Well and Thriving

Prevention and Early Intervention in California

Mental Health Services
Oversight & Accountability Commission

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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.

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Acknowledgement

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 healthcare. 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

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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 build 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	**Recommendation**
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.	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 these broad goals.
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.	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.
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	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

	and social media reinforce these misconceptions.	understand and support their own or another person's mental health needs.
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.	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.

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.

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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."[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, some in total isolation.[5] Against this backdrop, longstanding 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

According to the World Health Organization, *mental health* is "a state of wellbeing in which every individual 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."[13]

With the right tools and support, mental health is possible for all people, including those who live with mental health challenges.[14] Basic needs are foundational to such wellbeing, however.[15] 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.[16]

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.[17] *Substance use disorders*, a category of mental disorder, often occur in tandem with other mental health challenges.[18] Throughout this report, references to mental health challenges include substance use disorders.

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[26] through 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.[29] *Secondary prevention* aims to reduce the impact or progression of mental health challenges through early detection and connection to services and supports.[30] The third type, *tertiary prevention*, seeks to prevent relapse and improve the quality of life for people with existing mental health challenges.[31] 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.[32] Effective early intervention can ensure optimal outcomes even for those with the greatest challenges.[33]

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.[34] 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.[35] Recovery often is not linear or timebound, and many people experience cycles of relapse and recovery.[36] 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.[37]

Whole Community Approaches

Increasingly, national[38] and international[39] 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 political unrest.[40]

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.[41] 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.[42]

A population health approach builds on traditional public health practices by employing policies and interventions that improve the mental health of a whole population.[43] 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.[44] A population health approach works across various systems to promote health equity in each of these areas.[45]

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.[46] 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.[47] 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.[48] An understanding of how culture, beliefs, attitudes, and behaviors influence wellbeing is foundational to any effective population health approach.[49]

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.[50] Strategies are delivered in numerous settings, across specific life events and stages, among specific populations.[51] Such strategies target the root causes of disrupted wellbeing in communities. Continuous community engagement plays a critical role.[52]

Effective prevention and early intervention strategies also are nimble enough to adapt to changing risk factors, needs, and emerging events.[53] They respond to and mitigate the harmful impacts of unexpected stressful or traumatic events in communities,[54] such as mass shootings, terrorist attacks, natural disasters,[55] and political or social turmoil.[56]

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.[57] 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.[58]

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.[59]

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).[60] 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. [61] For each county, approximately 20 percent of MHSA annual revenues are earmarked to support prevention and early intervention (PEI) programs and services.[62] 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.[63] 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.[64] 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.[65] 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.[66] 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.[67] Current PEI priority areas also encompass practices that are community-centered and culturally responsive and that strive to advance mental health equity.[68]

Through SB 1004, the Governor and the Legislature identified the following priorities for local PEI program development and delivery: [69]

- 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.[70] 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.[71]

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.[72] 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.[73] 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.[74] Commission staff also compiled data and information from Annual PEI Reports submitted by local behavioral health departments.[75] 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.[76]

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	**Recommendation**
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.	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 these broad goals.
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.	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.
3	Strategies to increase public awareness and knowledge of mental health often are small and sporadic, while harmful	The State's strategic approach to prevention and early intervention must promote mental health awareness and combat stigma by

	misconceptions surrounding mental health challenges persist. Mass media and social media reinforce these misconceptions.	ensuring all people have access to information and resources necessary to understand and support their own or another person's mental health needs.
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.	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.[77] 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.[78] 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.[79] 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.

Conditions Reinforcing Inequities in Mental Health

California is known for its large public investments,[80] yet substantial socioeconomic and health inequities persist. These inequities drive disparities in mental health,[81] particularly among Black, Latinx, Native and Indigenous, Asian American, LGBTQ+, rural, and disabled communities.

With limited data capabilities and siloed systems, the impact of the State's investments can be difficult to measure. Also difficult to assess is how state policies and actions contribute to inequities and disparities.

Social Determinants of Health

Health equity is achieved when all people have access to resources and opportunities that support health and wellbeing.[82] Most health inequities arise when people are disproportionately exposed to factors that threaten wellbeing in the places where they are born, live, grow, work, play, learn, and age.[83] These factors, which affect both physical and mental health, are broadly referred to as social determinants of health (SDOH).[84] Deficits in these determinants increase vulnerability to psychosis, severe depression, and anxiety, as well as a host of chronic physical health conditions.[85] They are considered a fundamental cause of poor physical and mental health worldwide. 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[86]

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.[87] Two out of every three Californians who have died of COVID-19 had a high school degree or less.[88] Blacks, Latinx individuals,[89] immigrants and refugees[90] 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.[91] 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.[92]

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)[93]

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.[94] 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.[95] Examples of structural racism include "redlining," in which loans or insurance are denied to individuals or businesses in disadvantaged neighborhoods;[96] covenants, codes, and restrictions, which bar people from buying homes in neighborhoods based on race or religion;[97] and gerrymandering, in which voting boundaries are manipulated to favor or exclude certain racial and ethnic groups, socioeconomic classes, or political parties.[98] The lack of infrastructure, investments, and political power that results from such policies unfairly disadvantage segregated communities.[99] 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.[100] Although residential segregation has been outlawed in the U.S., its impacts on health endure.[101]

