas, D. (2021). PPIC Statewide Survey: California and their economic wellbeing. Public Policy Institute of California. https://www.ppic.org/publication/ppic-statewide-survey-californians-and-their-economic-well-being-november-2021/
279. Ibid.
280. Babones, S. J. (2008). Income inequality and population health: Correlation and causality. *Social Science & Medicine*, *66*(7), 1614-1626. https://doi.org/10.1016/j.socscimed.2007.12.012
281. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022. License: CC BY-NC-SA 3.0 IGO.
282. Benda, N. C., Veinot, T. C., Sieck, C. J., & Ancker, J. S. (2020). Broadband internet access is a social determinant of health! *American Journal of Public Health*, *110*(8), 1123-1125. https://dx.doi.org/10.2105/AJPH.2020.305784
283. Newman, K., Wang, A. H., Wang, A. Z. Y., & Hanna, D. (2019). The role of internet-based digital tools in reducing social isolation and addressing support needs among informal caregivers: A scoping review. *BMC Public Health*, *19*(1), 1495. https://dx.doi.org/10.1186/s12889-019-7837-3
284. Duplaga, M., & Szulc, K. (2019). The association of internet use with wellbeing, mental health and health behaviours of persons with disabilities. *International Journal of Environmental Research and Public Health*, *16*(18), 3252. https://dx.doi.org/10.3390/ijerph16183252
285. Vargo, D., Zhu, L., Benwell, B., & Yan, Z. (2021). Digital technology use during COVID-19 pandemic: A rapid review. *Human Behavior and Emerging Technologies*, *3*(1), 13-24. https://dx.doi.org/10.1002/hbe2.242
286. Graves, J. M., Abshire, D. A., Amiri, S., & Mackelprang, J. L. (2021). Disparities in technology and broadband internet access across rurality: Implications for health and education. *Family & Community Health*, *44*(4), 257–265. https://doi.org/10.1097/FCH.0000000000000306
287. Azzopardi-Muscat, N., & Sørensen, K. (2019). Towards an equitable digital public health era: Promoting equity through a health literacy perspective. *European Journal of Public Health*, *29*(Supplement_3), 13-17. https://doi.org/10.1093/eurpub/ckz166
288. Tebes, J. K., Champine, R. B., Matlin, S. L., & Strambler, M. J. (2019). Population health and trauma-informed practice: Implications for programs, systems, and policies. *American Journal of Community Psychology*, *64*(3-4), 494–508. https://doi.org/10.1002/ajcp.12382
289. Pinderhughes, H. Davis, R., & Williams, M. (2015). Adverse community experiences and resilience: A framework for addressing and preventing community trauma. *Justice Research and Statistics Association*. Retrieved November 12, 2020, from http://hdl.handle.net/20.500.11990/988
290. Franke, H. A. (2014). Toxic stress: Effects, prevention and treatment. *Children, 1*(3), 390-402. https://doi.org/10.3390/children1030390
291. Teicher, M. H., Andersen, S. L., Polcari, A., Anderson, C. M., Navalta, C. P., & Kim, D. M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience and Biobehavioral Reviews, 27*(1-2), 33-44. https://doi.org/10.1016/s0149-7634(03)00007-1
292. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8
293. Bhushan, D., Kotz, K., McCall, J., Wirtz, S., Gilgoff, R., Dube, S. R., Powers, C., Olson-Morgan, J., Galeste, M., Patterson, K., Harris, L., Mills, A., Bethell, C., Burke Harris, N., & Office of the California Surgeon General. (2020). *Roadmap for resilience: The California Surgeon General's report on adverse childhood experiences, toxic stress, and health.* Office of the California Surgeon General. https://dx.doi.org/10.48019/PEAM8812
294. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8
295. Centers for Disease Control and Prevention. (2019, November 5). *Vital signs: Adverse Childhood Experiences (ACEs)*. https://www.cdc.gov/vitalsigns/aces/index.html
296. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8
297. Bhushan, D., Kotz, K., McCall, J., Wirtz, S., Gilgoff, R., Dube, S. R., Powers, C., Olson-Morgan, J., Galeste, M., Patterson, K., Harris, L., Mills, A., Bethell, C., Burke Harris, N., & Office of the California Surgeon General. (2020). *Roadmap for resilience: The California Surgeon General's report on adverse childhood experiences, toxic stress, and health.* Office of the California Surgeon General. https://dx.doi.org/10.48019/PEAM8812
298. Let's Get Healthy California. (n.d.) Adverse childhood experiences have a lasting, harmful effect on health and well-being. Retrieved August 1, 2022, from https://letsgethealthy.ca.gov/goals/healthy-beginnings/adverse-childhood-experiences/
299. Ibid.
300. Miller, T. R., Waehrer, G. M., Oh, D. L., Boparai, S. P., Walker, S. O., Marques, S. S., & Harris, N. B. (2020). Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences. *PLoS One*, *15*(1), https://doi.org/10.1371/journal.pone.0228019

301. Thompson, M. P., Kingree, J. B., & Lamis, D. (2019). Associations of adverse childhood experiences and suicidal behaviors in adulthood in a U.S. nationally representative sample. *Child: Care, Health and Development, 45*(1), 121-128. https://doi.org/10.1111/cch.12617
302. Luo F, F. C. (2017). State-Level Lifetime Medical and Work-Loss Costs of Fatal Injuries — United States, 2014. *MWR Morbidity and Mortality Weekly Report, 66*, 1-11. https://doi.org/10.15585/mmwr.mm6601a1
303. Garcia, A. R., Gupta, M., Greeson, J. K. P., Thompson, A., & DeNard, C. (2017). Adverse childhood experiences among youth reported to child welfare: Results from the national survey of child & adolescent wellbeing. *Child Abuse & Neglect, 70*, 292-302. https://doi.org/10.1016/j.chiabu.2017.06.019
304. Child Trends (2018). Child Welfare Agency Spending in California. https://www.childtrends.org/wp-content/uploads/2018/12/California_SFY2016-CWFS_12.13.2018.pdf
305. Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics*, *111*(3), 564-572. https://doi.org/10.1542/peds.111.3.564
306. Bellis, M. A., Hughes, K., Ford, K., Rodriguez, G. R., Sethi, D., & Passmore, J. (2019). Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis. The Lancet Public Health, 4(10), e517-e528. https://doi.org/10.1016/S2468-2667(19)30145-8
307. Daines, C.L., Hansen, D., Novilla, M.L.B., & Crandall, A. (2021). Effects of positive and negative childhood experiences on adult family health. *BMC Public Health, 21*, 651 https://doi.org/10.1186/s12889-021-10732-w
308. Wang, D., Jiang, Q., Yang, Z., & Choi, J. K. (2021). The longitudinal influences of adverse childhood experiences and positive childhood experiences at family, school, and neighborhood on adolescent depression and anxiety. *Journal of affective disorders*, *292*, 542-551. https://doi.org/10.1016/j.jad.2021.05.108
309. Wang, D., Jiang, Q., Yang, Z., & Choi, J. K. (2021). The longitudinal influences of adverse childhood experiences and positive childhood experiences at family, school, and neighborhood on adolescent depression and anxiety. *Journal of affective disorders*, *292*, 542-551. https://doi.org/10.1016/j.jad.2021.05.108
310. Wang, D., Jiang, Q., Yang, Z., & Choi, J. K. (2021). The longitudinal influences of adverse childhood experiences and positive childhood experiences at family, school, and neighborhood on adolescent depression and anxiety. *Journal of affective disorders*, *292*, 542-551. https://doi.org/10.1016/j.jad.2021.05.108
311. Daines, C.L., Hansen, D., Novilla, M.L.B., & Crandall, A. (2021). Effects of positive and negative childhood experiences on adult family health. *BMC Public Health, 21*, 651 https://doi.org/10.1186/s12889-021-10732-w
312. Kira, I. A. (2001). Taxonomy of trauma and trauma assessment. *Traumatology, 7*(2), 73-86. https://doi.org/10.1177%2F153476560100700202
313. Luby, J. L., Constantino, J. N., & Barch, D. M. (2022). Poverty and developing brain. *Cerebrum: the Dana forum on brain science*, 2022, cer-04-22. http://www.ncbi.nlm.nih.gov/pmc/articles/pmc9224364/
314. Ibid.
315. Ibid.
316. Let's Get Healthy California. (n.d.) Adverse childhood experiences have a lasting, harmful effect on health and well-being. Retrieved August 1, 2022, from https://letsgethealthy.ca.gov/goals/healthy-beginnings/adverse-childhood-experiences/
317. Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*, *30*(4), 259-292. https://scielo.isciii.es/scielo.php?pid=S0213-61632016000400004&script=sci_arttext&tlng=en
318. Tan, S., Kudaravalli, S., & Kietzman, K. (2021). Who is caring for the caregivers? The financial, physical, and mental health costs of caregiving in California. *UCLA Center for Health Policy Research.* Policy Brief. ISSN 2691-7475. https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=2252
319. Reinhard, S. C., Feinberg, L. F., Choula, R., & Houser, A. (2015). Valuing the invaluable: 2015 update. *Insight on the Issues, 104*. https://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf
320. Johnson, B., Resnikoff, N., & Hashida, C. (2021). *The 2021-22 budget: Medi-Cal fiscal outlook*. *LAO Publications*. https://lao.ca.gov/reports/2020/4299/medi-cal-fiscal-outlook-111820.pdf
321. Meyer, K., Kaiser, N., Benton, D., Fitzpatrick, S. Gassoumis, Z., Wilber, K., & the California Task Force on Family Caregiving. (2018, July). Picking up the pace of change in California: A report from the California Task Force on Family Caregiving. USC Leonard Davis School of Gerontology. http://tffc.usc.edu/wp-content/uploads/2018/07/USC_CA_TFFC_Report_Digital-FINAL.pdf
322. Tan, S., Kudaravalli, S., & Kietzman, K. (2021). Who is caring for the caregivers? The financial, physical, and mental health costs of caregiving in California. *UCLA Center for Health Policy Research.* Policy Brief. ISSN 2691-7475. https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=2252
323. Pinderhughes, H. Davis, R., & Williams, M. (2015). Adverse community experiences and resilience: A framework for addressing and preventing community trauma. *Justice Research and Statistics Association*. Retrieved November 12, 2020, from http://hdl.handle.net/20.500.11990/988
324. Ibid.
325. Ibid.
326. Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981—2001. *Psychiatry*, *65*(3), 207-239.
327. Ibid.
328. Silver, R.C., Holman, E.A. & Garfin, D.R. Coping with cascading collective traumas in the United States. *Nature Human Behavior* 5, 4–6 (2021). https://doi.org/10.1038/s41562-020-00981-x
329. Dong, L., Leung, L. R., Qian, Y., Zou, Y., Song, F., & Chen, X. (2021). Meteorological environments associated with California wildfires and their potential roles in wildfire changes during 1984–2017. *Journal of Geophysical Research: Atmospheres*, *126*(5), e2020JD033180.
330. Afzal, M.H.B. (2021). California wildfire exposure, vulnerability, and mental health: Who gets to recover and who does not?" *APSA Preprints*. https://doi.org/10.33774/apsa-2021-c5jdz.
331. Silveira, S., Kornbluh, M., Withers, M. C., Grennan, G., Ramanathan, V., & Mishra, J. (2021). Chronic mental health sequelae of climate change extremes: A case study of the deadliest Californian wildfire. *International Journal of Environmental Research and Public Health*, *18*(4), 1487. https://doi.org/10.3390/ijerph18041487
332. Ibid.
333. Ibid.
334. Ingle, H. E., & Mikulewicz, M. (2020). Mental health and climate change: Tackling invisible injustice. *The Lancet Planetary Health*, *4*(4), e128-e130. https://doi.org/10.1016/S2542-5196(20)30081-4
335. Grajdura, S. & Niemeier, D. (2022). Inequities and injustices in large-scale California wildfire evacuations & post-evacuations. *SSRN.* http://dx.doi.org/10.2139/ssrn.4022006
336. Chase, J., & Hansen, P. (2021). Displacement after the Camp Fire: Where are the most vulnerable? *Society & Natural Resources, 34*(12), 1566-1583. https://doi.org/10.1080/08941920.2021.1977879
337. Wuebbles, D.J., D.W. Fahey, K.A. Hibbard, B. DeAngelo, S. Doherty, K. Hayhoe, R. Horton, J.P. Kossin, P.C. Taylor, A.M. Waple, and C.P. Weaver, 2017: Executive summary. In: Climate Science Special Report: Fourth National Climate Assessment, Volume I [Wuebbles, D.J., D.W. Fahey, K.A. Hibbard, D.J. Dokken, B.C. Stewart, and T.K. Maycock (eds.)]. U.S. Global Change Research Program, Washington, DC, USA, pp. 12-34. https://doi.org/10.7930/J0DJ5CTG.
338. Afzal, M.H.B. (2021). California wildfire exposure, vulnerability, and mental health: Who gets to recover and who does not?" *APSA Preprints*. https://doi.org/10.33774/apsa-2021-c5jdz.
339. World Health Organization. (2002). *Prevention and promotion in mental health*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf
340. Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. https://dx.doi.org/10.3109/09540261.2014.928270

