Lunch and Learn:
Health for All: Behavioral Health Population-Based Prevention

October 15, 2024

CalHHS
California Health & Human Services Agency

Welcome & Introductions

Ariel Ambruster, Lead Facilitator, Sacramento State University

CalHHS
California Health & Human Services Agency

Virtual Meeting Guidelines

Thank you for joining us today for this informational Lunch & Learn!

- This meeting is being recorded and will be available for viewing post-meeting
- American Sign Language interpretation is provided in pinned video
- Live captioning is provided – Select show/hide
- Participation: Members of the public can use the Q&A section to ask and upvote questions. BHTF members can use chat. Following the presentation, BHTF members can use the hand raise to get into queue to ask questions or share your thoughts

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ELEMENTS FROM BHTF GUIDELINES AND COMMITMENT TO ENGAGEMENT

- **SHARE THE AIRTIME – BE BRIEF AND BRILLIANT**
- **STRIVE FOR AN EQUITABLE AND INCLUSIVE MANNER**
- **RESPECT: ACTIVELY LISTEN, INVOLVE ALL**
- **STAY FOCUSED ON THE AGENDA**
- **WORK TO REDUCE STIGMA**
- **THINK INNOVATIVELY AND WELCOME NEW IDEAS**

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Agenda

- **Welcome and Overview – *5 mins***
- **Presentations: Promoting Health for All: Behavioral Health Population-Based Prevention– *50 mins***
    - **Dr. Tomás Aragón**, MD, DrPH, Director, California Department of Public Health, and State Public Health Officer
    - **Julie Nagasako**, Deputy Director, Office of Policy and Planning, California Department of Public Health
- **Questions and Discussion – 20 *mins***
- **Closing & Adjourn**

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CDPH
California Department of Public Health

Promoting Health for All: Behavioral Health Population-Based Prevention

Dr. Tomás Aragón, MD, DrPH
Director and State Public Health Officer

Julie Nagasako
Deputy Director, Office of Policy and Planning

Overview of Behavioral Health Outcomes in California

Select data illustrating statewide trends and disparities

Leading Causes of Death across the Life Course, 2022

Rank	Ages 0 - 4	Ages 5 - 14	Ages 15 - 24	Ages 25 - 34	Ages 35 - 44	Ages 45 - 54	Ages 55 - 64	Ages 65 - 74	Ages 75 - 84	Ages 85+
1	Neonatal conditions 1,002 (o)	Road injury 80 (›)	Road injury 765 (›)	Drug overdose 2,309 (›)	Drug overdose 2,382 (›)	Drug overdose 2,072 (›)	Ischemic heart disease 4,631 (¤)	Ischemic heart disease 8,190 (¤)	Ischemic heart disease 9,672 (¤)	Alzheimer's disease 20,246 (‹)
2	Congenital anomalies 423 (‹)	Congenital anomalies 45 (‹)	Drug overdose 723 (›)	Road injury 1,088 (›)	Alcohol-related 995 (›)	Alcohol-related 1,467 (›)	COVID-19 2,279 (ᵛ)	COVID-19 3,635 (ᵛ)	Alzheimer's disease 7,371 (‹)	Ischemic heart disease 13,073 (¤)
3	Other un-intentional injuries 97 (›)	Brain & nervous system cancers (^) 44	Homicide 480 (›)	Suicide 724 (›)	Road injury 827 (›)	Ischemic heart disease 1,433 (¤)	Drug overdose 2,254 (›)	Lung Cancer 3,034 (^)	Stroke 4,625 (¤)	Stroke 8,347 (¤)
4	Other Infections or Nutrition 39 (ᵛ)	Suicide 38 (›)	Suicide 441 (›)	Homicide 668 (›)	Suicide 654 (›)	COVID-19 977 (ᵛ)	Alcohol-related 2,065 (›)	Stroke 2,865 (¤)	COVID-19 4,325 (ᵛ)	Hyper-tensive heart disease (¤) 6,678
5	Endo., blood, immune dis. 37 (‹)	Other neurological 34 (‹)	Other neurological 104 (‹)	Alcohol-related 408 (›)	Homicide 506 (›)	Hyper-tensive heart disease (¤) 757	Hyper-tensive heart disease (¤) 1,768	Hyper-tensive heart disease (¤) 2,581	COPD 3,891 (‹)	COVID-19 5,409 (ᵛ)