Structural barriers can perpetuate poverty and other factors that increase mental health risk.[102] For example, poor communities experience greater shortages in mental health providers.[103] Structural barriers also can exacerbate the stigma, prejudice, and trauma that members of marginalized groups,[104] including those with mental health challenges, often experience.[105] 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.[106] "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.[107] She added: "At the same time, [these] communities all too often face barriers, rooted in systemic racism, in accessing life-saving behavioral health treatment."[108]

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,[109] and undocumented[110] 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.[111] 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.[112]

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.[113] According to community members, part of the problem is a lack of inclusive and equitable community representation in mental health decision making at the state and local level. 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.[114]

Unequal representation of certain populations in existing data reinforces discriminatory decision making and policy.[115] Large-scale health surveys used to inform health policy, for example, generally exclude smaller geographic areas or certain marginalized groups.[116] 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.[117] 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.[118] 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.[119] Also, many health data collection efforts are conducted only in English, thereby excluding those with limited English proficiency who are already underserved.[120]

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.[121] 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.[122]

Program and service data similarly lack consistency, reliability, and coordination.[123] 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.[124] 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.[125]

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.[126] 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.[127]

Leadership is needed to catalyze momentum and coordinate resources for change.[128] A strategic plan is needed to guide priorities for planning, collaboration, policies, and funding.[129] Investments in data and technical assistance are needed to evaluate and improve initiatives over time.[130] 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.[131]

"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.[132] 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.[133] Leadership at all levels is necessary to activate change agents and support collaboration.[134]

Leadership

Developing strong and effective leadership is necessary to activate change agents and bridge effective alliances.[135] Such leadership must be visionary and capable of braiding systems and resources to effect bold, innovative, and lasting change.[136]

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*.[137] In 2022, the Governor's executive order[138] 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.[139] Similar leadership is needed to drive equity, innovation, and partnerships so 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 existing and forthcoming resources is needed to achieve the state's broad goals around mental health.

In 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.[140] 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.[141] With this commitment, in addition to serving as top advisor to the Governor and key public health spokesperson, the Surgeon General is well positioned to develop and lead a statewide strategy for mental health prevention.[142]

Interagency Approaches

Partners outside the mental health system play a critical role in mental health prevention.[143] 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.[144]

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,[145] 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[146] for low-income individuals, older adults, and people with disabilities.[147]

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 heath.[148] Such partnerships generated health-promoting improvements such as new walking trails, bike lanes, and playgrounds, community and school gardens, and tobacco-free policies.[149] More than half of the initiatives yielded immediate positive health outcomes, including improved health behaviors and decreased health care costs.[150] although though most initiatives were designed to produce long-term outcomes through changes in policy, systems, and the environment.[151] 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.[152]

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 Child Welfare

California has taken an interagency approach to better serve children and youth in the foster care system and beyond through Assembly Bill 2083.[153] 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.[154] The legislation also calls for the establishment of a Joint Interagency Resolution team, to provide guidance, support, and technical assistance to counties.[155] 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.[156] Scaling this and similar interagency approaches to reach more communities could greatly enhance California's capacity to implement upstream, comprehensive prevention.[157]

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.[158] 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,[159] as well as its strategic plan for suicide prevention.[160] 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.[161]

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.[162] 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**.**[163] California does not yet have a comparable plan in place to drive a statewide, integrated approach to mental health 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.[164] 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.[165] 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.[166] This strategic approach could 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.[167] 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.[168] To guide local

program development and delivery, the State has identified several priority areas that include:[169]

- 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.[170]

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.[171] 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, build resiliency, and reduce disparities.

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.[172] In California, our communities form a diverse mosaic of cultures, languages, lifestyles, physical environments, and resources. We also differ in terms of what threatens[173] or protects[174] our mental health and wellbeing. However, every community is an expert in its local needs and assets.[175] 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.[176] And devoting space for community representation in

decision making promotes transparency, inclusion, and accountability for the way local resources are allocated.[177]

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: Equity through Community Voice

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.[178] This assessment asks about racial and ethnic background, age, and gender identity.[179] Departments use these data and other information to identify priority areas for CSS funding.[180] 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.[181]

In practice, mental health needs assessment strategies vary greatly depending on county resources.[182] In many cases, community members have not had the opportunity to communicate their needs.[183] 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.[184] 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.[185] Providing data and evaluation and delivering technical assistance and training are common capacity-building strategies.[186]

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.[187] Linking data 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.

Public health data approaches also can be used to understand and support a population's mental health. 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.[188] Assessing community trends in mental health diagnoses and risk factors can help guide targeted prevention strategies.[189] 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.