341. World Health Organization. (2002). *Prevention and promotion in mental health*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf
342. Hahn, H. (2017). *Strategies for supporting basic needs to promote opportunity and economic mobility: Building ladders of opportunity for young people in the Great Lakes states*, brief, 5. Urban Institute. https://www.urban.org/sites/default/files/publication/94511/strategies-for-supporting-basic-needs-to-promote-opportunity_2.pdf
343. Centers for Disease Control and Prevention. (2021, April 6). *Fast facts: Preventing adverse childhood experiences*. National Center for Injury Prevention and Control, Division of Violence Prevention. https://www.cdc.gov/violenceprevention/aces/fastfact.html
344. U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response. (2015, June 9). *Community resilience.* Public Health Emergency. https://www.phe.gov/Preparedness/planning/abc/Pages/community-resilience.aspx#:~:text=Community%20resilience%20is%20the%20sustained,big%20part%20of%20overall%20resilience
345. World Health Organization. (2002). *Prevention and promotion in mental health*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf
346. Hahn, H. (2017). *Strategies for supporting basic needs to promote opportunity and economic mobility: Building ladders of opportunity for young people in the Great Lakes states*, brief, 5. Urban Institute. https://www.urban.org/sites/default/files/publication/94511/strategies-for-supporting-basic-needs-to-promote-opportunity_2.pdf
347. World Health Organization. (2022). *Themes: Monitoring health for SDGs.* The Global Health Observatory. https://www.who.int/health-topics/sustainable-development-goals
348. United Nations Department of Economic and Social Affairs. (n.d.) *Do you know all 17 SDGs?*. Retrieved July 26, 2022 from https://sdgs.un.org/goals
349. World Health Organization. (2021, April 1). Universal health coverage (UHC). Fact sheets. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
350. Ibid.
351. Ibid.
352. Seervai, S., Shah, A., & Osborn, R. (2017, October 17). How other countries achieve universal coverage. *To the Point, The Commonwealth Fund.* https://www.commonwealthfund.org/blog/2017/how-other-countries-achieve-universal-coverage
353. Gindi, R. M., Cohen, R. A., & Kirzinger, W. K. (2012). Emergency room use among adults aged 18-64: Early release of estimates from the National Health Interview Survey, January-June 2011. *Centers for Disease Control and Prevention.* https://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf
354. California Health and Human Services Agency. (2022). *Key design considerations for a unified health care financing system in California, final report*. Healthy California for All Commission. https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf
355. Ibid.
356. Galvani, A. P., Durham, D. P., Vermund, S. H., & Fitzpatrick, M. C. (2017). California Universal Health Care Bill: An economic stimulus and life-saving proposal. *Lancet*, *390*(10106), 2012–2014. https://doi.org/10.1016/S0140-6736(17)32148-7
357. Maruthappu, M., Watkins, J., Noor, A. M., Williams, C., Ali, R., Sullivan, R., Zeltner, T., & Atun, R. (2016). Economic downturns, universal health coverage, and cancer mortality in high-income and middle-income countries, 1990-2010: A longitudinal analysis. *Lancet*, *388*(10045), 684–695. https://doi.org/10.1016/S0140-6736(16)00577-8
358. California Health and Human Services Agency. (2022). *Key design considerations for a unified health care financing system in California, final report*. Healthy California for All Commission. https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf
359. Ibid.
360. National Center for Injury Prevention and Control (U.S.). Division of Violence Prevention. (2019). *Preventing adverse childhood experiences (ACEs): Leveraging the best available evidence*. Centers for Disease Control and Prevention. https://stacks.cdc.gov/view/cdc/82316
361. Ibid.
362. Troller-Renfree, S. V., Costanzo, M. A., Duncan, G. J., Magnuson, K., Gennetian, L. A., Yoshikawa, H., Halpern-Meekin, S., Fox, N. A., & Noble, K. G. (2022). The impact of a poverty reduction intervention on infant brain activity. *Proceedings of the National Academy of Sciences of the United States of America*, *119*(5), e2115649119. https://doi.org/10.1073/pnas.2115649119
363. Ibid.
364. West, S., Castro Baker, A., Samra, S., & Coltrera, E. (2020) Preliminary analysis: SEED's fist year. White Paper. Stocton, CA. https://static1.squarespace.com/static/6039d612b17d055cac14070f/t/6050294a1212aa40fdaf773a/1615866187890/SEED_Preliminary+Analysis-SEEDs+First+Year_Final+Report_Individual+Pages+.pdf
365. Ibid.
366. Ibid.
367. Felfe, C., Nollenberger, N., & Rodríguez-Planas, N. (2015). Can't buy mommy's love? Universal childcare and children's long-term cognitive development. *Journal of Population Economics*, *28*, 393–422. https://doi.org/10.1007/s00148-014-0532-x
368. National Center for Injury Prevention and Control (U.S.). Division of Violence Prevention. (2019). *Preventing adverse childhood experiences (ACEs): Leveraging the best available evidence*. Centers for Disease Control and Prevention. https://stacks.cdc.gov/view/cdc/82316
369. Larose, M., Côté, S. M., Ouellet-Morin, I., Maughan, B., & Barker, E. D. (2020). Promoting better functioning among children exposed to high levels of family adversity: The protective role of childcare attendance. *Journal of Child Psychology and Psychiatry, 62*(6), 762–770. https://dx.doi.org/10.1111/jcpp.13313
370. Berry, D., Blair, C., Willoughby, M., Garrett-Peters, P., Vernon-Feagans, L., Mills-Koonce, W. R., & Family Life Project Key Investigators. (2016). Household chaos and children's cognitive and socio-emotional development in early childhood: Does childcare play a buffering role? *Early Childhood Research Quarterly*, *34*, 115–127. https://dx.doi.org/10.1016/j.ecresq.2015.09.003
371. Powell, A., Thomason, S., & Jacobs, K. (2019, May). *Investing in early care and education: The economic benefits for California.* UC Berkeley Center for Labor Research and Education. https://laborcenter.berkeley.edu/investing-early-care-education-economic-benefits-california.
372. Ibid.
373. Ibid.
374. Ibid.
375. Ibid.
376. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
377. Silver, R.C., Holman, E.A. & Garfin, D.R. Coping with cascading collective traumas in the United States. *Nature Human Behavior* 5, 4–6 (2021). https://doi.org/10.1038/s41562-020-00981-x
378. Pastor, M., & Morello-Frosch, R. (2014). Integrating public health and community development to tackle neighborhood distress and promote well-being. *Health Affairs*, *33*(11), 1890-1896. https://doi.org/10.1377/hlthaff.2014.0640
379. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
380. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3

381. Levasseur, M., Généreux, M., Bruneau, J. F., Vanasse, A., Chabot, É., Beaulac, C., & Bédard, M. M. (2015). Importance of proximity to resources, social support, transportation and neighborhood security for mobility and social participation in older adults: Results from a scoping study. *BMC Public Health*, *15*(1), 503.
382. de Almeida, S. I. L., Gomes da Silva, M., & Marques, A. S. P. D. D. (2020). Home-based physical activity programs for people with dementia: Systematic review and meta-analysis. *The Gerontologist*, *60*(8), e600-e608. https://doi.org/10.1093/geront/gnz176
383. Fratiglioni, L., Marseglia, A., & Dekhtyar, S. (2020). Ageing without dementia: Can stimulating psychosocial and lifestyle experiences make a difference?. *The Lancet Neurology*, *19*(6), 533-543. https://doi.org/10.1016/S1474-4422(20)30039-9
384. Berkman, L. F., & Glass, T. (2000). Social integration, social networks, social support, and health. *Social Epidemiology, 1*(6), 137-173.
385. Tubadji, A. (2021). Culture and mental health resilience in times of COVID-19. *Journal of Population Economics, 34*, 1219–1259. https://doi.org/10.1007/s00148-021-00840-7
386. Sugiyama, T., Carver, A., Koohsari, M. J., & Veitch, J. (2018). Advantages of public green spaces in enhancing population health. *Landscape and Urban Planning*, *178*, 12-17. https://dx.doi.org/10.1016/j.landurbplan.2018.05.019
387. Maggi, S., Roberts, W., MacLennan, D., & D'Angiulli, A. (2011). Community resilience, quality childcare, and preschoolers' mental health: A three-city comparison. *Social Science & Medicine*, *73*(7), 1080–1087. https://doi.org/10.1016/j.socscimed.2011.06.052
388. Castillo, E.G., Ijadi-Maghsoodi, R., Shasravan, S., Moor, E., Mensah, M.O., Docherty, M., Aguilera Nunez, G.A., Barcelo, N., Goodsmith, N., Halpin, L.E., Morton, I., Mango, J., Montero, A.E., Rahmanian, K., Bromley, E., Chung, B., Jones, F., Gabrielian, S., Gelberg, L., Greenberg, J.M., Kalofonsos, I., Kataoka, S.H., Miranda, J., Pincus, H.A., Zima, B.T., & Wells, K.B. (2019). Community interventions to promote mental health and social equity. *Current Psychiatry Reports*, *21*(5), 1-14. https://doi.org/10.1007/s11920-019-1017-0
389. Azzopardi-Muscat, N., & Sørensen, K. (2019). Towards an equitable digital public health era: Promoting equity through a health literacy perspective. *European Journal of Public Health*, *29*(Supplement_3), 13-17. https://doi.org/10.1093/eurpub/ckz166
390. Ibid.
391. Chaptered by the Secretary of State. Chapter 112, Statutes of 2021.
392. Ibid.
393. State of California. (2022). *About opportunity zones.* https://opzones.ca.gov/
394. Office of the Comptroller of the Currency. (2021, January). *Community developments investments: Strengthening communities with opportunity zone investments community developments investments.* https://www.occ.gov/publications-and-resources/publications/community-affairs/community-developments-investments/jan-2021/pub-ca-cdi-newsletter-jan-2021.pdf
395. City of Eureka California. (2021, October). *Economic development strategic plan update.* https://legistarweb-production.s3.amazonaws.com/uploads/attachment/pdf/1080888/Attachment_1._Economic_Development_Strategic_Plan_Update.pdf
396. Ibid.
397. Ibid.
398. Ibid.
399. Pastor, M., & Morello-Frosch, R. (2014). Integrating public health and community development to tackle neighborhood distress and promote well-being. *Health Affairs*, *33*(11), 1890-1896. https://doi.org/10.1377/hlthaff.2014.0640
400. Ibid.
401. Wiehe, V. R. (1998). *Understanding family violence: Treating and preventing partner, child, sibling, and elder abuse.* Sage Publications, Inc. https://dx.doi.org/10.4135/9781452232003
402. Shonkoff, J. P., & Fisher, P. A. (2013). Rethinking evidence-based practice and two-generation programs to create the future of early childhood policy. *Development and Psychopathology, 25*(40 2), 1635–1653. https://dx.doi.org/10.1017%2FS0954579413000813
403. National Alliance for Caregiving & AARP. (2020, May). *Research report: Caregiving in the U.S.* Caregiving.org. https://www.caregiving.org/wp-content/uploads/2021/01/full-report-caregiving-in-the-united-states-01-21.pdf
404. Newland, L. A. (2014). Supportive family contexts: Promoting child well-being and resilience. *Early Child Development and Care*, *184*(9–10), 1336–1346. https://doi.org/10.1080/03004430.2013.875543
405. Shonkoff, J. P., & Fisher, P. A. (2013). Rethinking evidence-based practice and two-generation programs to create the future of early childhood policy. *Development and Psychopathology, 25*(40 2), 1635–1653. https://dx.doi.org/10.1017%2FS0954579413000813
406. Ibid.
407. Child Welfare Information Gateway. (2021). In-home services to strengthen children and families. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/issuebriefs/inhome-services/
408. Nurse Family Partnerships. (n.d.). *About us*. Retrieved November 6, 2020 from https://www.nursefamilypartnership.org/about/
409. Miller, T. R. (2015). Projected outcomes of nurse-family partnership home visitation during 1996–2013, USA. *Prevention Science*, *16*(6), 765-777. https://dx.doi.org/10.1007%2Fs11121-015-0572-9
410. Ibid.
411. Ibid.
412. Anderson, E. (2022). *A jump start on literacy: The effectiveness of a caregiver-implemented phonological awareness intervention* (Doctoral dissertation). http://hdl.handle.net/1773/48931
413. Jonson-Reid, M., Drake, B., Constantino, J. N., Tandon, M., Pons, L., Kohl, P., Roesch, S., Wideman, E., Dunnigan, A., & Auslander, W. (2018). A randomized trial of home visitation for CPS-involved families: The moderating impact of maternal depression and CPS history. *Child Maltreatment*, *23*(3), 281–293. https://doi.org/10.1177/1077559517751671
414. Reinhard, S. C., Given, B., Petlick, N. H., Bemis, A., & Hughes, R. G. (2008). Supporting family caregivers in providing care. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK2665/
415. Miller-Lewis, L. R., Sawyer, A. C., Searle, A. K., Mittinty, M. N., Sawyer, M. G., & Lynch, J. W. (2014). Student-teacher relationship trajectories and mental health problems in young children. *BMC Psychology,* 2(1), 27. https://doi.org/10.1186/s40359-014-0027-2
416. Daniels, D. H., & Shumow, L. (2003). Child development and classroom teaching: A review of the literature and implications for educating teachers. *Journal of Applied Developmental Psychology*, *23*(5), 495-526. https://dx.doi.org/10.1016/S0193-3973(02)00139-9
417. Sutherland, K. S., Conroy, M. A., Algina, J., Ladwig, C., Jessee, G., & Gyure, M. (2018). Reducing child problem behaviors and improving teacher-child interactions and relationships: A randomized controlled trial of BEST in CLASS. *Early Childhood Research Quarterly*, *42*(1st Quarter), 31-43. https://dx.doi.org/10.1016/j.ecresq.2017.08.001
418. Duran, F. B., Hepburn, K. S., Kaufmann, R. K., Le, L. T., Allen, M. D., Brennan, E. M., & Green, B. L. (2020). Early childhood mental health consultation. *Infant Mental Health Journal. 41*(3). http://dx.doi.org/10.1002/imhj.21865
419. Ibid.
420. Ibid.
421. Ibid.