Broad Condition Group

(ᵛ) Communicable	(^) Cancer	(¤) Cardiovascular
(‹) Other Chronic	(›) Injury	(o) Perinatal

California State of Public Health Report, 2024. Sacramento, CA: California Department of Public Health, Office of Policy and Planning; 2024. https://www.cdph.ca.gov/Programs/OPP/Pages/State-of-Public-Health-Report.aspx

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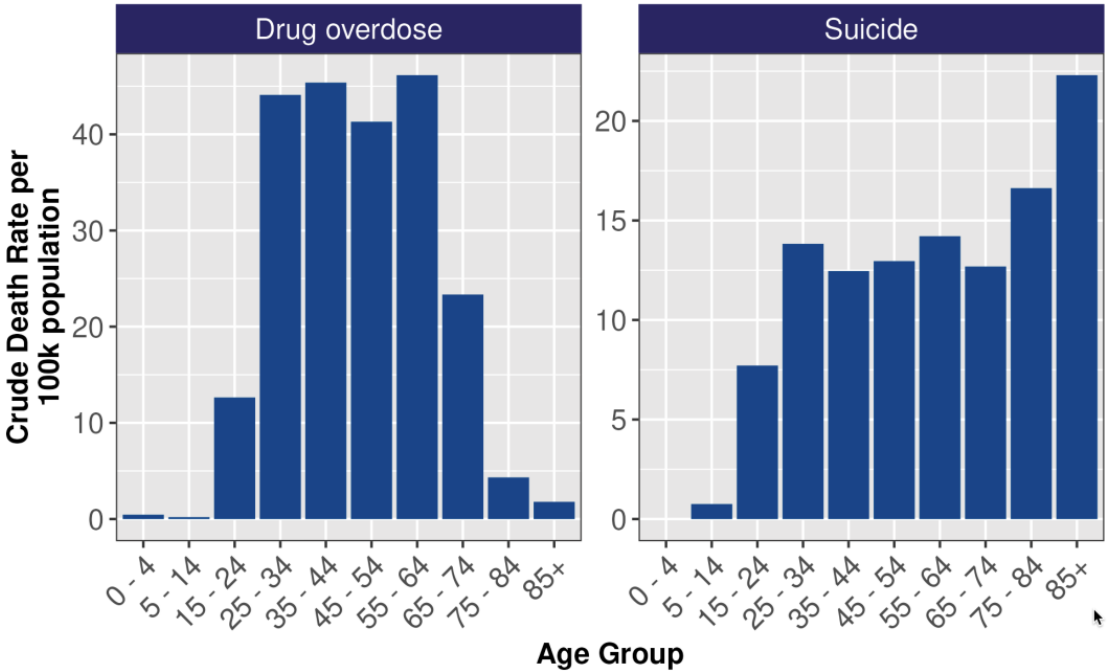
Death Rates for Drug Overdose and Suicide by Age Group, 2022



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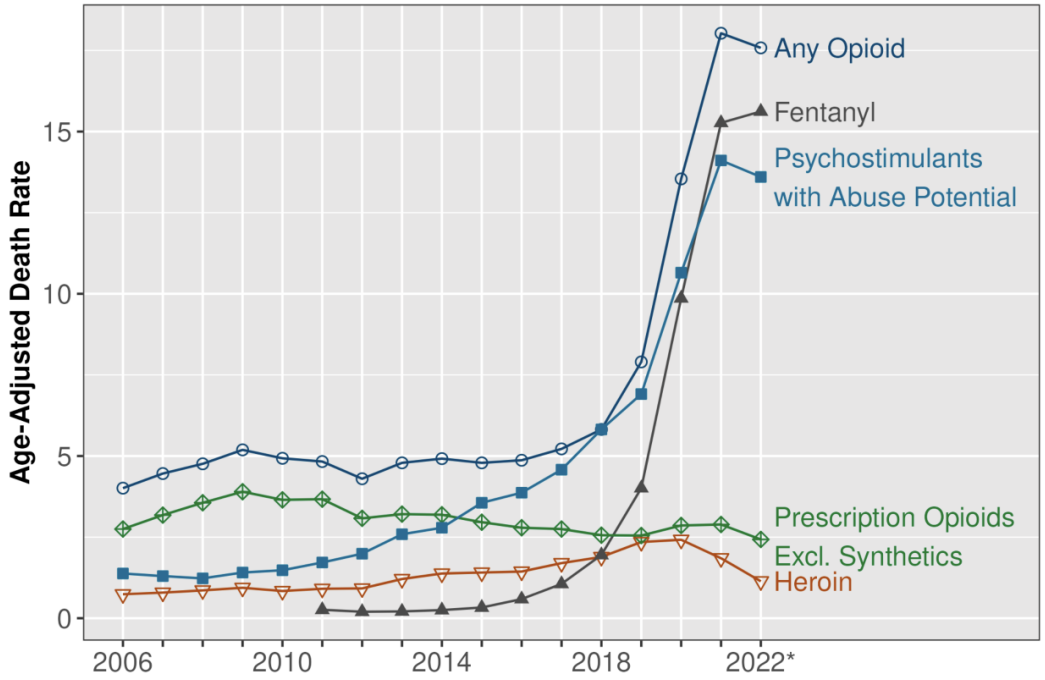
California State of Public Health Report, 2024. Sacramento, CA: California Department of Public Health, Office of Policy and Planning; 2024. https://www.cdph.ca.gov/Programs/OPP/Pages/State-of-Public-Health-Report.aspx