Public data also is 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.[190] Identifying disparities in service access and utilization can inform priorities for program funding and capacity building.[191] 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 awareness, and empower individuals, communities, and advocates.[192]

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

California possesses many tools for measuring and tracking mental health data, such as the California Health Interview Survey[193] and the Behavioral Risk Factor Surveillance System.[194] Each measures an array of physical and mental health and wellbeing factors, including those related to social determinants of health.[195] 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.[196] 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.[197] 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.[198]

Throughout the Commission's public engagement activities, participants reiterated the need for more State guidance and resources to support data-informed 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.[199] 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.[200] 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.[201]

Standardized data also could enhance local behavioral health department's capacity for better supporting underserved populations such as youth, older adults,[202] 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.[203]

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.[204]

Technical assistance is the process of providing an organization or community with focused support that meets resource and development needs.[205] 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.[206] 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.[207] Technical assistance also can enhance program capacity by supporting the sharing and coordination of resources, assets, and information.[208]

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.[209] Training in trauma-informed practices for emergency first responders can help prevent the escalation of a mental health crisis,[210] 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.[211]

Training and technical assistance in organizations also can promote policies and decisions that are mental-health and trauma-informed.[212] 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.[213] Among its many roles, the NCCTS provides training and technical assistance to build capacity across its network of 286 centers from 48 states.[214] Resources include a carefully curated, publicly available online library of information about rigorously evaluated treatments for trauma, as well as promising emerging practices.[215] 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.[216] 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.[217] 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.[218]

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.[219]

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).[220] The aim of this project was to enhance cultural and linguistic competencies required to understand and support the needs of Filipino American, Latinx, 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.[221] 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.[222] 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:

1.a. 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.

1.b. 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 on expanding best practices.

1.c. 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.

1.d. 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.[223] Prevention strategies should focus on reducing the factors that carry negative impacts while increasing those that protect and improve mental health.[224] Prevention efforts have the greatest impact when they focus on factors that are shared in common by a community or population.[225] 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.[226] Those that increase risks of developing mental health challenges are called *risk factors*. Those that buffer against risk are called *protective factors*.[227] 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,[228] poor attachment to caregivers, child abuse and neglect, poverty, job loss,[229] mental health stigma, access to substances,[230] and exposure to racism, community or domestic violence, and other forms of trauma.[231] 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,[232] feeling connected to and supported by another person, or belonging to a social support network.[233] 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.[234]

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.[235] 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.[236] Many experts also consider access to transportation, health care, education, and supportive social relationships as basic human needs.[237]

Research repeatedly has shown that a person deprived of basic needs is at greater risk of experiencing mental health challenges including psychosis,[238] severe depression, and anxiety,[239] as well as physical challenges like diabetes and heart disease.[240] Those who lack basic human needs also have a shorter life expectancy than people with greater social and economic opportunities**.**[241]

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.[242] Unmet basic needs disproportionately impact Latinx, Black, Native and indigenous, and refugee communities[243], as well as caregivers and many rural residents.[244]

"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.[245] This number rises to one in two among households with children under age 6.[246] Such deprivation is confounding, given that California has one of the world's largest economies,[247] 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.[248] 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.[249]

Health Care

Many Californians have unmet basic health needs due to lack of access to affordable health care.[250] Access to mental health care is even more limited.[251] 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.[252]

Health care access based on ability to pay is an important driver of health care disparities,[253] as approximately 3 million Californians lack health care insurance.[254] 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.[255] Residents of rural and poor communities face additional challenges in accessing health care, as providers and care facilities are scarcer in these areas.[256]

Mental health is one of the largest drivers of health care costs in the United States.[257] According to a White House report, costs associated with mental health services have more than doubled nationally in the last decade,[258] approaching $280 billion in 2020.[259] At the individual level, people with the most severe mental health challenges shoulder far greater financial burdens than those who are less impacted.[260]

Lack of affordable health coverage takes an enormous toll on a person's mental and physical health and quality of life.[261] 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.[262] 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.[263] 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.[264]

Community Disparities

Ongoing socioeconomic and health care disparities disproportionately impact certain communities. For example, uninsured rates are highest among Latinx, Native,[265] and undocumented Californians.[266] In rural communities, which account for roughly 850,000 Californians, incomes are about 25 percent lower than for the state as a whole.[267] Rural areas also experience above-average unemployment rates.[268] 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.[269]

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.[270] 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.[271] This is profound given that older adults are expected to represent one quarter of the state's population by 2030.[272]

In all communities, a massive gap remains between the most impoverished and the most resourced Californians,[273] and the potential for upward socioeconomic mobility[274] has not improved for many communities in the past two decades.[275] According to the Public Policy Institute of California, the gap between high-and low-income households in California continues to grow.[276] Families at the top of the income distribution curve today earn up to 11 times more than those at the bottom.[277] 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.[278] Research shows that populations with greater income inequality have a higher prevalence of schizophrenia, depression, anxiety, and substance abuse.[279]

Digital technology is a fundamental need in modern society.[280] The internet has become a critical conduit of social and emotional support for many people, especially those who are underserved, isolated,[281] or have disabilities.[282] 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.[283] 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.[284] 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.[285]

Trauma Exposure

Trauma can have profound and lifelong effects on a person's physical and mental health.[286] 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.[287] 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.[288] The more severe or frequent the trauma, the higher the risk of toxic stress.[289]

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.[290] 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.[291] Adverse childhood experiences also predict liver disease, heart disease, stroke, smoking, Alzheimer's disease, and dementia.[292] As many as 21 million cases of depression among U.S. adults are attributed to ACEs.[293]

A person with six or more ACEs is expected to die 20 years earlier on average than someone who has none.[294] 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."[295]