422. Virmani, E. A., Masyn, K. E., Thompson, R. A., Conners-Burrow, N. A. & Mansell, L. W. (2013). Early childhood mental health consultation: Promoting change in the quality of teacher-child interactions. *Infant Mental Health Journal, 34*(2), 156-172. https://doi.org/10.1002/imhj.21358
423. Davis, A. E., Barrueco, S., & Perry, D. F. (2021). The role of consultative alliance in infant and early childhood mental health consultation: Child, teacher, and classroom outcomes. *Infant Mental Health Journal*, *42*(2), 246-262. https://doi.org/10.1002/imhj.21889
424. California State Preschool Programs: General Child Care and Development Programs: Mental Health Consultation Services: Adjustment Factors, 2698 California Assembly Bill § 8265.5 https://legiscan.com/CA/text/AB2698/id/1822040 (2018).
425. California Department of Education. (n.d.). Management Bulletin 19-02. https://www.cde.ca.gov/sp/cd/ci/mb1902.asp.
426. Governor Gavin Newsom. (2021). *California budget.* https://www.ebudget.ca.gov/2022-23/pdf/BudgetSummary/EarlyChildhood.pdf
427. Fredman, G., Papadopoulou, A., & Worwood, E. (2018). *Collaborative consultation in mental health: Guidelines for the new consultant*. Routledge. https://dx.doi.org/10.4324/9781315696652
428. World Health Organization. (2002). *Prevention and promotion in mental health*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf
429. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
430. Ibid.
431. Centers for Disease Control and Prevention. 2020, December 18). *Featured Campaigns.* https://www.cdc.gov/healthcommunication/campaigns/index.html
432. Jorm A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957
433. Gary F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*(10), 979–999. https://doi.org/10.1080/01612840500280638
434. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
435. Jorm A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957
436. Brown, J. S., Evans-Lacko, S., Aschan, L., Henderson, M. J., Hatch, S. L., & Hotopf, M. (2014). Seeking informal and formal help for mental health problems in the community: A secondary analysis from a psychiatric morbidity survey in South London. *BMC Psychiatry, 14*(1), 275. https://doi.org/10.1186/s12888-014-0275-y
437. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
438. Rickwood, D.J., Deane, F.P. and Wilson, C.J. (2007). When and how do young people seek professional help for mental health problems? *Medical Journal of Australia, 187*: S35-S39. https://doi.org/10.5694/j.1326-5377.2007.tb01334.x
439. Satcher, D. S. (2000). Executive summary: A report of the Surgeon General on mental health. *Public Health Reports*, *115*(1), 89-101. https://dx.doi.org/10.1093/phr/115.1.89
440. NBA.com. (2020, June 9). *Q.A. Surgeon General Jerome Adams on maintaining mental health during challenging times*. News Archive. https://www.nba.com/news/nba-together-surgeon-general-jerome-adams-qa
441. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
442. Ibid.
443. Haigh, C. B., Kringen, A. L., & Kringen, J. A. (2020). Mental illness stigma: Limitations of crisis intervention team training. *Criminal Justice Policy Review*, *31*(1), 42-57. https://dx.doi.org/10.1177/0887403418804871
444. Wong, E. C., Collins, R. L., Cerully, J. L., Roth, E., & Marks, J. S. (2015). Stigma, discrimination, and wellbeing among California adults experiencing mental health challenges. *RAND Health Quarterly, 5*(2), 11. https://doi.org/10.7249/RR1074
445. Mental Health Services Oversight and Accountability Commission. (2022). Workplace mental health: Creating voluntary standards to support mental health in the workplace for all Californians. https://mhsoac.ca.gov/initiatives/workplace-mental-health/
446. Ibid.
447. Wong, E. C., Collins, R. L., Cerully, J., Seelam, R., & Roth, B. (2017). Racial and ethnic differences in mental illness stigma and discrimination among Californians experiencing mental health challenges. *Rand health quarterly*, *6*(2). https://pubmed.ncbi.nlm.nih.gov/28845344
448. Ibid.
449. Listening Session summaries are posted here Visit www. https://mhsoac.ca.gov/initiatives/prevention-early-intervention/prevention-and-early-intervention-resources/#welltogether
450. Gary F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*(10), 979–999. https://doi.org/10.1080/01612840500280638
451. Wong, E. C., Collins, R. L., Cerully, J., Seelam, R., & Roth, B. (2017). Racial and ethnic differences in mental illness stigma and discrimination among Californians experiencing mental health challenges. *Rand health quarterly*, *6*(2). https://pubmed.ncbi.nlm.nih.gov/28845344
452. Jorm A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957
453. Kular, A., Perry, B. I., Brown, L., Gajwani, R., Jasini, R., Islam, Z., Birchwood, M., & Singh, S. P. (2019). Stigma and access to care in first-episode psychosis. *Early Intervention in Psychiatry*, *13*(5), 1208–1213. https://doi.org/10.1111/eip.12756
454. National Alliance on Mental Health. (n.d.). Warning signs and symptoms. Retrieved July 27, 2022 from https://www.nami.org/About-Mental-Illness/Warning-Signs-and-Symptoms
455. McGorry, P. D., Hartmann, J. A., Spooner, R., & Nelson, B. (2018). Beyond the "at risk mental state" concept: Transitioning to transdiagnostic psychiatry. *World Psychiatry*, *17*(2), 133-142. https://doi.org/10.1002/wps.20514
456. Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry, 20*(4), 359-364. https://doi.org/10.1097/YCO.0b013e32816ebc8c
457. Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiology and Psychiatric Sciences*, *17*(1), 14-19. https://doi.org/10.1017/S1121189X00002621
458. Kosyluk, K., Kenneally, R. G., Tran, J. T., Cheong, Y. F., Bolton, C., & Conner, K. (2022). Overcoming stigma as a barrier to children's mental health care: The role of empowerment and mental health literacy. *Stigma and Health*. https://doi.org/10.1037/sah0000402
459. Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179
460. Derose, K. P., Escarce, J. J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. *Health Affairs, 26*(5), 1258-1268. https://doi.org/10.1377/hlthaff.26.5.1258
461. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
462. Jorm A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957
463. Ibid.

464. Centers for Disease Control and Prevention. (2022, April 15). *Health communication strategies and resources*. https://npin.cdc.gov/pages/health-communication-strategies
465. Caulfield, A., Vatansever, D., Lambert, G., & Van Bortel, T. (2019). WHO guidance on mental health training: A systematic review of the progress for non-specialist health workers. *British Medical Journal Open*, *9*(1), e024059. https://doi.org/10.1136/bmjopen-2018-024059
466. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
467. Ibid.
468. Jung, H., von Sternberg, K., & Davis, K. (2017). The impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. *International Journal of Mental Health Promotion, 19*(5), 252-267. https://psycnet.apa.org/doi/10.1080/14623730.2017.1345687
469. Jorm A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957
470. Vamos, S., Okan, O., Sentell, T., & Rootman, I. (2020). Making a case for "Education for health literacy": An international perspective. *International Journal of Environmental Research and Public Health*, *17*(4), 1436. https://doi.org/10.3390/ijerph17041436
471. Jorm A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957
472. Ibid.
473. Mehta, N., Clement, S., Marcus, E., Stona, A. C., Bezborodovs, N., Evans-Lacko, S., Palacios, J., Docherty, M., Barley, E., Rose, D., Koschorke, M., Shidhaye, R., Henderson, C., & Thornicroft, G. (2015). Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: Systematic review. *The British Journal of Psychiatry*, *207*(5), 377–384. https://doi.org/10.1192/bjp.bp.114.151944
474. Collins, R.L., Wong, E.C., Breslau, J., Burnam, M. A., Cefalu, M., & Roth, E. (2019). Social marketing of mental treatment: California's mental illness stigma reduction campaign. *American Journal of Public Health, 109*, S228_S235, https://doi.org/10.2105/AJPH.2019.305129
475. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
476. Rideout, V., Fox, S., Peebles, A., & Robb, M. B. (2021). Coping with COVID-19: *How young people use digital media to manage their mental health*. San Francisco, CA: Common Sense and Hopelab. Retrieved from https://www.commonsensemedia.org/sites/default/files/research/report/2021-coping-with-covid19-full-report.pdf
477. Mheidly, N., & Fares, J. (2020). Leveraging media and health communication strategies to overcome the COVID-19 infodemic. *Journal of Public Health Policy*, *41*(4), 410-420. https://doi.org/10.1057/s41271-020-00247-w
478. Anwar, A., Malik, M., Raees, V., & Anwar, A. (2020). Role of mass media and public health communications in the COVID-19 pandemic. *Cureus*, *12*(9), e10453. https://doi.org/10.7759/cureus.10453
479. Kreuter, M. W., & McClure, S. M. (2004). The role of culture in health communication. *Annual Review of Public Health*, *25*(1), 439-455. https://doi.org/10.1146/annurev.publhealth.25.101802.123000
480. Nutbeam, D., Levin-Zamir, D., & Rowlands, G. (2018). Health literacy and health promotion in context. *Global Health Promotion*, *25*(4), 3-5. https://doi.org/10.1177/1757975918814436
481. Centers for Disease Control and Prevention. (2022, April 15). Health communication strategies and resources. Retrieved July 27, 2022, from https://npin.cdc.gov/pages/health-communication-strategies
482. HIV.gov. (2022, July 14). *Awareness campaigns*. U.S. Department of Health & Human Services. Retrieved July 27, 2022, from https://www.hiv.gov/federal-response/campaigns
483. U.S. Department of Health and Human Services, National Institute of Child Health and Development. (n.d.). *About SIDS and safe infant sleep*. https://safetosleep.nichd.nih.gov/safesleepbasics/about
484. U.S. Department of Health and Human Services, National Institute of Child Health and Development. (n.d.). *What is SIDS?* https://safetosleep.nichd.nih.gov/safesleepbasics/SIDS
485. U.S. Department of Health and Human Services, National Institute of Child Health and Development. (n.d.). *Key moments in Safe to Sleep® history: 1969–1993*. https://safetosleep.nichd.nih.gov/safesleepbasics/moments/1969-1993
486. U.S. Department of Health and Human Services, National Institute of Child Health and Development. (n.d.). Key moments in Safe to Sleep® history: 1994–2003. https://safetosleep.nichd.nih.gov/safesleepbasics/moments/1994-2003
487. Ibid.
488. U.S. Department of Health and Human Services, National Institute of Child Health and Development. (n.d.). *Progress in reducing SIDS*. https://safetosleep.nichd.nih.gov/activities/SIDS/progress
489. U.S. Department of Health and Human Services, National Institute of Child Health and Development. (n.d.). *Outreach activities in specific communities*. https://safetosleep.nichd.nih.gov/activities/outreach/activities
490. Collins, R.L., Wong, E.C., Breslau, J., Burnam, M. A., Cefalu, M., & Roth, E. (2019). Social marketing of mental treatment: California's mental illness stigma reduction campaign. *American Journal of Public Health, 109*, S228_S235, https://doi.org/10.2105/AJPH.2019.305129
491. Ibid.
492. Ibid.
493. Ibid.
494. Mehta, N., Clement, S., Marcus, E., Stona, A. C., Bezborodovs, N., Evans-Lacko, S., Palacios, J., Docherty, M., Barley, E., Rose, D., Koschorke, M., Shidhaye, R., Henderson, C., & Thornicroft, G. (2015). Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: Systematic review. *The British Journal of Psychiatry*, *207*(5), 377–384. https://doi.org/10.1192/bjp.bp.114.151944
495. Mental Health America. (n.d.). Position statement 41: Early identification of mental health issues in young people. https://www.mhanational.org/issues/position-statement-41-early-identification-mental-health-issues-young-people#_edn4
496. Fontanella, C. A., Warner, L. A., Steelesmith, D. L., Brock, G., Bridge, J. A., & Campo, J. V. (2020). Association of timely outpatient mental health services for youths after psychiatric hospitalization with risk of death by suicide. *JAMA Network Open, 3*(8), e2012887–e2012887. https://doi.org/10.1001/jamanetworkopen.2020.12887
497. Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Shin, J.I., Kirkbride, J.B., Jones, P., Kim, J.H., Kim, J.Y., Carbalho, A.F., Seeman, M.V., Correl, C.U., & Fusar-Poli, Paolo. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry* 27, 281–295 (2022). https://doi.org/10.1038/s41380-021-01161-7
498. Golay, P., Alameda, L., Mebdouhi, N., Baumann, P., Ferrari, C., Solida, A., Progin, P., Elowe, J., & Conus, P. (2017). Age at the time of onset of psychosis: A marker of specific needs rather than a determinant of outcome? *European Psychiatry*, *45*, 20–6. https://doi.org/10.1016/j.eurpsy.2017.06.002
499. Golay, P., Alameda, L., Mebdouhi, N., Baumann, P., Ferrari, C., Solida, A., Progin, P., Elowe, J., & Conus, P. (2017). Age at the time of onset of psychosis: A marker of specific needs rather than a determinant of outcome? *European Psychiatry*, *45*, 20–6. https://doi.org/10.1016/j.eurpsy.2017.06.002
500. Kular, A., Perry, B. I., Brown, L., Gajwani, R., Jasini, R., Islam, Z., Birchwood, M., & Singh, S. P. (2019). Stigma and access to care in first-episode psychosis. *Early Intervention in Psychiatry*, *13*(5), 1208–1213. https://doi.org/10.1111/eip.12756
501. Hasson-Ohayon, I., Goldzweig, G., Lavi-Rotenberg, A., Roe, D., & Pijnenborg, G. H. M. (2019). Illness representations among parents of children and adults with serious mental disorders: A systematic review and theoretical model. *European Psychiatry*, *58*, 27-37. https://dx.doi.org/10.1016/j.eurpsy.2019.02.001
502. Cabassa, L. J., Piscitelli, S., Haselden, M., Lee, R. J., Essock, S. M., & Dixon, L. B. (2018). Understanding pathways to care of individuals entering a specialized early intervention service for first-episode psychosis. *Psychiatric Services*, *69*(6), 648-656. https://dx.doi.org/10.1176/appi.ps.201700018