Opioid and Stimulant-Related Overdose Death Rate (per 100,000), 2006–2022



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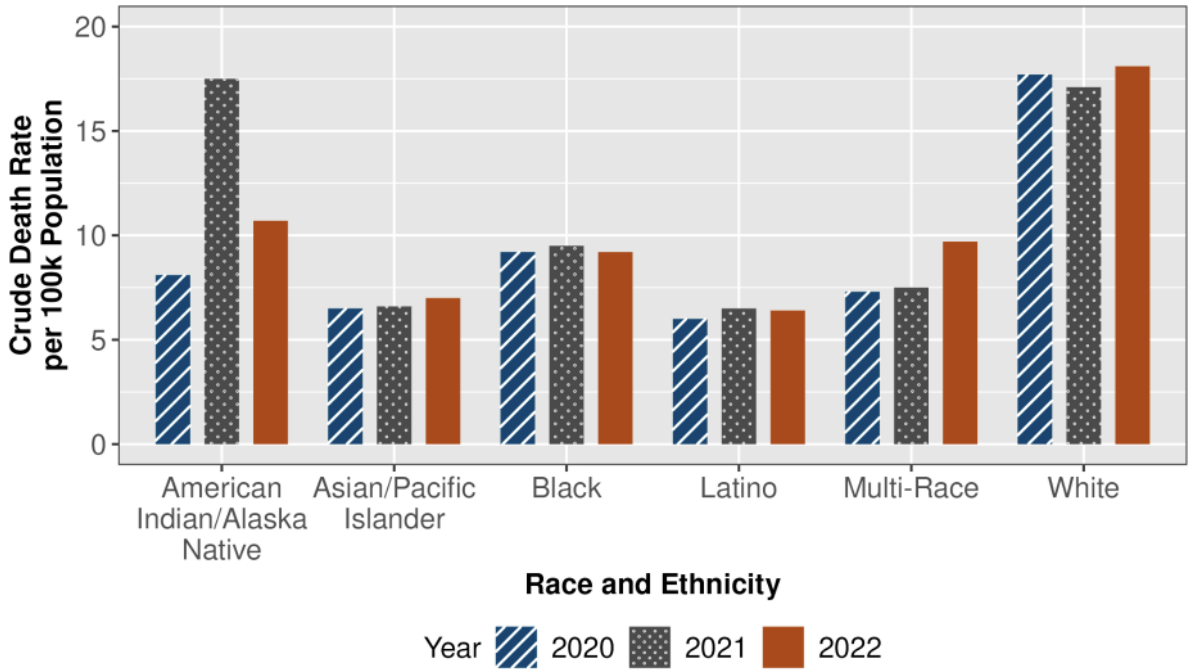
Suicide Rate by Race and Ethnicity, 2020–2022