"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

Childhood trauma is exceedingly common in California. At least three out of every five Californian adults have experienced at least one adverse childhood experience,[296] with rates even higher in rural areas.[297] Indeed, the fallout of adverse childhood experiences is estimated to cost California more than $112 billion annually in health care expenses and lost productivity.[298]

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.[299] 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.[300] When children don't have access to such experiences in their home, they can still benefit from positive experiences in other settings.[301] 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.[302] The extent to which a child has access to any of these experiences is dependent on the health of their household and community.[303] 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,[304] impacting a person's body and brain in ways similar to physical abuse and neglect.[305] At the same time, poverty and severe deprivation set the stage for further trauma.[306] People living in poor areas, on average, experience higher rates of crime, violence, and stressors in their communities and homes.[307] Overall, children living in poor households experience more ACEs than their peers.[308] 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.[309]

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.[310] 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.[311] According to a 2018 report by California's Task Force on Family Caregiving, the combined economic value of these unpaid caregiving contributions[312] surpasses the entire Medi-Cal budget.[313] 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.[314] Together these challenges place caregivers at significantly greater risk of stress, burnout, poverty, and poorer physical and mental health.[315]

Wildfires and other Large-Scale Adversities

In addition to individual and generational traumas, trauma can be shared by communities.[316] *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.[317] Symptoms of community trauma include severed social networks, a low sense of political efficacy, deteriorating living environments, neighborhood violence, and intergenerational poverty.[318] 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.[319] Cumulatively, large-scale adversity weakens a community, strips its resilience, and threatens the collective pursuit of healing and wellness.[320]

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.[321]

Thousands of Californians have lost their homes, livelihoods, and communities due to wildfires. Many have lost their lives.[322] As wildfires continue across the state, many health experts are concerned about the mental health impacts of these traumatic events.[323] 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.[324] Mental health risk increased with proximity to the fire and was greatest among people with a history of childhood trauma.[325] Resilience was greatest among those with strong social supports and those who engaged in mindfulness coping practices.[326]

Many impacted by wildfire are already on the margins of poverty and deprivation[327] and lack the means to replace lost homes, vehicles, and other basic needs.[328] At the same time, skyrocketing home insurance costs in designated high-risk fire zones are exacerbating disparities in housing affordability.[329] Without immediate and bold interventions, climate researchers expect the incidence and severity of wildfires to increase dramatically over the next few decades.[330] Disparities in exposure and vulnerability to wildfire mean that some Californians are subjected to disproportionate – yet preventable – mental health risk.[331]

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.[332] Larger and more sustainable

improvements will be achieved when strategies move upstream to target broad, overlapping social, economic, environmental, and systemic barriers to wellbeing.[333]

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.[334] Many of the strategies coincide. For example, reducing poverty can improve access to basic needs like housing,[335] reduce violence and the risk of child abuse,[336] and improve a community's ability to recover financially and emotionally from acute adversities,[337] 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.[338] 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.[339]

Health Care without Hardship

Universal health coverage that includes mental health coverage is among the targets set by the World Health Organizations[340] and United Nations[341] 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.[342] 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."[343]

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.[344] While there are multiple approaches to achieving universal health coverage, paths generally include some combination of public and private insurance.[345] 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.[346]

Opportunity Spotlight: Universal Health Coverage

Implementing universal health coverage can incur substantial startup costs, but research suggests money[347] – and lives – would be saved beginning in the first year. Recent analyses suggest California could save up to $500 billion[348] 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.[349]

Californians' health also would improve. Worldwide, universal health coverage is associated with reduced mortality.[350] Some estimates suggest that as many as 4,000 Californian lives would be saved each year if universal health coverage were achieved.[351]

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.[352]

Combat Poverty

Reducing poverty will decrease trauma and improve mental health outcomes across the lifespan for current and future generations of Californians.[353] 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. [354]

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.[355] The effect was not seen in a comparison group of children whose mothers received a nominal $20 monthly payment.[356]

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.[357]

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.[358] 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.[359] 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.[360] 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.[361] 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.[362] To be effective, child care must be high quality, affordable, and available to diverse cultural and linguistic populations.[363]

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.[364] 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.[365]

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.[366] Further economic benefits derive from increased workforce participation and productivity among parents and higher salaries for women.[367] Such estimates do not include the financial impacts of projected lifetime improvements in outcomes for the 4.2 million California children with working parents.[368]

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.[369] 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.[370]

Evidence has shown that resilience is greater in communities that promote physical activity, civic participation, social engagement, and other healthy coping behaviors.[371] Communities as a whole become more resilient when diverse groups and institutions are united by a shared sense of participation, co-operation, and inclusivity.[372]

Research on healthy aging makes clear that being socially and physically active leads to better health and quality of life.[373] These benefits are not just physical, but also have a profound effect on a person's mental and cognitive wellbeing.[374] For example, staying physically[375] and socially[376] 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.[377] Supportive relationships in the home, school, and community are especially important for promoting resilience against trauma.