503. Ivey-Stephenson, A.Z., Demissie, Z., Crosby, A.E., Stone, D.M., GAylor, E., Wilkis, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students — Youth risk behavior survey, United States, 2019. *MMWR Supplements, 69*(Suppl-1):47–55. http://dx.doi.org/10.15585/mmwr.su6901a6external icon
504. Centers for Disease Control and Prevention. (2022, July 25). *10 leading causes of death, United States.* Leading Causes of Death (data visualization tool). https://wisqars.cdc.gov/data/lcd/home
505. Kular, A., Perry, B. I., Brown, L., Gajwani, R., Jasini, R., Islam, Z., Birchwood, M., & Singh, S. P. (2019). Stigma and access to care in first-episode psychosis. *Early Intervention in Psychiatry*, *13*(5), 1208–1213. https://doi.org/10.1111/eip.12756
506. Vamos, S., Okan, O., Sentell, T., & Rootman, I. (2020). Making a case for "Education for health literacy": An international perspective. *International Journal of Environmental Research and Public Health*, *17*(4), 1436. https://doi.org/10.3390/ijerph17041436
507. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
508. Delgado, M. (2019). *Community health workers in action: The efforts of "Promotores de Salud" in bringing health care to marginalized communities*. Oxford University Press.
509. Ibid.
510. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
511. Rideout, V., Fox, S., Peebles, A., & Robb, M. B. (2021). Coping with COVID-19: *How young people use digital media to manage their mental health*. San Francisco, CA: Common Sense and Hopelab. Retrieved from https://www.commonsensemedia.org/sites/default/files/research/report/2021-coping-with-covid19-full-report.pdf
512. National Institute of Mental Health. (2019, September). *Technology and the future of mental health treatment*. Retrieved December 8, 2021, from https://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment
513. Pretorius, C., Chambers, D., Cowan, B., & Coyle, D. (2019). Young people seeking help online for mental health: Cross-sectional survey study. *JMIR Mental Health*, *6*(8), e13524. https://doi.org/10.2196/13524
514. Swire-Thompson, B., & Lazer, D. (2019). Public health and online misinformation: Challenges and recommendations. *Annual Review of Public Health*, *41*, 433-451. https://doi.org/10.1146/annurev-publhealth-040119-094127
515. Stawarz, K., Preist, C., & Coyle, D. (2019). Use of smartphone apps, social media, and web-based resources to support mental health and well-being: Online survey. *JMIR mental health*, *6*(7), e12546. https://doi.org/10.2196/12546
516. Abi-Jaoude, E., Naylor, K. T., & Pignatiello, A. (2020). Smartphones, social media use and youth mental health. *Canadian Medical Association Journal, 192*(6), E136-E141. https://doi.org/10.1503/cmaj.190434
517. Figueroa, C. A., & Aguilera, A. (2020). The need for a mental health technology revolution in the COVID-19 pandemic. *Frontiers in Psychiatry*, *11*, 523. https://doi.org/10.3389/fpsyt.2020.00523
518. CredibleMind. (2020). *Live well Madera County resources for mental health and wellbeing*. Retrieved August 07, 2022, from https://madera.crediblemind.com/
519. CalHOPE. (2021). *Together for wellness*. https://calhope.semel.ucla.edu/
520. Vamos, S., Okan, O., Sentell, T., & Rootman, I. (2020). Making a case for "Education for health literacy": An international perspective. *International Journal of Environmental Research and Public Health*, *17*(4), 1436. https://doi.org/10.3390/ijerph17041436
521. Sanne, B., Mykletun, A., Dahl, A.A., Moen, B.E., & Tell, GS. (2005). *Testing the job demand-control-support model with anxiety and depression as outcomes: The Hordaland Health Study*. *Occupational Medicine 55,* 463-73. https://doi.org/10.1093/occmed/kqi071
522. Caulfield, A., Vatansever, D., Lambert, G., & Van Bortel, T. (2019). WHO guidance on mental health training: A systematic review of the progress for non-specialist health workers. *British Medical Journal Open*, *9*(1), e024059. https://doi.org/10.1136/bmjopen-2018-024059



523. United States Census Bureau. (n.d.). *Quick facts.* [Data summary tables]. Retrieved August 07, 2022, from https://www.census.gov/quickfacts/fact/table/CA/LFE041220
524. Taillac, C. (2020, October 5). *The new workplace is trauma informed*. Kaiser Permanente: Business. Retrieved December 31, 2020, from https://business.kaiserpermanente.org/insights/covid-19/trauma-informed-workplace
525. Abdin, S., Welch, R.K., Byron-Daniel, J. & Meyrick, J. (2018). The effectiveness of physical activity interventions in improving well-being across office-based workplace settings: A systematic review. *Public Health, 160*: 70-76. https://doi.org/10.1016/j.puhe.2018.03.029
526. Canadian Centre for Occupational Health and Safety.(2022, August, 24). *Mental health – Psychosocial risk factors in the workplace.* Retrieved August 24, 2022, from https://www.ccohs.ca/oshanswers/psychosocial/mentalhealth_risk.html
527. Brohan, E., & Thornicroft, G. (2010). Stigma and discrimination of mental health problems: Workplace implications. [Editorial]. *Occupational Medicine, 60*(6), 414–415. https://psycnet.apa.org/doi/10.1093/occmed/kqq048
528. Dimoff, J. K., & Kelloway, E. K. (2019). With a little help from my boss: The impact of workplace mental health training on leader behaviors and employee resource utilization. *JOURNAL OF OCCUPATIONAL HEALTH PSYCHOLOGY*, *24*(1), 4–19. https://doi.org/10.1037/ocp0000126
529. Gayed, A., Milligan-Saville, J. S., Nicholas, J., Bryan, B. T., LaMontagne, A. D., Milner, A., Madan, I., Calvo, R.A., Christnsen, H., Mykletun, A., Nicholas, G., & Harvey, S. B. (2018). Effectiveness of training workplace managers to understand and support the mental health needs of employees: A systematic review and meta-analysis. *Occupational and Environmental Medicine*, *75*(6), 462-470. http://dx.doi.org/10.1136/oemed-2017-104789
530. Attridge, M. (2019). A global perspective on promoting workplace mental health and the role of employee assistance programs. *American Journal of Health Promotion*, *33*(4), 622-629. https://doi.org/10.1177%2F0890117119838101c
531. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
532. Ibid.
533. Dimoff, J. K., & Kelloway, E. K. (2019). With a little help from my boss: The impact of workplace mental health training on leader behaviors and employee resource utilization. *JOURNAL OF OCCUPATIONAL HEALTH PSYCHOLOGY*, *24*(1), 4–19. https://doi.org/10.1037/ocp0000126
534. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
535. Kaiser Permanente. (2022). Mental health awareness training. https://business.kaiserpermanente.org/thrive/leadership-training-mental-health-awareness
536. Ibid.
537. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
538. Ibid.
539. Mcluckie, A., Kutcher, S., Wei, Y., & Weaver, C. (2014). Sustained improvements in students' mental health literacy with use of a mental health curriculum in Canadian schools. *BMC Psychiatry*, *14*(1), 1-6. https://doi.org/10.1186/s12888-014-0379-4
540. Chao, H. J., Lien, Y. J., Kao, Y. C., Tasi, I. C., Lin, H. S., & Lien, Y. Y. (2020). Mental health literacy in health care students: An expansion of the Mental Health Literacy Scale. *International Journal of Environmental Research and Public Health*, *17*(3), 948. https://doi.org/10.3390/ijerph17030948
541. Chao, H. J., Lien, Y. J., Kao, Y. C., Tasi, I. C., Lin, H. S., & Lien, Y. Y. (2020). Mental health literacy in health care students: An expansion of the Mental Health Literacy Scale. *International Journal of Environmental Research and Public Health*, *17*(3), 948. https://doi.org/10.3390/ijerph17030948