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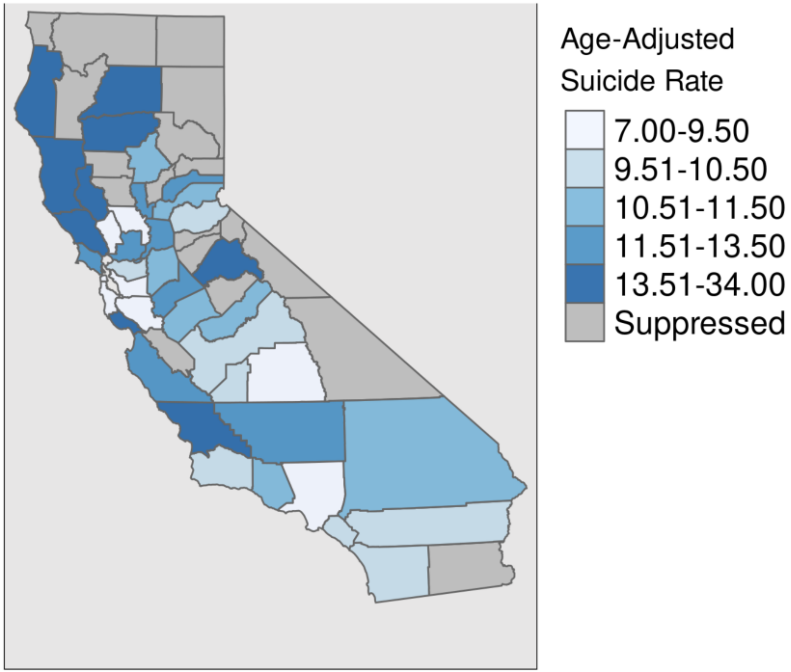
Age-Adjusted Suicide Death Rate (per 100,000) by County, California, 2022



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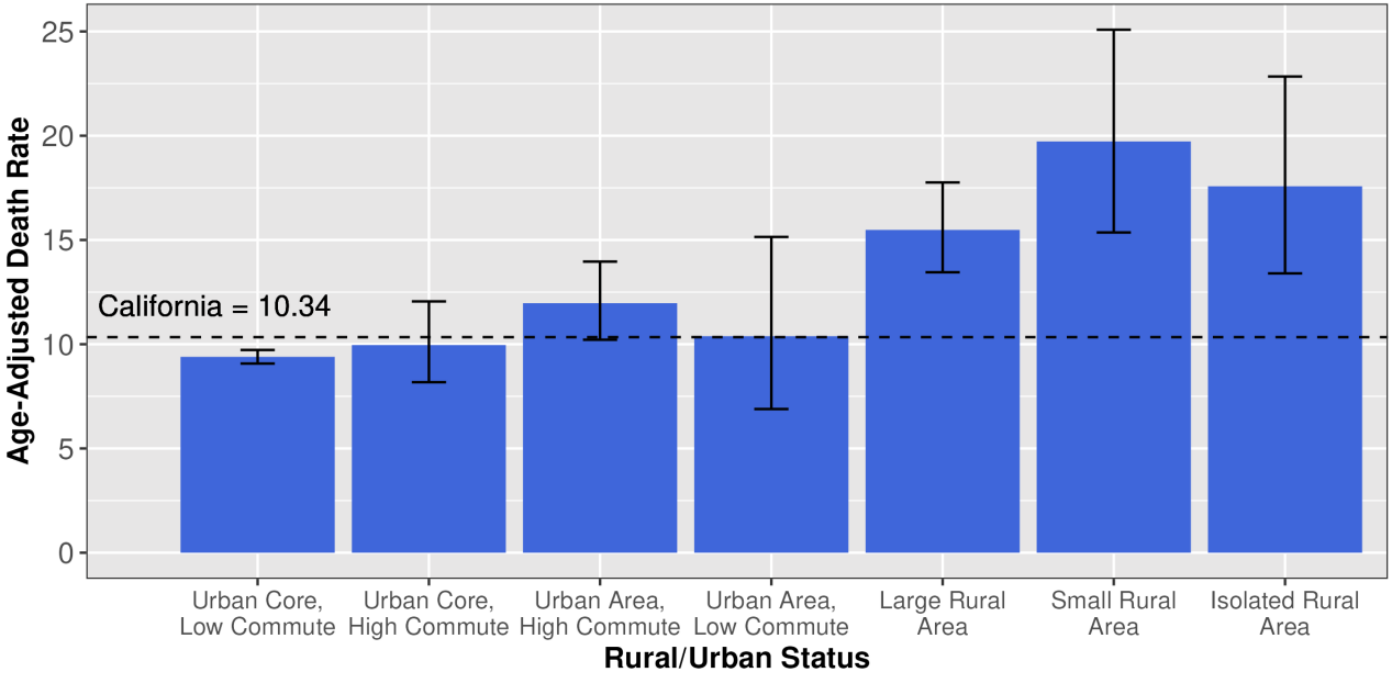
Age-Adjusted Suicide Death Rate (per 100,000) by Rural/Urban Status, 2022