Evidence-informed strategies to promote healthy physical and social environments include building public green spaces, parks, and safe walkable and bikeable paths that are accessible to people of all ages and abilities.[378] 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.[379] For these and other approaches, community participation is critical to identify local needs and lead local solutions.[380]

Resilience also is enhanced when people have opportunities to engage in activities that align with their cultures and beliefs.[381] 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.[382] That project, along with three large sample studies in two countries (Canada and the United States),[383] 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 well-being.[384]

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.[385] 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.[386]

Northern California's Humboldt County is using its Opportunity Zone to revitalize the Port of Humboldt Bay.[387] This area, once a vital local resource, was neglected and underutilized following years of economic downturn and the demise of the local logging industry.[388] Steady increases in poverty, substance use, homelessness, and unaddressed mental health challenges ensued.[389] 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.[390] 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.[391] 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.[392]

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.[393] These strategies help to promote resilience across the lifespan for both caregivers and those for whom they care.[394]

"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 or aging adults 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.[395] These caregivers can better meet the physical and emotional needs of their loved ones when their own physical and emotional needs are met.[396] 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.[397] 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.[398]

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.[399]

The Parents as Teachers Evidence-Based Home Visiting Model offers an example of a comprehensive home-visiting education approach.[400] 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.[401]

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.[402] While most home visiting programs do not rely on clinically trained professionals, NFP utilizes trained nurses to provide in-home services. 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.[403] 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.[404]

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.[405]

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.[406] 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.[407] 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.[408] 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.[409]

Opportunity Spotlight: Early Childhood Mental Health 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.[410] 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.[411] Children who benefit from these services experience improved social skills and emotional regulation, healthier relationships, and reductions in challenging behaviors and school expulsions.[412] 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.[413] The program also reduces staff turnover and enhances a culture of wellbeing in early childhood settings.[414]

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)[415] allows subsidized early child-care and education programs to use State funds for staffing and other costs associated with consultation services.[416] Additionally, the 2021–2022 State budget included a $10 million investment in ECMHC over two years.[417] This investment represents an opportunity to apply mental health consultation in more early childhood settings.[418]

Caregiving to Support Aging in Place

Most Californians will rely on another person for assistance or long-term care as they age.[419] Supporting caregiving for adults, like caregiving for children, is essential for family and community wellbeing.[420] Allowing people to be cared for in their home and/or community of choice promotes optimal health and a higher quality of life.[421] People aging at home also are less likely to experience loneliness and social isolation, and therefore are at lower risk of depression, dementia, and other mental health challenges that can occur with older age.[422]

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.[423] 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.[424]

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.[425] 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.[426] 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.[427] Throughout California, PACE programs currently serve over 17,000 participants in 22 counties.[428] According to the California PACE Association (CalPACE), PACE services costs up to 40% less than placement in skilled nursing facilities, saving California more than $130 million in 2021 alone.[429] 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:

2.a. 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.

2.b. 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.

2.c. 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.

2.d. 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.[430] Enhancing people's basic knowledge and awareness of health is central to this process.[431] 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.[432] 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.[433] Yet comparable investments have yet to be made in the mental health arena.[434] Limited understanding and awareness of what constitutes mental health and what is meant by mental illness contribute to stigma, misperceptions, and discrimination.[435] Lack of awareness impedes access to care, and drives negative outcomes that disproportionately impact those in underserved communities.[436]

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.[437] 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.[438] 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.[439] 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.[440]

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.[441] "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!"[442]

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.[443] Stigma can delay or prevent the early identification of mental health needs.[444] It also can impede appropriate management of mental health crises, resulting in delayed care, increased fear, and excessive use of force or restraint.[445]

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.[446]

"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.[447] Especially harmful are implicit biases that manifest in hiring practices, paid leave decisions, or job protection policies.[448]

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.[449] At the same time, they were less likely to have received mental health services during the previous year.[450]

Members of diverse communities reinforced the harm of stigma during the Commission's 2020 public engagement events.[451] 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.[452]

Information and Education

Limited mental health information and education[453] prevent many Californians from supporting their own mental health needs or the needs of someone for whom they care.[454] 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.[455] 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.[456]

"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.[457] 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.[458] Other mental health challenges such as personality disorders and psychosis also can emerge during youth through early adulthood.[459] Worldwide an estimated 35 percent of all mental health challenges occur before age 14, 50 percent before 18, and over 62 percent by the age of 25.[460]

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.[461] According to the World Health Organization, approximately 15 percent of adults aged 60 and over are living with a mental health challenge.[462]

Despite such evidence, mental health challenges among both 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.[463]

Culture 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.[464] Likewise, the degree of cultural and linguistic competency among providers themselves impacts the effectiveness of services they provide to diverse communities.[465]

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.[466] 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.[467] 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.[468] 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.[469] Key opportunities to improve mental health awareness include broad dissemination of public information[470] and resources, alongside mental health training[471] and education.[472] Such strategies should include improving knowledge of mental health disparities and the structures and systems that reinforce such disparities.[473]

Mental health awareness initiatives also help to reduce stigma, normalize help-seeking behavior, and provide tools for managing emotional health.[474] 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.[475] Enhancing public awareness also informs policy decisions[476] that impact the mental health of people in communities and in organizations.[477]

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.[478]

"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.[479] Large-scale public campaigns,[480] community outreach,[481] and technology-based resources[482] 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.[483] Multiple mediums were used to disseminate and reinforce information about vaccination and other protective measures, and to combat misinformation.[484]