542. Fagan, A.A., Bumbarger, B.K., Barth, R.P., Bradshaw, C.P., Cooper, B.R., Supplee, L.H., & Walker, D.K. (2019). Scaling up evidence-based interventions in US public systems to prevent behavioral health problems: Challenges and opportunities. *Prevention Science 20,* 1147–1168. https://doi.org/10.1007/s11121-019-01048-8
543. Milin, R., Kutcher, S., Lewis, S. P., Walker, S., Wei, Y., Ferrill, N., & Armstrong, M. A. (2016). Impact of a mental health curriculum on knowledge and stigma among high school students: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*(5), 383-391. https://doi.org/10.1016/j.jaac.2016.02.018
544. Muir-Cochrane, E., O'Kane, D., McAllister, M., Levett-Jones, T., & Gerace, A. (2018). Reshaping curricula: Culture and mental health in undergraduate health degrees. *International Journal of Mental Health Nursing*, *27*(2), 652–661. https://doi.org/10.1111/inm.12350
545. Chao, H. J., Lien, Y. J., Kao, Y. C., Tasi, I. C., Lin, H. S., & Lien, Y. Y. (2020). Mental health literacy in health care students: An expansion of the Mental Health Literacy Scale. *International Journal of Environmental Research and Public Health*, *17*(3), 948. https://doi.org/10.3390/ijerph17030948
546. Whitley, J., Smith, J. D., & Vaillancourt, T. (2013). Promoting mental health literacy among educators: Critical in school-based prevention and intervention. *Canadian Journal of School Psychology*, *28*(1), 56-70. https://doi.org/10.1111/eip.12793
547. Lane-Martin, A. (2019). The benefits of student-led health promotion intervention. *The Journal of Mental Health Training, Education and Practice*. https://doi.org/10.1108/JMHTEP-04-2019-0023
548. Davis-Bordovsky, K. (2020). Project mental health awareness: A multimedia, peer-to-peer pilot school curriculum. *Contemporary School Psychology*, 1-5. https://doi.org/10.1007/s40688-020-00296-8
549. Mental Health Services Oversight and Accountability Commission. (2021). *The school mental health project*. https://mhsoac.ca.gov/initiatives/school-mental-health-project/
550. Ibid.
551. Chaptered by the Secretary of State. Chapter 675, Statues of 2021
552. Ibid.
553. Chaptered by the Secretary of State. Chapter 672, Statues of 2021
554. Atkins, M. S., Hoagwood, K. E., Kutash, K., & Seidman, E. (2010). Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1-2), 40-47. https://doi.org/10.1007/s10488-010-0299-7
555. National Alliance on Mental Illness. (n.d.) *Mental health in California.* https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/CaliforniaStateFactSheet.pdf
556. Padilla-Frausto, I., & Salem, S. (2020). Nearly 2 million California adults not getting needed public mental health services. *UCLA Center for Health Policy Research.* (Policy brief ISSN 2691-7475) https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/mentalhealth-policybrief-jun2020.pdf
557. Ibid.
558. Wright, B., Padilla-Frausto, D.I., Crawford-Roberts, A., Tse, H.W., Kabir, F., & Salem, S., (2021). *Nearly 1 in 3 adolescents in California reports serious psychological distress*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/Teen_Mental_Health_PB_FINAL.pdf
559. World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, and practice. Summary report*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42940/9241591595.pdf
560. Williams, M. E., Latta, J., & Conversano, P. (2008). Eliminating the wait for mental health services. *Journal of Behavioral Health Services & Research, 35*(1), 107–114. https://doi.org/10.1007/s11414-007-9091-1
561. Bruns EJ, Kerns SEU, Pullmann MD, Hensley SW, Lutterman T, & Hoagwood KE. (2016). Research, data, and evidence-based treatment use in state behavioral health systems, 2001–2012. *Psychiatric Services, 67*:496– 503. https://doi.org/10.1176/appi.ps.201500014
562. Csillag, C., Nordentoft, M., Mizuno, M., Jones, P. B., Killackey, E., Taylor, M., Chen, E., Kane, J., & McDaid, D. (2016). Early intervention services in psychosis: From evidence to wide implementation. *Early Intervention in Psychiatry, 10*(6), 540–546. https://doi.org/10.1111/eip.12279
563. World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
564. Ibid.
565. Padilla-Frausto, I., & Salem, S. (2020). Nearly 2 million California adults not getting needed public mental health services. *UCLA Center for Health Policy Research.* (Policy brief ISSN 2691-7475) https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/mentalhealth-policybrief-jun2020.pdf
566. Ibid.
567. Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research, 39*(2), 393-415. https://doi.org/10.1111/j.1475-6773.2004.00234.x
568. Bloom, D. E., Cafiero, E., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., Feigl, A. B., Gaziano, T., Hamandi, A., Mowafi, M., O'Farrell, D., Ozaltin, E., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. Z., Weinstein, C., & Weiss, J. (2011). The global economic burden of noncommunicable diseases. *World Economic Forum.* https://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf.
569. Tran, L. D., & Ponce, N. A. (2017). Who gets needed mental health care? Use of mental health services among adults with mental health need in California. *Californian journal of Health Promotion*, *15*(1), 36. https://pubmed.ncbi.nlm.nih.gov/28729814
570. California Code of Regulations, Title 9, Section 1830.
571. Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine, 41(8)*, 1751–1761. https://doi.org/10.1017/S0033291710002291
572. Williams, M. E., Latta, J., & Conversano, P. (2008). Eliminating the wait for mental health services. *Journal of Behavioral Health Services & Research, 35*(1), 107–114. https://doi.org/10.1007/s11414-007-9091-1
573. Kessler, R. C., & Price, R. H. (1993). Primary prevention of secondary disorders: A proposal and agenda. *American Journal of Community Psychology, 21*(5), 607-633. http://dx.doi.org/10.1007/bf00942174
574. Padilla-Frausto, I., & Salem, S. (2020). Nearly 2 million California adults not getting needed public mental health services. *UCLA Center for Health Policy Research.* (Policy brief ISSN 2691-7475) https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/mentalhealth-policybrief-jun2020.pdf
575. Schley, C., Pace, N., Mann, R., McKenzie, C., McRoberts, A., & Parker, A. (2019). The headspace brief interventions clinic: Increasing timely access to effective treatments for young people with early signs of mental health problems. *Early Intervention in Psychiatry, 13*(5), 1073-1082. https://doi.org/10.1111/eip.12729
576. Schley, C., Pace, N., Mann, R., McKenzie, C., McRoberts, A., & Parker, A. (2019). The headspace brief interventions clinic: Increasing timely access to effective treatments for young people with early signs of mental health problems. *Early Intervention in Psychiatry, 13*(5), 1073-1082. https://doi.org/10.1111/eip.12729
577. Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry, 20*(4), 359-364. https://doi.org/10.1097/YCO.0b013e32816ebc8c
578. Shuffrey, L.C., Thomason, M.E., Brito, N.H. (2022). Improving perinatal maternal mental health starts with addressing structural inequities. *JAMA Psychiatry, 79*(5):387–388. https://doi.org/10.1001/jamapsychiatry.2022.0097
579. American Association of Geriatric Psychiatry) (2008). *Geriatrics and mental health—the facts*. http://www.aagponline.org/prof/facts_mh.asp
580. California Department of Public Health. (2021). *California suicide and self-harm trends in 2020.* https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/SuicideAndSelfHarmIn2020-DataBrief-ADA.pdf

581. California State Auditor. (2019). Department of health care services. Millions of children in Medi-Cal are not receiving preventive health services. Report 2018-111. https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf
582. Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Shin, J.I., Kirkbride, J.B., Jones, P., Kim, J.H., Kim, J.Y., Carbalho, A.F., Seeman, M.V., Correl, C.U., & Fusar-Poli, Paolo. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry, 27,* 281–295. https://doi.org/10.1038/s41380-021-01161-7
583. California Code of Regulations, Title 9, Section 1830.
584. Ibid.
585. Ibid.
586. McGorry, P. D., Hartmann, J. A., Spooner, R., & Nelson, B. (2018). Beyond the "at risk mental state" concept: Transitioning to transdiagnostic psychiatry. *World Psychiatry*, *17*(2), 133-142. https://doi.org/10.1002/wps.20514
587. Schley, C., Pace, N., Mann, R., McKenzie, C., McRoberts, A., & Parker, A. (2019). The headspace brief interventions clinic: Increasing timely access to effective treatments for young people with early signs of mental health problems. *Early Intervention in Psychiatry, 13*(5), 1073-1082. https://doi.org/10.1111/eip.12729
588. Reichert, A., & Jacobs, R. (2018). The impact of waiting time on patient outcomes: Evidence from early intervention in psychosis services in England. *Health Economics, 27*(11), 1772-1787. http://doi.org/10.1002/hec.3800
589. Fontanella, C. A., Warner, L. A., Steelesmith, D. L., Brock, G., Bridge, J. A., & Campo, J. V. (2020). Association of timely outpatient mental health services for youths after psychiatric hospitalization with risk of death by suicide. *JAMA Network Open, 3*(8), e2012887–e2012887. https://doi.org/10.1001/jamanetworkopen.2020.12887
590. Mental Health Services Oversight and Accountability Commission. (2022). *Mental health crisis triage*. Retrieved August 16, 2022 from https://mhsoac.ca.gov/initiatives/triage/
591. Johnson, S., Dalton-Locke, C., Baker, J., Hanlon, C., Salisbury, T. T., Fossey, M., Newbigging, K., Carr, S. E., Hensel, J., Carrà, G., Hepp, U., Caneo, C., Needle, J. J., & Lloyd-Evans, B. (2022). Acute psychiatric care: Approaches to increasing the range of services and improving access and quality of care. *World Psychiatry, 21*(2), 220–236. https://doi.org/10.1002/wps.20962
592. Mental Health Services Oversight and Accountability Commission. (2022). *Mental health crisis triage*. Retrieved August 16, 2022, from https://mhsoac.ca.gov/initiatives/triage/
593. Ibid.
594. Ibid.
595. Durbin, J., Goering, P., Streiner, D. L., & Pink, G. (2006). Does Systems Integration Affect Continuity of Mental Health Care? Administration and Policy in Mental Health and Mental Health Services Research, 33(6), 705-717. doi:10.1007/s10488-006-0087-6
596. Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across of mental health care. *Health Services Research, 49*(1), 206-229. https://doi.org/10.1111/1475-6773.12095
597. Romanelli, M., & Hudson, K. D. (2017). Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *American Journal of Orthopsychiatry, 87*(6), 714. https://doi.org/10.1037/ort0000306
598. Pomerantz, A., Cole, B. H., Watts, B. V., & Weeks, W. B. (2008). Improving efficiency and access to mental health care: Combining integrated care and advanced access.*General Hospital Psychiatry, 30*(6), 546-551. https://doi.org/10.1016/j.genhosppsych.2008.09.004
599. Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629-640. https://doi.org/10.1001/archpsyc.62.6.629
600. Durbin, J., Goering, P., Streiner, D. L., & Pink, G. (2006). Does systems integration affect continuity of mental health care? *Administration and Policy in Mental Health and Mental Health Services Research, 33*(6), 705-717. https://doi.org/10.1007/s10488-006-0087-6
601. Smith, T.E., Kurk, M., Sawhney, R., Bao, Y., Nossel, I., Cohen, D.E., & Dixon, L.B., (2019). Estimated staff time effort, costs, and medicaid revenues for Coordinated Specialty Care clinics serving clients with first-episode psychosis. *Psychiatric Services 70,* 425–427. https://doi.org/10.1176/appi.ps.201900039
602. Coffman, J., Bates, T., Geyn, I., & Spetz, J. (2018). *California's current and future behavioral health workforce.* Health Force Center, University of California San Francisco. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf
603. Feinstein, R. E., Kotara, S., Jones, B., Shanor, D., & Nemeroff, C. B. (2020). A health care workers mental health crisis line in the age of COVID-19. *Depression and Anxiety*, *37*(8), 822-826. https://doi.org/10.1002/da.23073
604. Health Resources and Services Administration. (2022). *About the data.* Retrieved September 16, 2022, from https://data.hrsa.gov/data/about
605. Health Resources and Services Administration. (2022). *About the data.* Retrieved September 16, 2022, from https://data.hrsa.gov/data/about
606. Health Resources and Services Administration. (2022). *HPSA Find.* Retrieved September 16, 2022, from https://data.hrsa.gov/tools/shortage-area/hpsa-find
607. Coffman, J., Bates, T., Geyn, I., & Spetz, J. (2018). *California's current and future behavioral health workforce.* Health Force Center, University of California San Francisco. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf
608. American Association for Marriage and Family Therapy. (2022). *Medicare Coverage of Marriage and Family Therapists.* https://www.aamft.org/Advocacy/Medicare.aspx
609. Feinstein, R. E., Kotara, S., Jones, B., Shanor, D., & Nemeroff, C. B. (2020). A health care workers mental health crisis line in the age of COVID-19. *Depression and Anxiety*, *37*(8), 822-826. https://doi.org/10.1002/da.23073
610. American Academy of Child and Adolescent Psychiatry. (2022). *Workforce maps by state.* Retrieved September 16, 2022, from https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx
611. California Task Force on the Status of Maternal Mental Health and 2020 Mom. (2017). *A report from the California Task Force on the Status of Maternal Mental Health Care.* CATaskForce MMH Report.pdf
612. Ibid.
613. Coffman, J., Bates, T., Geyn, I., & Spetz, J. (2018). *California's current and future behavioral health workforce.* Health Force Center, University of California San Francisco. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf
614. Coffman, J., Bates, T., Geyn, I., & Spetz, J. (2018). *California's current and future behavioral health workforce.* Health Force Center, University of California San Francisco. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf
615. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). *Communities in action: Pathways to health equity*. National Academies Press (US).
616. Bates, T., Blash, L., & Chapman, S. (2014). *Diversity in California's mental health workforce and education pipeline.* University of California San Francisco, Center for the Health Professionals. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/2014_07_Diversity_in_Californias_Mental_Health_Workforce_and_Education_Pipeline_0.pdf
617. Frank, J.C., Kietzman, K.G., & Palimaru, A. (2019). California's behavioral health services workforce is inadequate for older adults. *UCLA Center for Health Policy Research*. Los Angeles, CA. https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/workforce-policybrief-jan2019.pdf
618. Ibid.https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/workforce-policybrief-jan2019.pdf
619. Ibid.
620. Ibid.