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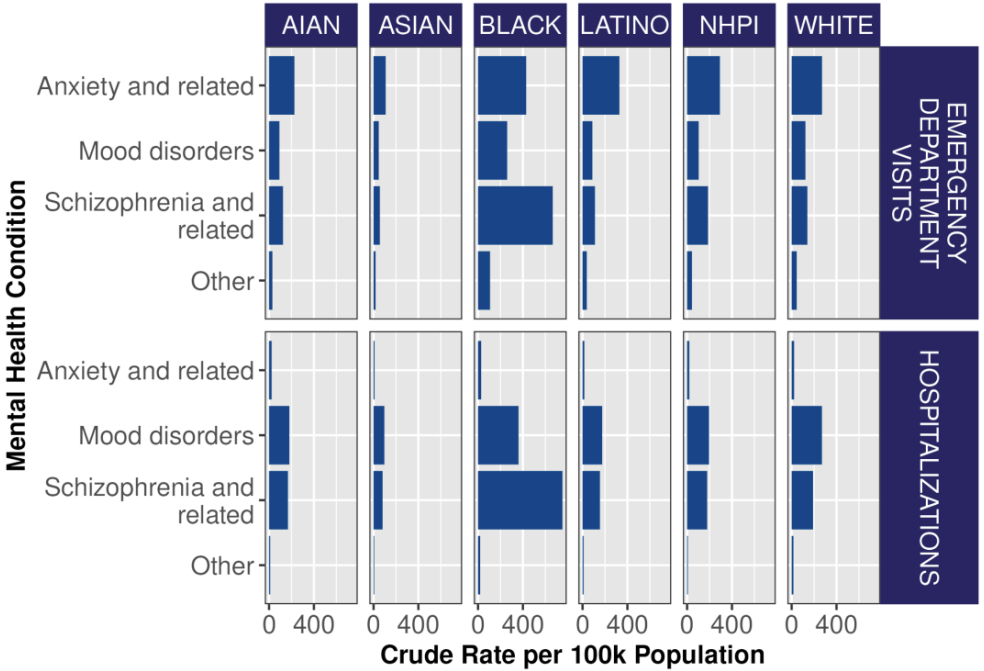
Emergency Department Visit and Hospitalization Rate (per 100,000) for Selected Mental Health Conditions by Race and Ethnicity, 2022



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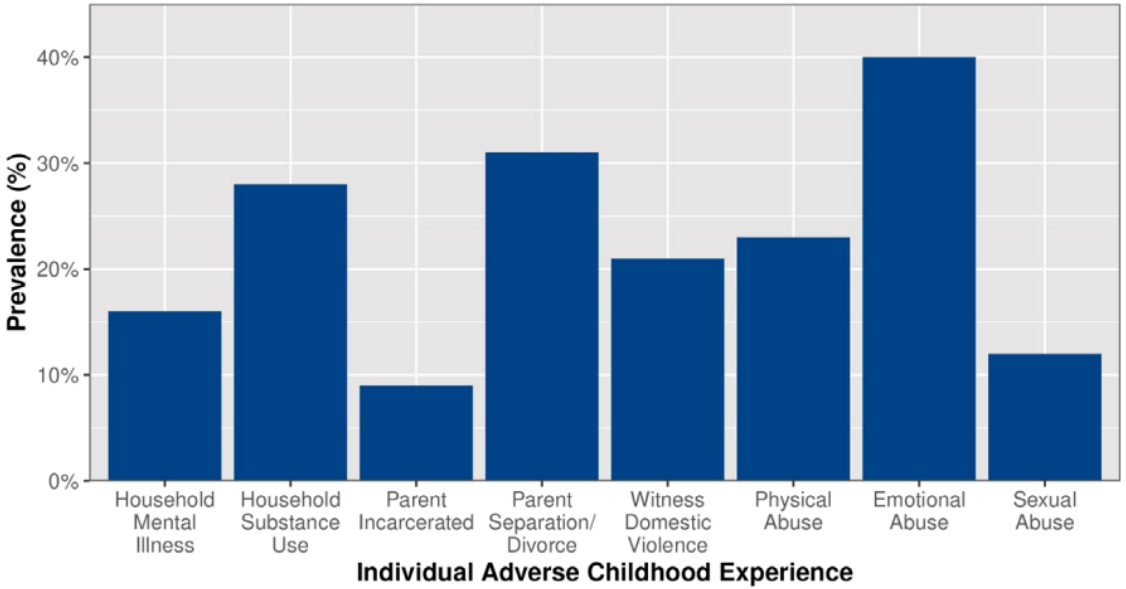
Prevalence of Individual Adverse Childhood Experiences, 2015–2021 (N=18,240)