Public health awareness strategies are most effective when they are designed for diverse audiences across age groups, cultures, languages, and geographic areas.[485] They also must adapt over time to incorporate emerging media technology and changes in social norms.[486]

Public Campaigns

Public health campaigns can have a significant impact on health knowledge and perceptions.[487] Successful previous campaigns have helped to combat stigma and raise awareness of AIDs,[488] 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.[489] 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.[490] It followed research in the late 1980s and early 1990s that linked SIDS with stomach sleeping.[491] Nationwide public awareness campaigns ranged from public service announcements to partnerships with large companies to include messaging on infant-related product packaging.[492] Respected public figures, including then- second lady Tipper Gore, helped to raise the campaign's visibility.[493] Experts credit the effort with preventing thousands of infant deaths,[494] even as work continues to reach the highest-risk infants with adapted messaging and updated science.[495]

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.[496] In the study, California residents with a probable mental health challenge were assessed following exposure to a statewide stigma reduction campaign.[497] 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.[498] 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.[499] Despite such potential, however, mental health campaigns often are short-lived and may fail to reach diverse audiences.[500]

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

The lack of awareness of mental health 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.[501] Fear, stigma, and misperceptions among peers, family members[502] and providers[503] further increase the likelihood that critical early signs will be overlooked or unaddressed. Young people[504] and older adults[505] are uniquely impacted, as mental health challenges experienced during these ages – primarily before the age of 24 and after age 65 - are not as well understood and are therefore more likely to go undetected and under supported. 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.[506] Increased risk of suicide is one factor.

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.[507] Indeed, suicide is the second-leading cause of death among people between the ages of 10 and 24.[508] While suicide attempts are more frequent among youth, the rate of deaths by suicide increases starting at the age of 60.[509] 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.[510]

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.[511] In fact, recognizing subtle changes in behavior or functioning can prevent a mental health relapse or crisis from occurring, or prevent their negative consequences.[512]

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.[513]

Community Outreach

Because mental health information and supports are sometimes best received from trusted community sources,[514] outreach and engagement strategies are key mechanisms for enhancing public awareness and combatting stigma.[515] 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.[516] In this program, community health workers serve as cultural brokers, offering translation, service navigation assistance, and advocacy for underrepresented populations in health care settings.[517]

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.[518] It was a lifeline for many Californians during the COVID-19 pandemic.[519] With the click of a button, people today can access more mental health information than at any other time in history.[520]

Yet, despite the potential to enhance mental health promotion in the digital era, people cannot always trust the information they consume online.[521] Some websites post inaccurate or biased information, while others are not up to date, leaving consumers lost or discouraged.[522]

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.[523] 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.[524]

The opportunities for internet technology in the mental health space are virtually endless,[525] as is the potential for harm caused by its misuse.[526] 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.[527]

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.[528] 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.[529]

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.[530] 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.[531] 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.[532]

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.

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.[533] The staff employed in these settings must be well informed.[534] 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.[535]

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.[536] 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,[537] encourage healthy behaviors such as work breaks and physical activity,[538] 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.[539] Stigma and discrimination directed at an employee's mental health challenges also can cause significant harm both to individuals and the organization.[540]

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. [541] Evidence-based strategies include providing mental health literacy training to staff and leadership, incorporating[542] mental health education in staff induction and professional development activities, and offering access to mental health information and resources to reinforce training content.[543] Training can be universal or designed with specific professions or populations in mind.[544] 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.[545]

"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.[546] 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.[547]

Kaiser Permanente, for example, has developed a free online Mental Health Awareness training program designed for people in the workplace.[548] 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.[549]

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.[550] 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.[551]

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."[552] 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.[553] Although, what constitutes literacy in these areas may vary depending on a person's age, culture, and other contextual 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,[554] secondary,[555] and higher education settings,[556] including licensure certification and other programs for health care practitioners.[557] School-based programs also can promote mental health literacy among educators and school staff.[558]

School-based approaches that are developed and led by youth themselves are especially effective.[559] Examples include peer-led outreach and curricula in classes,[560] mentorship for between-grades support, youth wellness centers and zones, and student voice committees.[561]

In addition, students benefit from access to information and resources that affirm their cultures, languages, and identities.[562]

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).[563] This bill will require middle and high schools that provide health classes to also provide mental health education.[564] 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.[565] Such programs could be expanded to enhance mental health literacy throughout California.[566]

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:

3.a. Expand upon the State's investments in digital mental health resources, such as its CalHOPE initiative 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. Such strategies and information must be inclusive of diverse ages, cultures, languages, and LGBTQ+ communities, and easy to access for those with limited digital literacy.

3.b. 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.

3.c. 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.