621. Gaeta, L., & Brydges, C. R. (2021). Coronavirus-related anxiety, social isolation, and loneliness in older adults in Northern California during the stay-at-home order. *Journal of Aging & Social Policy*, *33*(4-5), 320-331. https://doi.org/10.1080/08959420.2020.1824541
622. Lebrasseur, A., Fortin-Bédard, N., Lettre, J., Raymond, E., Bussières, E. L., Lapierre, N., Faieta, J., Vincent, C., Duchesne, L., Ouellet, M., Gagon, E., Touringny, A., Lamontagne, M., & Routhier, F. (2021). Impact of the COVID-19 pandemic on older adults: Rapid review. *JMIR Aging*, *4*(2), e26474. https://doi.org/10.2196/26474
623. Krendl, A. C., & Perry, B. L. (2021). The impact of sheltering in place during the COVID-19 pandemic on older adults' social and mental well-being. *The Journals of Gerontology: Series B*, *76*(2), e53-e58. https://doi.org/10.1093/geronb/gbaa110
624. Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10(2)*, 227-237. https://doi.org/10.1177%2F1745691614568352
625. World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, and practice. Summary report*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42940/9241591595.pdf
626. Marquine, M. J., & Jimenez, D. (2020). Cultural and linguistic proficiency in mental health care: A crucial aspect of professional competence. *International Psychogeriatrics*, *32*(1), 1–3. https://doi.org/10.1017/S1041610219000541
627. Williams, M. E., Latta, J., & Conversano, P. (2008). Eliminating the wait for mental health services. *Journal of Behavioral Health Services & Research, 35*(1), 107–114. https://doi.org/10.1007/s11414-007-9091-1
628. Mental Health America. (n.d.). Position statement 41: Early identification of mental health issues in young people. https://www.mhanational.org/issues/position-statement-41-early-identification-mental-health-issues-young-people#_edn4
629. Butkus, R., Rapp, K., Cooney, T. G., Engel, L. S., & Health and Public Policy Committee of the American College of Physicians. (2020). Envisioning a better U. S. health care system for all: Reducing barriers to care and addressing social determinants of health. *Annals of Internal Medicine*, *172*(2_Supplement), S50-S59. https://doi.org/10.7326/M19-2410
630. Mental Health Services Oversight and Accountability Commission. (2022). *Mental health crisis triage*. Retrieved August 16, 2022, from https://mhsoac.ca.gov/initiatives/triage/
631. Speechley, M., Kunnilathu, A., Aluckal, E., Balakrishna, M. S., Mathew, B., & George, E. K. (2017). Screening in public health and clinical care: Similarities and differences in definitions, types, and aims - A systematic review. *Journal of Cinical and Diagnostic Research*, *11*(3), LE01–LE04. https://doi.org/10.7860/JCDR/2017/24811.9419
632. Marlow, M., Servili, C., & Tomlinson, M. (2019). A review of screening tools for the identification of autism spectrum disorders and developmental delay in infants and young children: Recommendations for use in low-and middle-income countries. *Autism Research*, *12*(2), 176-199. https://doi.org/10.1002/aur.2033
633. Smith, R. A., Andrews, K. S., Brooks, D., Fedewa, S. A., Manassaram-Baptiste, D., Saslow, D., & Wender, R. C. (2019). Cancer screening in the United States, 2019: A review of current American Cancer Society guidelines and current issues in cancer screening. *CA: A Cancer Journal for Clinicians*, *69*(3), 184-210. https://doi.org/10.3322/caac.21557
634. Ekoe, J. M., Goldenberg, R., & Katz, P. (2018). Screening for diabetes in adults. *Canadian Journal of Diabetes*, *42*, S16-S19. https://doi.org/10.1016/j.jcjd.2017.10.004
635. Lofters, A. K., O'Brien, M. A., Sutradhar, R., Pinto, A. D., Baxter, N. N., Donnelly, P., Elliott, R., Glazier, R.H., Huizinga, J., Kyle, R., Manca, D., Pietrusiak, M.A., Rabeneck, L., Riordan, B., Selby, P., Sivayoganathan, K., Snider, C., Sopcak, N., Thorpe, K., Tinmouth, J., Wall, B., Zuo, F., Grunfeld, E., & Paszat, L. (2021). Building on existing tools to improve chronic disease prevention and screening in public health: A cluster randomized trial. *BMC Public Health*, *21*(1), 1-11. https://doi.org/10.1186/s12889-021-11452-x
636. World Health Organization. (2013). *Systematic screening for active tuberculosis: Principles and recommendations*. World Health Organization.
637. Mental Health America Board of Directors. (2016, September 18). Position statement 41: Early identification of mental health issues in young people. *Mental Health America.* https://www.mhanational.org/issues/position-statement-41-early-identification-mental-health-issues-young-people.
638. Ibid.
639. Mulvaney-Day, N., Marshall, T., Downey Piscopo, K., Korsen, N., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Ghose, S. S. (2018). Screening for behavioral health conditions in primary care settings: A systematic review of the literature. *Journal of General Internal Medicine*, *33*(3), 335–346. https://doi.org/10.1007/s11606-017-4181-0
640. Selvaraj, K., Ruiz, M. J., Aschkenasy, J., Chang, J. D., Heard, A., Minier, M., Osta, A.D., Pavelack, M., Samelson, M., Schwartz, A., Scotellaro, M.A., Seo-Lee, A., Sonu, S., Stillerman, A., & Bayldon, B. W. (2019). Screening for toxic stress risk factors at well-child visits: The addressing social key questions for health study. *The Journal of Pediatrics*, *205*, 244-249. https://doi.org/10.1016/j.jpeds.2018.09.004
641. de Pablo, G. S., De Micheli, A., Solmi, M., Oliver, D., Catalan, A., Verdino, V., Di Maggion, L., Bonoldi, I., Radua, J., Boy, O.B., Provenzani, U., Ruzzi, F., Calorio, F., Nosari, G., Di Marco, B., Famularo, I., Montealegre, I., Signorini, L.,... & Fusar-Poli, P. (2021). Universal and selective interventions to prevent poor mental health outcomes in young people: Systematic review and meta-analysis. *Harvard Review of Psychiatry*, *29*(3), 196-215. https://doi.org/10.1097/hrp.0000000000000294
642. American Academy of Pediatrics. (2022). Recommendations for preventive pediatric health care. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
643. Mental Health America Board of Directors. (2016, September 18). Position statement 41: Early identification of mental health issues in young people. *Mental Health America.* https://www.mhanational.org/issues/position-statement-41-early-identification-mental-health-issues-young-people.
644. Kamphaus, R. W., Reynolds, C. R., & Dever, B. V. (2014). Behavioral and mental health screening. In R. J. Kettler, T. A. Glover, C. A. Albers, & K. A. Feeney-Kettler (Eds.), Universal screening in educational settings: Evidence-based decision making for schools (pp. 249–273). *American Psychological Association.* https://doi.org/10.1037/14316-010
645. World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
646. American Academy of Pediatrics. (2022). Recommendations for preventive pediatric health care. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
647. Hansen H, Braslow J, Rohrbaugh RM. From cultural to structural competency—training psychiatry residents to act on social determinants of health and institutional racism. JAMA Psychiatry 2018;75:117- 118. doi: 10.1097/HRP.0000000000000294
648. Butkus, R., Rapp, K., Cooney, T. G., Engel, L. S., & Health and Public Policy Committee of the American College of Physicians*. (2020). Envisioning a better US health care system for all: Reducing barriers to care and addressing social determinants of health. *Annals of Internal Medicine*, *172*(2_Supplement), S50-S59. https://doi.org/10.7326/M19-2410
649. Adler, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing social determinants of health and health inequalities. *JAMA*, *316*(16), 1641-1642. https://doi.org/10.1001/jama.2016.14058
650. California Health & Human Services Agency. (n.d.) *Master Plan for Early Learning and Care*. https://www.chhs.ca.gov/home/master-plan-for-early-learning-and-care/
651. California Department of Health Care Services. (2021). *California advancing and innovating Medi-Cal (CalAIM): Population health management.* https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspxhttps://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-PH-a11y.pdf
652. Adler, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing social determinants of health and health inequalities. *JAMA*, *316*(16), 1641-1642. https://doi.org/10.1001/jama.2016.14058
653. Ibid.
654. Ibid.
655. Huffstetler, A. N., & Phillips Jr, R. L. (2019). Payment structures that support social care integration with clinical care: Social deprivation indices and novel payment models. *American Journal of Preventive Medicine*, *57*(6), S82-S88. https://doi.org/10.1016/j.amepre.2019.07.011

656. Ash, A. S., & Mick, E. (2016). *UMass risk adjustment project for MassHealth payment and care delivery reform: Describing the 2017 payment model*. UMass Medical School, Center for Health Policy and Research. https://www.mass.gov/files/documents/2017/11/03/1610-umass-modeling-sdh-summary-report.pdf
657. Ibid.
658. Adler, N.E., D.M. Cutler, J.E. Jonathan, S. Galea, M. Glymour, H.K. Koh, & D. Satcher. (2016). Addressing social determinants of health and health disparities. *Vital Directions for Health and Health Care Series.* National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2016/09/addressingsocial-determinants-of-health-and-health-disparities.pdf
659. Minnesota Department of Human Services. (2016, April). *Accounting for social risk factors in Minnesota health care program payments*: *Phase I initial findings*. https://www.lrl.mn.gov/docs/2016/mandated/160992.pdf
660. Adler, N.E., D.M. Cutler, J.E. Jonathan, S. Galea, M. Glymour, H.K. Koh, & D. Satcher. (2016). Addressing social determinants of health and health disparities. *Vital Directions for Health and Health Care Series.* National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2016/09/addressingsocial-determinants-of-health-and-health-disparities.pdf
661. Substance Abuse and Mental Health Services Administration. (2014). Crisis services: Effectiveness, cost effectiveness, and funding strategies. *Health and Human Services Publication No. (SMA)-14-4848*. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf
662. National Association of State Mental Health Program Directors. (2018). A comprehensive crisis system: Ending unnecessary emergency room admissions and jail bookings associated with mental illness. https://www.nasmhpd.org/sites/default/files/TACPaper5_ComprehensiveCrisisSystem_508C.pdf
663. Department of Health Care Services. (2022, January 10). *Assessing the continuum of care for behavioral health services in California: Data, stakeholder perspectives, and implications*. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf
664. Ibid.
665. National Suicide Hotline Designation Act of 2020, S.2661 116th Congress § 116-172 (2022). https://www.congress.gov/bill/116th-congress/senate-bill/2661
666. Substance Abuse and Mental Health Services Administration. (2022, July 29). *988 suicide & crisis lifeline.* U.S. Department of Health and Human Services. Retrieved August 16, 2022, from https://www.samhsa.gov/find-help/988.
667. Ibid.
668. 988 California Suicide Prevention and Mental health Crisis Lifeline. (2022). *About 988*. WellSpace Health. Retrieved August 16, 2022, from https://www.988california.org/
669. Kalafat, J., Gould, M.S., Munfakh, J.L.H. & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 1: Non-suicidal crisis callers. *Suicide and Life-Threatening Behavior, 37*: 322-337. https://doi.org/10.1521/suli.2007.37.3.322
670. California Department of Health and Human Services. (2022). *Planning to improve the behavioral health crisis care continuum.* CA.gov. Retrieved August 16, 2022, from https://www.chhs.ca.gov/988-cccp/
671. Mental Health:988 Crisis Hotline, 988 California Assembly Bill § Article 63. (2021) https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB988
672. Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Washington, DC: Education Development Center, Inc. https://theactionalliance.org/sites/default/files/crisisnow.pdf
673. Mental Health Services Oversight and Accountability Commission. (2022). *Innovation incubator.* Retrieved August 16, 2022, from https://mhsoac.ca.gov/initiatives/innovation-incubator/
674. Senate Bill 82, Committee on Budget and Fiscal Review, 2013
675. Mental Health Services Oversight and Accountability Commission. (2022). *Mental health crisis triage*. Retrieved August 16, 2022, from https://mhsoac.ca.gov/initiatives/triage/
676. Senate Bill 82, Committee on Budget and Fiscal Review, 2013
677. Ibid.
678. Cummings, N. A., & O'Donohue, W. T. (2012). *Understanding the behavioral healthcare crisis: The promise of integrated care and diagnostic reform*. Routledge. https://doi.org/10.4324/9780203828069
679. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing Mental Health Promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
680. Satcher, D., & Rachel, S. A. (2017). Promoting mental health equity: The role of integrated care. *Journal of Clinical Psychology in Medical Settings, 24*(3-4), 182-186. https://doi.org/10.1007/s10880-016-9465-8
681. Butler, M., Kane, R. L., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., & Wilt, T. J. (2008). Integration of mental health/substance abuse and primary care No. 173. *Agency for Healthcare Research and Quality*. https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf
682. Cornwell, B. L., Szymanski, B. R., Bohnert, K. M., & McCarthy, J. F. (2021). Treatment initiation following positive depression screens in primary care: A propensity score–weighted analysis of integrated mental health services. *Journal of General Internal Medicine, 36*(2), 561-563. https://dx.doi.org/10.1007/s11606-020-05694-5
683. Crowley, R. A., Kirschner, N., & Health and Public Policy Committee of the American College of Physicians. (2015). The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: Executive summary of an American College of Physicians position paper. *Annals of Internal Medicine, 163*(4), 298–299. https://doi.org/10.7326/M15-0510
684. Szymanski, B. R., Bohnert, K. M., Zivin, K., & McCarthy, J. F. (2013). Integrated care: Treatment initiation following positive depression screens. *Journal of General Internal Medicine, 28*(3), 346-352. https://doi.org/10.1007/s11606-012-2218-y
685. Spoorenberg, S. L. W., Wynia, K., Fokkens, A. S., Slotman, K., Kremer, H. P. H., & Reijneveld, S. A. (2015). Experiences of community-living older adults receiving integrated care based on the chronic care model: A qualitative study. *PLoS One, 10*(10), e0137803. https://doi.org/10.1371/journal.pone.0137803
686. Rodgers, M., Dalton, J., Harden, M., Street, A., Parker, G., & Eastwood, A. (2018). Integrated care to address the physical health needs of people with severe mental illness: A mapping review of the recent evidence on barriers, facilitators and evaluations. *International Journal of Integrated Care*, *18*(1), 9. https://doi.org/10.5334/ijic.2605
687. California Department of Health Care Services. (2021). *CalAim*. https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx
688. Ibid.
689. Ibid.
690. Hope Sparks Family Services. (2022). *Lighting the way for children and families.* Retrieved August 23, 2022, from https://hopesparks.org/
691. Hope Sparks Family Services. (2022). *Pediatric healthcare integration.* Retrieved August 23, 2022, https://hopesparks.org/programs/pediatric-healthcare-integration/
692. Ibid.
693. Ibid.
694. Marquine, M. J., & Jimenez, D. (2020). Cultural and linguistic proficiency in mental health care: A crucial aspect of professional competence. *International Psychogeriatrics, 32*(1), 1–3. https://doi.org/10.1017/S1041610219000541