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Root Causes and Population-Level Prevention

Public Health's Approach to Behavioral Health

- **Behavioral health:** Behavioral health refers to emotional, psychological, and social well-being. Public health approaches addressing behavioral health focus on mental health, substance use, interpersonal relationships, and patterns of behavior. From a population-level, primary prevention, and socio-ecological perspective, CDPH recognizes behavioral health to include not only the strengths, distress, and resilience of individuals, but also that of families, communities, and organizations.

Foundational Principles Guiding the Public Health Approach

- Primary Prevention
- Life Course Perspective
- Shared Risk and Protective Factors
- Social-Ecological Approach
- Health Equity
- Cultural Humility
- Trauma Informed

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Social determinants of behavioral health in the wider social environment

- Socioeconomic disadvantage
- Early life adversity
- Migration
- Racial/ethnic discrimination
- Inequalities experienced by the LGBTQ+ community
- Sex-based inequalities
- Loneliness and social isolation

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Social determinants of behavioral health in the wider social environment

- Neighborhood socioeconomic disadvantage and inequality
- Social capital, fragmentation, and ethnic/cultural density
- Physical environment
- Social determinants are not pre-determined characteristics of a place or community but rather determined and influenced by systems, structures, social norms, policies, practices, and institutions.

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Promotion and Primary Prevention

- **Promotion**
- **Primary prevention** (life course-based interventions)
  - Universal primary prevention (everyone)
  - Selective primary prevention (group or individual with risk factor)
  - Indicated primary prevention (individual with highest-risk for progression)
- **Secondary prevention** (diagnosis in in course of illness)
- **Tertiary prevention** (reduce complications of illness)

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World Health Organization's classification of preventive approaches for mental disorders

Public health framework	US Institute of Medicine
Primary prevention aims at preventing the new onset (incidence) of one or more mental disorders, or of suicidal ideation.	**Universal primary prevention** targets the general public, or a whole population that has not been identified on the basis of increased risk.
Secondary prevention aims to lower the prevalence of established cases of the disorder or illness in the population (prevalence) through early identification and treatment of diagnosable diseases.	**Selective primary prevention** targets individuals or subgroups of the population whose risk of developing a mental disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors.
Tertiary prevention includes interventions that reduce disability, enhance rehabilitation and prevent relapses or recurrences of the illness.	**Indicated primary prevention** targets high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder, or biological markers indicating predisposition for mental disorders, but who do not meet diagnostic criteria for disorder at that time.

James B. Kirkbride et al., "The Social Determinants of Mental Health and Disorder: Evidence, Prevention and Recommendations," *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 23, no. 1 (February 2024): 58–90, https://doi.org/10.1002/wps.21160.

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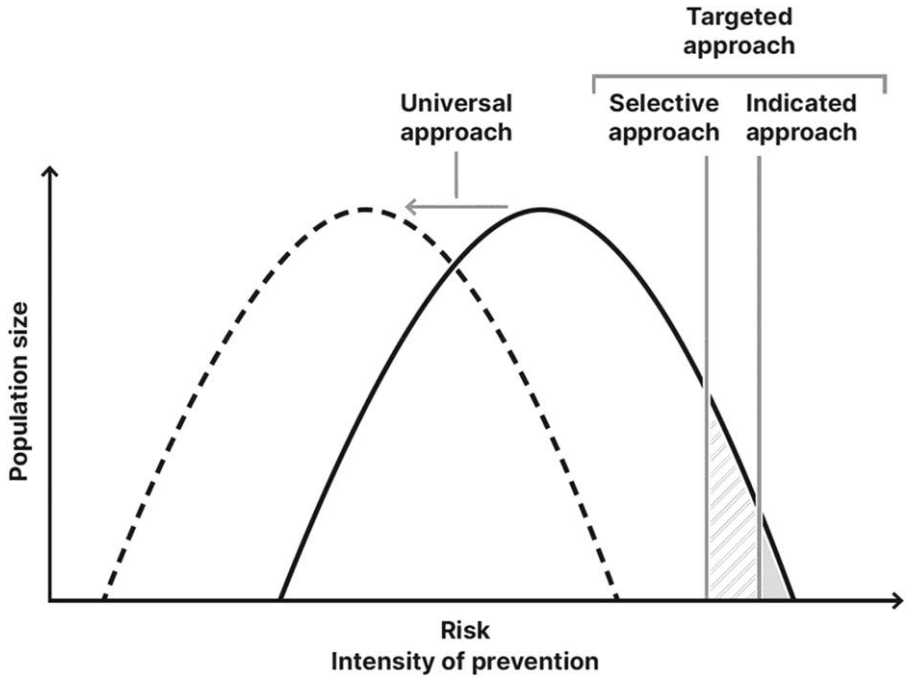
Universal, selective and indicated primary prevention. Selective and indicated approaches aim to reduce risk amongst those with the most to gain, and therefore reach a small proportion of the population. Universal approaches aim to shift the risk profile of the whole population.