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.[567] 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.[568] Survey data indicate that the prevalence of mental health challenges among California adults has increased by at least 41 percent since 2014.[569] 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.[570]

People with mental health challenges can live full and meaningful lives when they receive appropriate care and support.[571] In almost all cases, the earlier a person's mental health needs are identified and supported the better the outcome.[572] 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.[573] 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.[574]

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.[575] Early intervention includes services and supports for both newly emerging and reoccurring mental health challenges.[576]

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.[577] Among the 2 million who reported moderate challenges, almost 70 percent reported receiving no services in the previous year.[578] 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.[579] 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.[580]

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,[581] narrow eligibility criteria,[582] 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.[583] 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.[584] This is true for both newly emerging and existing mental health needs.[585] 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.[586]

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.[587] Youth and early adulthood, for example, is one period when half to three-fourths of people report experiencing their first mental health symptoms.[588]

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.[589] 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% of people over the age of 55 experience at least one mental health challenge, depression is the most prevalent.[590]

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.[591]

"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.[592]

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."

Eligibility and Financing Barriers

People may get worse before they get mental health care due to strict eligibility and reimbursement policies.[593] 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."[594] 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.[595] 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.[596] As a result, many people who could benefit from early intervention[597] are forced to forgo services until their mental health challenges become more severe and disabling.[598]

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.[599] 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.[600] In general, emergency staff and settings are ill-equipped to provide appropriate mental health crisis care.[601] 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.[602] Californians need consistent access to appropriate, recovery-focused services when experiencing a frightening mental health crisis.[603] Properly addressing such crises will reduce costs, prevent suffering, and save lives.[604]

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.[605] 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.[606, 607]

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.[608] Fragmented services also represent a missed opportunity, as non-mental health care partners play a critical role in identifying and supporting mental health needs.[609] 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.[610]

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.[611] “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.[612] This estimate is modest given the dramatic increase in needs following COVID-19.[613]

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.[614] 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).[615] 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.[616]

California’s mental health providers are not evenly distributed nor are they equally compensated.[617] 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.[618] High caseloads, administrative hurdles, and burnout are becoming more common among mental health providers, especially during the pandemic.[619]

Shortage of specialty providers is a key concern. As it stands, close to one third of counties have zero child and adolescent psychiatrist.[620] Mental health providers specializing in maternal mental health,[621] geriatric mental health,[622] substance abuse, and crisis intervention also are in short supply across the state.[623] Even more scarce are non-English speaking providers and/or providers from diverse racial, ethnic, and socioeconomic backgrounds.[624]

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[625] 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.[626]

Participants at Commission public engagement events also emphasized the lack of 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.[627] A 2019 UCLA study, for example, [628] identified significant gaps in programs, services, providers, and data focused on the unique mental health needs of adults over age 60.[629] 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.[630] The COVID-19 pandemic only exacerbated these challenges.[631] Older adults not only faced a greater risk of infection and hospitalization,[632] but also were more likely to experience prolonged isolation and loss of agency as a result of shelter-in-place orders.[633] Such conditions increase mental health risk for any age group, particularly older people.[634]

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.[635] 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 such 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.[636]

The need to fortify California's behavioral health care system is reflected in its 2021 Youth Behavioral Health Initiative (CYBHI).[637] Catalyzed by a one-time $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.[638] 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, including older adults, 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.[639] Universal screening is necessary to enhance early detection and linkage to mental health supports,[640] as are reforms to make care more accessible, including for people at risk[641] or experiencing a crisis.[642]

Mental Health Screening

Screening is an indispensable health care practice that helps millions of people live longer and healthier lives despite health challenges.[643] 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,[644] detect cancer,[645] and diagnose diabetes[646] and other chronic illnesses.[647] Universal screening also has been instrumental in preventing transmission of infectious diseases such as tuberculosis.[648]

National health leaders, including the American Academy of Pediatrics and the U.S. Preventive Services Task Force,[649] endorse universal mental health screening in the same settings where physical health screenings occur.[650] Mental health screening tools can identify signs and symptoms of depression, anxiety, psychosis, suicide, and impending relapses.[651] Screening also can identify mental health risk factors, and, when used among[652] high-risk or underserved populations, help to reduce mental health disparities.[653] 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.[654] Standardized screening should be accompanied by protocols that document how to respond in the event of a positive screen.[655] Mental health screening tools and practices also must be appropriate for use across diverse setting and adapted for unique cultures and languages.

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.[656] Health care settings present ideal opportunities for routine mental health screening.[657]

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.[658] 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.[659] 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.[660] Historically, mental health systems have relied on "illness-centered" approaches, where programs and services benefit only people with severe mental health challenges.[661] 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.

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.[662] 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.[663] Similar reforms in the private health care sector would further move California's mental health care system toward risk-informed care and prevention.[664]

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.[665] Such restrictions represent a lost opportunity, because strategies that address risk beyond traditional diagnostic criteria can improve both the efficacy and cost of services.[666]

Some health care systems are exploring ways to promote risk-informed services.[667] Insurance agencies in some states are beginning to factor in clients' social determinants of health when determining provider reimbursement rates.[668] In these models, providers caring for clients with greater risk receive higher reimbursements.[669] Such risks may include unstable housing, food insecurity, or history of trauma.[670] Other models reward providers when their clients' outcomes exceed expectations based on risk.[671] 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.[672]

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.[673] 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.[674] California has a complex web of crisis services, funded through various mechanisms with little standardization or uniformity of care.[675] 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. [676]

Recent federal legislation has taken a step toward an integrated crisis response system.[677] As of July 16, 2022, the National Suicide Prevention & Mental Health Crisis Lifeline has transitioned to a three-digit dialing code, 988.[678] 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.[679] 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.[680] 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.[681]