695. Ibid.
696. Ibid.
697. United Health Group. (2020). *Expanding and diversifying the mental health workforce in California to meet the need*. https://www.unitedhealthgroup.com/newsroom/posts/2020-10-20-uhg-ucsandiego-ucsanfrancisco-four-year-grant-378761.html
698. Ibid.
699. Ibid.
700. Shalaby, R. A. H., & Agyapong, V. I. (2020). Peer support in mental health: Literature review. *JMIR Mental Health*, *7*(6), Article e15572. https://doi.org/10.2196/15572
701. Ibid.
702. Sokol, R., & Fisher, E. (2016). Peer support for the hardly reached: A systematic review. *American Journal of Public Health, 106*(7), e1–e8. https://doi.org/10.2105/AJPH.2016.303180
703. Bakshi, S. (2021). Peer support as a tool for community care: "Nothing about us, without us". *Columbia Social Work Review, 19*(1), 20-43. https://doi.org/10.52214/cswr.v19i1.7602
704. Nealy, E. C. (2008). Working with LGBT families. In M. McGoldrick & K. V. Hardy (Eds.), *Re-visioning family therapy: Addressing diversity in clinical practice* (pp. 363–387). The Guilford Pres.
705. Gagne, C. A., Finch, W. L., Myrick, K. J., & Davis, L. M. (2018). Peer workers in the behavioral and integrated health workforce: Opportunities and future directions. *American Journal of Preventive Medicine, 54*(6), S258-S266. https://doi.org/10.1016/j.amepre.2018.03.010
706. Schlichthorst, M., Ozols, I., Reifels, L., & Morgan, A. (2020). Lived experience peer support programs for suicide prevention: A systematic scoping review. *International Journal of Mental Health Systems, 14*(1), 1-12. https://doi.org/10.1186/s13033-020-00396-1
707. Suresh, R., Alam, A., & Karkossa, Z. (2021). Using peer support to strengthen mental health during the COVID-19 pandemic: A review. *Frontiers in Psychiatry, 12*, 714181. https://dx.doi.org/10.3389Ffpsyt.2021.714181
708. Shediac-Razallah, M. C., & Bone, L. R. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy. *Health Education Research, 13*(1), 87–108. https://dx.doi.org/10.1093/her/13.1.87
709. Shalaby, R. A. H., & Agyapong, V. I. (2020). Peer support in mental health: Literature review. *JMIR Mental Health*, *7*(6), Article e15572. https://doi.org/10.2196/15572
710. Chaptered by the Secretary of State. Chapter 803, Statutes of 2020.
711. Ibid.
712. Ibid.
713. Gagne, C. A., Finch, W. L., Myrick, K. J., & Davis, L. M. (2018). Peer workers in the behavioral and integrated health workforce: Opportunities and future directions. *American Journal of Preventive Medicine, 54*(6), S258-S266. https://doi.org/10.1016/j.amepre.2018.03.010
714. Ibid.
715. Sokol, R., & Fisher, E. (2016). Peer support for the hardly reached: A systematic review. *American Journal of Public Health, 106*(7), e1–e8. https://doi.org/10.2105/AJPH.2016.303180
716. Sacramento County. (2021, August 24). Mental Health Services Act fiscal year 2021-22, 2022-23, 2023-24 three-year program and expenditure plan. https://dhs.saccounty.gov/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2021-22--2022-23--2023-24-MHSA-Three-Year-Plan.pdf
717. Ibid.
718. Ibid.
719. World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. World Health Organization. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
720. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
721. Ibid.
722. Ibid.
723. Ibid.
724. Shediac-Razallah, M. C., & Bone, L. R. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy. *Health Education Research, 13*(1), 87–108. https://dx.doi.org/10.1093/her/13.1.87
725. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3
726. Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing community health workers to address mental health disparities for underserved populations: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research, 45*,195–211. https://dx.doi.org/10.1007/s10488-017-0815-0
727. Looi, J. C. L., Allison, S., Bastiampillai, T., & Kisely, S. R. (2021). Headspace, an Australian youth mental health network: Lessons for Canadian mental healthcare. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *30*(2), 116-122.
728. Painter, K. R., Scannapieco, M., Blau, G., Andre, A., & Kohn, K. (2018). Improving the mental health outcomes of LGBTQ youth and young adults: A longitudinal study. *Journal of Social Service Research*, *44*(2), 223–235. https://doi.org/10.1080/01488376.2018.1441097
729. Brewster, A. L., Wilson, T. L., Curry, L. A., & Kunkel, S. R. (2021). Achieving population health impacts through health promotion programs offered by community-based organizations. *Medical Care*, *59*(3), 273–279. https://doi.org/10.1097/MLR.0000000000001492
730. Nguyen, T. U. N., Tanjasiri, S. P., Kagawa-Singer, M., Tran, J. H., & Foo, M. A. (2008). Community health navigators for breast- and cervical-cancer screening among Cambodian and Laotian women: Intervention strategies and relationship-building processes. *Health Promotion Practice*, *9*(4), 356–367. https://doi.org/10.1177/1524839906290251
731. Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med 7(7): e1000316*. https://doi.org/10.1371/journal.pmed.1000316
732. Martino, J., Pegg, J., & Frates, E. P. (2017). The connection prescription: Using the power of social interactions and the deep desire for connectedness to empower health and wellness. *American Journal of Lifestyle Medicine, 11*(6), 466-475. https://dx.doi.org/10.1177/1559827615608788
733. Tuolumne County Behavioral Health Department. (2021). *Mental health services act (MHSA): Three year program and expenditure plan FY 2020-2023.* Available at: https://www.tuolumnecounty.ca.gov/DocumentCenter/View/19718/MHSA-3-Year-Program--Expenditure-Plan-FY-20-23-Signed--Approved?bidId=
734. Ibid.
735. Tuolumne County Behavioral Health Department. (2021). *Mental health services act (MHSA): Three year program and expenditure plan FY 2020-2023.* Available at: https://www.tuolumnecounty.ca.gov/DocumentCenter/View/19718/MHSA-3-Year-Program--Expenditure-Plan-FY-20-23-Signed--Approved?bidId=
736. Settipani, C. A., Hawke, L. D., Cleverley, K., Chaim, G., Cheung, A., Mehra, K., Rice, M., Szatmari, P., & Henderson, J. (2019). Key attributes of integrated community-based youth service hubs for mental health: A scoping review. *International Journal of Mental Health Systems*, *13*(1), 52-78. https://dx.doi.org/10.1186/s13033-019-0306-7
737. Mental Health Services Oversight and Accountability Commission. (2021). *allcove™ youth drop-in center*. https://mhsoac.ca.gov/initiatives/allcove-youth-drop-in-centers/
738. Hmong Cultural Center of Butte County. (2022). *Programs and services, Cov kev pab*. https://hmongculturalcenter.net/programs-and-services.html

739. Ibid.
740. Siegler, E. L., Lama, S. D., Knight, M. G., Laureano, E., & Reid, M. C. (2015). Community-based supports and services for older adults: A primer for clinicians. *Journal of Geriatrics*, *2015*, 678625. https://doi.org/10.1155/2015/678625
741. San Francisco Village. (2022). *Who we are*. Retrieved August 02, 2022, from https://www.sfvillage.org/
742. San Francisco Village. (2022). *Events and programs*. Retrieved August 02, 2022, from https://www.sfvillage.org/programs/
743. Ibid.
744. Ibid.
745. Newman, M. G., & Zainal, N. H. (2020). The value of maintaining social connections for mental health in older people. *The Lancet. Public Health, 5*(1), e12–e13. https://doi.org/10.1016/S2468-2667(19)30253-1
746. Ibid.
747. Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (Eds.). (2019). *Implementing mental health promotion.* Springer Nature. https://doi.org/10.1007/978-3-030-23455-3

# MISCELLANEOUS ENCLOSURES

**February 23, 2023 Commission Meeting**

**Enclosures (4):**

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) 2023 Commission Meeting Dates (Tentative)

Mental Health Services
Oversight & Accountability Commission

# Summary of Updates

## Contracts

New Contract: None

Total Contracts: 3

## Funds Spent Since the November Commission Meeting

| Contract Number | Amount |
|---|---|
| 17MHSOAC073 | $ 0.00 |
| 17MHSOAC074 | $ 0.00 |
| 21MHSOAC023 | $ 0.00 |
| **Total** | **$ 0.00** |

## Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

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

**MHSOAC Staff:** Kai LeMasson

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

**Total Contract Amount:** $2,453,736.50

**Total Spent:** $**1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed 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<br>Updated Formative/Process Evaluation Plan | Complete<br>Complete | 1/24/20<br>1/15/21 | No<br>No |
| Data Collection and Management Report | Complete | 6/15/20 | No |

| 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-<br>6/15/23 | No |
| Co-host Statewide Conference and Workplan (a and b) | In Progress | 9/15/21<br>Fall 2022 | No |
| Midpoint Progress Report for Formative/Process Evaluation Plan | Complete | 7/15/21 | No |
| Draft**s** Formative/Process Evaluation Final Report (a and b) | Not Started | 3/30/23<br>7/15/23 | No |
| Final Report and Recommendations | Not Started | 11/30/23 | No |

Mental Health Services
Oversight & Accountability Commission

# The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

**MHSOAC Staff:** Kai LeMasson

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

**Total Contract Amount:** $2,453,736.50

**Total Spent:** **1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed 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<br>Updated Formative/Process Evaluation Plan | Complete<br>Complete | 1/24/20<br>1/15/21 | No<br>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<br>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-<br>6/15/23 | No |
| Co-host Statewide Conference and Workplan (a and b) | In Progress | 9/15/21<br>TBD | No |
| Midpoint Progress Report for Formative/Process Evaluation Plan | Complete | 7/15/21 | No |
| Drafts Formative/Process Evaluation Final Report (a and b) | Not Started | 3/30/23<br>7/15/23 | No |
| Final Report and Recommendations | Not Started | 11/30/23 | No |

Mental Health Services
Oversight & Accountability Commission

# The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

**MHSOAC Staff:** Rachel Heffley

**Active Dates:** 07/01/21 - 06/30/24

**Total Contract Amount:** $5,414,545.00

**Total Spent:** **$1,061,087.52**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Quarterly Progress Reports | Complete | 09/30/21 | No |
| Quarterly Progress Reports | Complete | 12/31/21 | No |
| Quarterly Progress Reports | Complete | 03/31/2022 | No |
| Quarterly Progress Reports | Complete | 06/30/2022 | No |
| Quarterly Progress Reports | Complete | 09/30/2022 | No |
| Quarterly Progress Reports | Complete | 12/31/2022 | Yes |
| Quarterly Progress Reports | Not Started | 03/31/2023 | No |
| Quarterly Progress Reports | Not Started | 06/30/2023 | No |

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Quarterly Progress Reports | Not Started | 09/30/2023 | No |
| Quarterly Progress Reports | Not Started | 12/31/2023 | No |
| Quarterly Progress Reports | Not Started | 03/31/2024 | No |
| Quarterly Progress Reports | Not Started | 06/30/2024 | No |

Mental Health Services
Oversight & Accountability Commission

# INNOVATION DASHBOARD

FEBRUARY 2023

| UNDER REVIEW | Final Proposals Received | Draft Proposals Received | TOTALS |
|---|---|---|---|
| Number of Projects | 5 | 8 | **13** |
| Participating Counties (unduplicated) | 2 | 7 | **9** |
| Dollars Requested | $7,760,892 | $39,457,082 | **$47,217,974** |

| PREVIOUS PROJECTS | Reviewed | Approved | Total INN Dollars Approved | Participating Counties |
|---|---|---|---|---|
| FY 2017-2018 | 34 | 33 | $149,548,570 | 19 (32%) |
| FY 2018-2019 | 54 | 54 | $303,143,420 | 32 (54%) |
| FY 2019-2020 | 28 | 28 | $62,258,683 | 19 (32%) |
| FY 2020-2021 | 35 | 33 | $84,935,894 | 22 (37%) |
| FY 2021-2022 | 21 | 21 | $50,997,068 | 19 (32%) |

| TO DATE | Reviewed | Approved | Total INN Dollars Approved | Participating Counties |
|---|---|---|---|---|
| 2022-2023 | 17 | 17 | $73,549,335.67 | 16 |

## 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 | Santa Cruz | Healing The Streets | $5,735,209 | 5 Years | 12/9/2021 | Pending |
| Under Review | Yolo | Crisis Now | $3,584,357 | 3 Years | 6/1/2022 | Pending |
| Under Review | Santa Clara | TGE Center | $17,298,034 | 54 Months | 10/4/2022 | Pending |
| Under Review | Contra Costa | Grants for Supporting Equity through Community Defined Practices | $6,119,182 | 4 Years | 10/24/2022 | Pending |
| Under Review | Fresno | The Lodge (EXTENSION) | $3,160,000 | 5 Years | 12/2/2022 | Pending |
| Under Review | Fresno | Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework | $3,000,000 | 3 Years | 8/15/2022 | Pending |
| Under Review | Marin | From Housing to Healing, A Re-Entry Community for Women | $560,300 | 5 Years | 12/5/2022 | Pending |
| Under Review | Monterey | Rainbow Connection | 1,000,001 | 5 Years | 1/6/2023 | 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 | Tuolumne | Family Ties: Youth and Family Wellness | $925,892 | 5 Years | 8/22/2022 | 12/7/2022 |
| Under Final Review | San Mateo | Mobile Behavioral Health Services for Farmworkers | $1,815,000 | 4 Years | 10/27/2022 | 12/21/2022 |

| 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 Mateo | Music Therapy for Asian Americans | $940,000 | 4 Years | 10/27/2022 | 12/21/2022 |
| Under Final Review | San Mateo | Recovery Connection Drop-in-Center | $2,840,000 | 5 Years | 10/27/2022 | 12/21/2022 |
| Under Final Review | San Mateo | Adult Residential In-Home Support Element (ARISE) | $1,240,000 | 4 Years | 10/27/2022 | 12/21/2022 |

| APPROVED PROJECTS (FY 22-23) | | | |
|---|---|---|---|
| County | Project Name | Funding Amount | Approval Date |
| Napa | FSP Multi-County Collaborative | $844,750 | 10/11/2022 |
| Sonoma | Semi-Statewide Enterprise Health Record | $4,420,447.54 | 11/17/2022 |
| Tulare | Semi-Statewide Enterprise Health Record | $6,281,021 | 11/17/2022 |
| Humboldt | Semi-Statewide Enterprise Health Record | $608,678 | 11/17/2022 |
| Colusa | Social Determinants of Rural Mental Health (Extension) | $983,124 | 11/18/2022 |
| Sacramento | Behavioral Health Crisis Services Collaborative | $1,000,000 | 1/4/2023 |
| Alameda | Peer-led Continuum for Forensics and Reentry Services | $8,692,893 | 1/25/2023 |
| Alameda | Alternatives to Confinement | $13,432,651 | 1/25/2023 |
| Santa Barbara | Housing Assistance and Retention Team | $7,552,606 | 1/25/2023 |
| Kings | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $3,203,101.78 | 1/25/2023 |

| APPROVED PROJECTS (FY 22-23) | | | |
|---|---|---|---|
| County | Project Name | Funding Amount | Approval Date |
| Imperial | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $2,974,849 | 1/25/2023 |
| Mono | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $986,403 | 1/25/2023 |
| Placer | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $4,562,393 | 1/25/2023 |
| San Benito | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $4,940,202 | 1/25/2023 |
| San Joaquin | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $8,478,140 | 1/25/2023 |
| Siskiyou | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $1,073,106 | 1/25/2023 |
| Ventura | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $3,514,910 | 1/25/2023 |

DHCS Status Chart of County RERs Received
February 23, 2023, Commission Meeting

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 February 6, 2023. This Status Report covers FY 2019 -2020 through FY 2021-2022, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2021-2022 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 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 2021-22 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.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

## DCHS MHSA Annual Revenue and Expenditure Report Status Update

There is one RER not finalized for FY 19-20, Inyo.

| County | FY 20-21 Electronic Copy Submission | FY 20-21 Return to County | FY 20-21 Final Review Completion | FY 21-22 Electronic Copy Submission | FY 21-22 Return to County | FY 21-22 Final Review Completion |
|---|---|---|---|---|---|---|
| Alameda | 1/26/2022 | 2/3/2022 | 2/8/2022 | 1/31/2023 | | |
| Alpine | 1/26/2022 | 2/3/2022 | 2/15/2022 | | | |
| Amador | 1/27/2022 | 2/3/2022 | 2/10/2022 | 1/31/2023 | | |
| Berkeley City | 2/1/2022 | 2/3/2022 | 3/1/2022 | 1/31/2023 | 2/2/2023 | |
| Butte | 8/11/2022 | 8/12/2022 | 8/15/2022 | | | |
| Calaveras | 1/31/2022 | 2/4/2022 | 2/8/2022 | 1/27/2023 | | |
| Colusa | 2/1/2022 | 2/4/2022 | 2/15/2022 | | | |
| Contra Costa | 1/31/2022 | 2/4/2022 | 3/11/2022 | 1/30/2023 | | 2/1/2023 |
| Del Norte | 1/28/2022 | 2/7/2022 | 2/23/2022 | 1/30/2023 | | |
| El Dorado | 1/28/2022 | 2/4/2022 | 2/9/2022 | | | |
| Fresno | 1/26/2022 | 2/7/2022 | 2/16/2022 | 1/31/2023 | 2/2/2023 | |
| Glenn | 3/21/2022 | 3/22/2022 | 4/6/2022 | | | |
| Humboldt | 8/15/2022 | 8/16/2022 | 8/24/2022 | 1/31/2023 | | |
| Imperial | 1/31/2022 | 2/4/2022 | 2/15/2022 | 1/20/2023 | 1/23/2023 | 2/1/2023 |
| Inyo | 4/1/2022 | 4/12/2022 | | | | |
| Kern | 2/3/2022 | 2/7/2022 | 2/17/2022 | 1/31/2023 | 2/1/2023 | |
| Kings | 2/22/2022 | 2/22/2022 | 3/11/2022 | 1/10/2023 | | |
| Lake | 2/1/2022 | 2/8/2022 | 2/23/2022 | 1/31/2023 | | 2/1/2023 |
| Lassen | 2/2/2022 | 2/8/2022 | 2/17/2022 | | | |
| Los Angeles | 2/1/2022 | 2/7/2022 | 2/22/2022 | 1/31/2023 | 2/2/2023 | |
| Madera | 3/25/2022 | 3/29/2022 | 5/19/2022 | | | |
| Marin | 1/31/2022 | 2/7/2022 | 2/9/2022 | 1/30/2023 | 1/31/2023 | |
| Mariposa | 1/31/2022 | 2/7/2022 | 2/25/2022 | | | |

DHCS Status Chart of County RERs Received
February 23, 2023, Commission Meeting

| County | FY 20-21 Electronic Copy Submission | FY 20-21 Return to County | FY 20-21 Final Review Completion | FY 21-22 Electronic Copy Submission | FY 21-22 Return to County | FY 21-22 Final Review Completion |
|---|---|---|---|---|---|---|
| Mendocino | 2/1/2022 | 2/7/2022 | 2/24/2022 | 1/31/2023 | 2/2/2023 | |
| Merced | 1/27/2022 | 2/7/2022 | 2/8/2022 | 1/19/2023 | | |
| Modoc | 4/27/2022 | 4/28/2022 | 4/28/2022 | | | |
| Mono | 1/18/2022 | 2/7/2022 | 2/17/2022 | 1/31/2023 | | 2/2/2023 |
| Monterey | 2/2/2022 | 2/7/2022 | 2/9/2022 | 1/31/2023 | 2/2/2023 | 2/2/2023 |
| Napa | 2/7/2022 | 2/8/2022 | 3/3/2022 | 1/31/2023 | 2/1/2023 | |
| Nevada | 1/31/2022 | 2/2/2022 | 2/3/2022 | 1/31/2023 | 2/1/2023 | 2/2/2023 |
| Orange | 1/31/2022 | 2/3/2022 | 2/17/2022 | 1/31/2023 | | 2/1/2023 |
| Placer | 1/31/2022 | 3/17/2022 | 4/13/2022 | 1/31/2023 | 2/1/2023 | |
| Plumas | 7/14/2022 | 7/14/2022 | 11/29/2022 | | | |
| Riverside | 1/31/2022 | 2/4/2022 | 3/11/2022 | 1/31/2023 | 2/1/2023 | |
| Sacramento | 1/31/2022 | 2/3/2022 | 3/11/2022 | 1/25/2023 | 1/26/2023 | 1/27/2023 |
| San Benito | | | | | | |
| San Bernardino | 3/23/2022 | 3/23/2022 | 3/29/2022 | 1/31/2023 | | |
| San Diego | 1/31/2022 | 2/3/2022 | 2/18/2022 | 1/31/2023 | 1/31/2023 | |
| San Francisco | 1/31/2022 | | 2/4/2022 | 1/31/2023 | | |
| San Joaquin | 3/22/2022 | 3/23/2022 | 3/25/2022 | 1/31/2023 | | 2/1/2023 |
| San Luis Obispo | 1/26/2022 | 2/2/2022 | 2/7/2022 | 12/30/2023 | 1/6/2023 | 1/19/2023 |
| San Mateo | 1/31/2022 | 8/3/2022 | 8/4/2022 | | | |
| Santa Barbara | 1/26/2022 | 1/26/2022 | 2/10/2022 | | | |
| Santa Clara | 1/31/2022 | 2/15/20222 | 2/18/2022 | 1/31/2023 | 1/31/2023 | |
| Santa Cruz | 3/25/2022 | 3/25/2022 | 4/4/2022 | | | |
| Shasta | 1/25/2022 | 1/26/2022 | 2/10/2022 | 1/31/2023 | 2/2/2023 | |
| Sierra | 1/31/2022 | 2/2/2022 | 2/28/2022 | 1/27/2023 | 1/30/2023 | |
| Siskiyou | 7/18/2022 | 7/18/2022 | 8/10/2022 | | | |
| Solano | 1/31/2022 | 2/2/2022 | 2/8/2022 | 1/31/2023 | 1/31/2023 | |

DHCS Status Chart of County RERs Received
February 23, 2023, Commission Meeting

| County | FY 20-21 Electronic Copy Submission | FY 20-21 Return to County | FY 20-21 Final Review Completion | FY 21-22 Electronic Copy Submission | FY 21-22 Return to County | FY 21-22 Final Review Completion |
|---|---|---|---|---|---|---|
| Sonoma | 1/31/2022 | 2/3/2022 | 2/22/2022 | 1/31/2023 | 2/2/2023 | |
| Stanislaus | 1/31/2022 | 2/2/2022 | 2/15/2022 | 1/31/2023 | 2/2/2023 | 2/3/2023 |
| Sutter-Yuba | 2/9/2022 | 2/10/2022 | 2/15/2022 | 1/31/2023 | 2/2/2023 | |
| Tehama | | | | | | |
| Tri-City | 1/31/2022 | 2/2/2022 | 5/25/2022 | 1/25/2023 | 1/25/2023 | |
| Trinity | 7/5/2022 | 7/5/2022 | 7/27/2022 | | | |
| Tulare | 1/31/2022 | 2/2/2022 | 2/10/2022 | 1/31/2023 | 1/31/2023 | |
| Tuolumne | 1/31/2022 | | 2/4/2022 | | | |
| Ventura | 1/28/2022 | 2/2/2022 | 2/14/2022 | 1/30/2023 | 1/30/2023 | 1/31/2023 |
| Yolo | 1/31/2022 | 2/2/2022 | 2/2/2022 | 1/31/2023 | 2/2/203 | |
| **Total** | **57** | **55** | **56** | **40** | **25** | **12** |

Mental Health Services
Oversight & Accountability Commission

1812 9th Street, Sacramento, CA 95811
(916) 500-0577
www.mhsoac.ca.gov

# 2023 Commission Meeting Dates (Tentative)

| |
|---|
| **January 25-26th** |
| **February 23rd** |
| **March 23rd** |
| **April 27th** |
| **May 25th** |
| **June (tentatively no meeting)** |
| **July 27th** |
| **August 24th** |
| **September 28th** |
| **October 26th** |
| **November 16th** |
| **December (tentatively no meeting)** |