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.[682] For example, Assembly Bill 988 (Bauer-Kahan, 2021), would connect and expand mobile crisis teams, crisis stabilization services, and crisis counseling.[683] Locally, California counties are exploring opportunities to connect their crisis services using a best-practice approach called the Crisis Now model.[684] 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.[685]

Opportunity Spotlight: Investment in Mental Health Wellness Act

California's Investment in Mental Health Wellness Act[686] provides funds to improve California's response to mental health crisis services.[687] Recently changes to the act allow those funds to be used for crisis prevention and early intervention in addition to crisis response.[688] This Act and related funding is intended to reduce reliance on hospitalization, improve access to care, and enhance outcomes.[689] 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.[690] 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.[691]

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.[692]

Integrated care broadly refers to models in which mental health and substance use are embedded within primary care services in one care delivery system.[693] 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.[694] 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.[695] 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[696] or disabilities related to aging.[697]

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.[698] To address these challenges, California's public health care system, Medi-Cal, has begun an initiative to coordinate and integrate its systems and services.[699] 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.[700] 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.[701] 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.

Opportunity 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,[702] 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.[703] 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.[704] 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.[705] Integrated models like the one in operation at Pediatrics Northwest can make mental health care timely and accessible to families and reduce the strain on emergency systems.

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.[706] 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.[707] One way to achieve these goals is through employing providers of similar linguistic and cultural backgrounds as the communities they serve.[708]

"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.[709] The goal of the collaboration is to address a projected critical shortage of psychiatrists,

psychologists, social workers, and counselors in California.[710] 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.[711] 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.[712] Broadly defined, *peers* refer to people with common challenges who can help one another based on shared experience.[713] Peers can be especially powerful in engaging community members from marginalized groups,[714] such as people of color[715] and LGBTQ+ communities.[716] *Peers* can promote mental health awareness and resources, lead support groups, and link those with mental health needs to appropriate services.[717]

Peer-supported programs have proved effective at preventing relapse and suicide risk[718] for people following a mental health intervention.[719] In these programs, individuals who are recovering from mental health or substance use challenges draw upon their first-hand experiences to support others.[720] Research confirms that such programs improve participants' life satisfaction and functioning and reduce homelessness and hospitalization.[721]

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.[722] The law defines *peers* as individuals who have recovered from a mental disorder, substance use disorder, or both.[723] Certified peer providers will be eligible for Medi-Cal reimbursement for such services as coaching and skill-building.[724]

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.[725] 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.[726]

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.[727] One example is The Ripple Effect Respite Program.[728] 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+.[729] 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.[730]

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.[731] 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.[732] 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.[733]

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Community-based Supports

Strategies to achieve mental health and wellbeing must be nimble as they respond to the diverse and fluctuating needs of communities.[736] 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.[737] Community-based programs can ensure that people have access to basic needs.[738] They are especially important for promoting early detection and intervention and for supporting a person through recovery.[739] Community-based supports are most effective when they promote connectedness and belonging by engaging peers and respecting the perspectives of diverse cultures.[740]

Community-based programs also involve mobilizing agencies, institutions, and groups to work together to improve the wellbeing of a community.[741] In addition to mental health information and supports, community-based programs can offer a variety of social, informational, and tangible resources.[742] They can be especially successful in meeting the needs of local underserved populations.[743] Examples of community-based programs include native cultural centers, youth mental health drop-in centers,[744] LGBTQ+ community centers,[745] senior centers,[746] and community-based health navigators.[747]

Community-based programs are unique in their ability to promote social inclusion and cohesion,[748] and a sense of connection to one's community and culture – factors which strongly predict positive physical and mental health outcomes.[749] For example, the Tuolumne Me-Wuk Indian Health Clinic provides outreach and engagement services for Native American youth and their families.[750] 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.[751] The focus is on identifying needs, assisting with linkages to services, reducing barriers to services, and providing culturally competent responses to behavioral health problems.[752]

Community-based programs also have proved effective in providing high-quality mental health services and supports for youth.[753] An example is California's allcove6 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, allcove6 centers include youth-led outreach and education and peer-support activities aimed at reducing stigma, increasing community connection and empowering youth.[754]

"One-stop-shop" community-based models like allcove6 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.[755] 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.[756] 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.[757] The program facilitates social connectedness through regular phone calls, home visits, and warm relationships with providers.[758] 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."[759] By 2050, one in five people in the United States will be aged 65 years or older.[760] Enhancing support for aging adults and their unique physical and mental health risks must be a public health priority.[761] 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 older adults.[762]

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.[763] 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.[764] Such practices are commonly developed and evaluated alongside community members and incorporate cultural activities to supplement or complement more traditional therapeutic services.[765]

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.[766] 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. [767]

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 for California's African American, Asians and Pacific Islander, Latinx, LGBTQ+, and Native communities.[768] The CDRP has yet to release the results 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,[769] 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:

4.a. Establish a goal to achieve universal behavioral health screening and, consistent with Recommendation 1, appoint a state leader, develop a strategy, and identify metrics to support progress towards that goal.

4.b. 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.

4.c. 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."

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.

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