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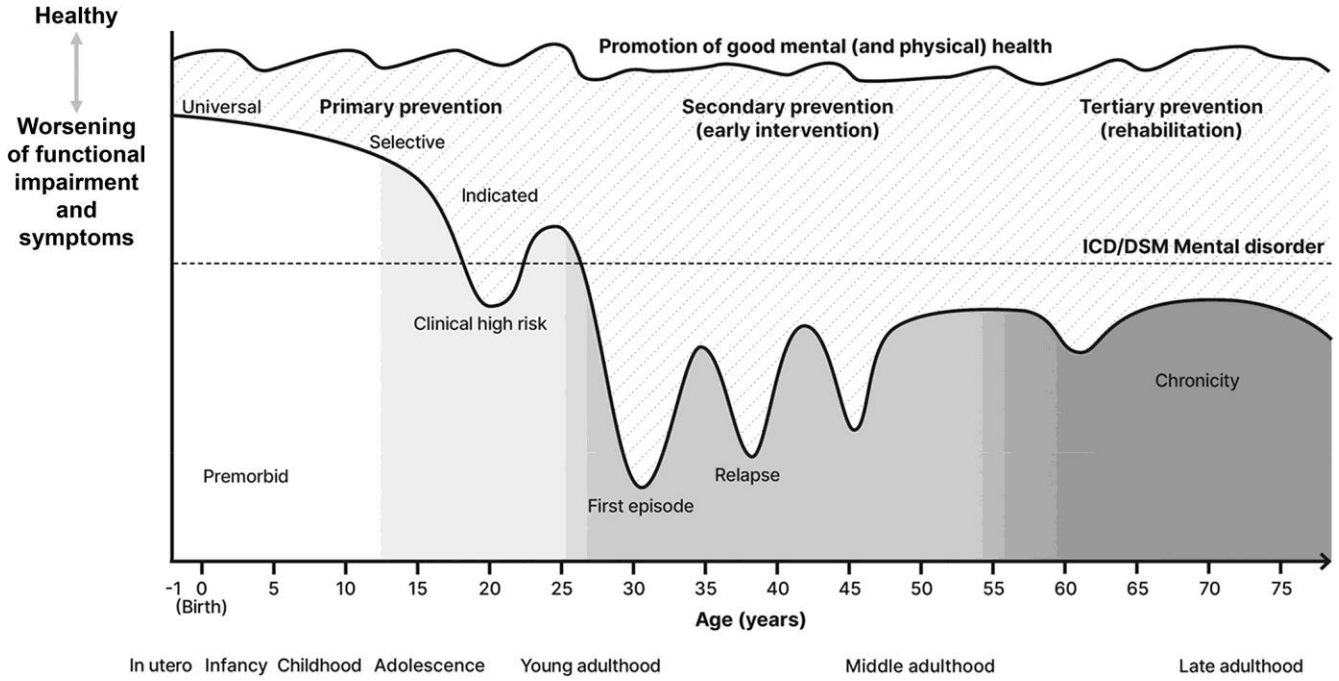
Paolo Fusar-Poli et al., “Preventive Psychiatry: A Blueprint for Improving the Mental Health of Young People,” *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 20, no. 2 (June 2021): 200–221, https://doi.org/10.1002/wps.20869.

Neurodevelopmental continuum model for prevention of psychosis, bipolar disorder and common mental disorders, and promotion of good mental and physical health



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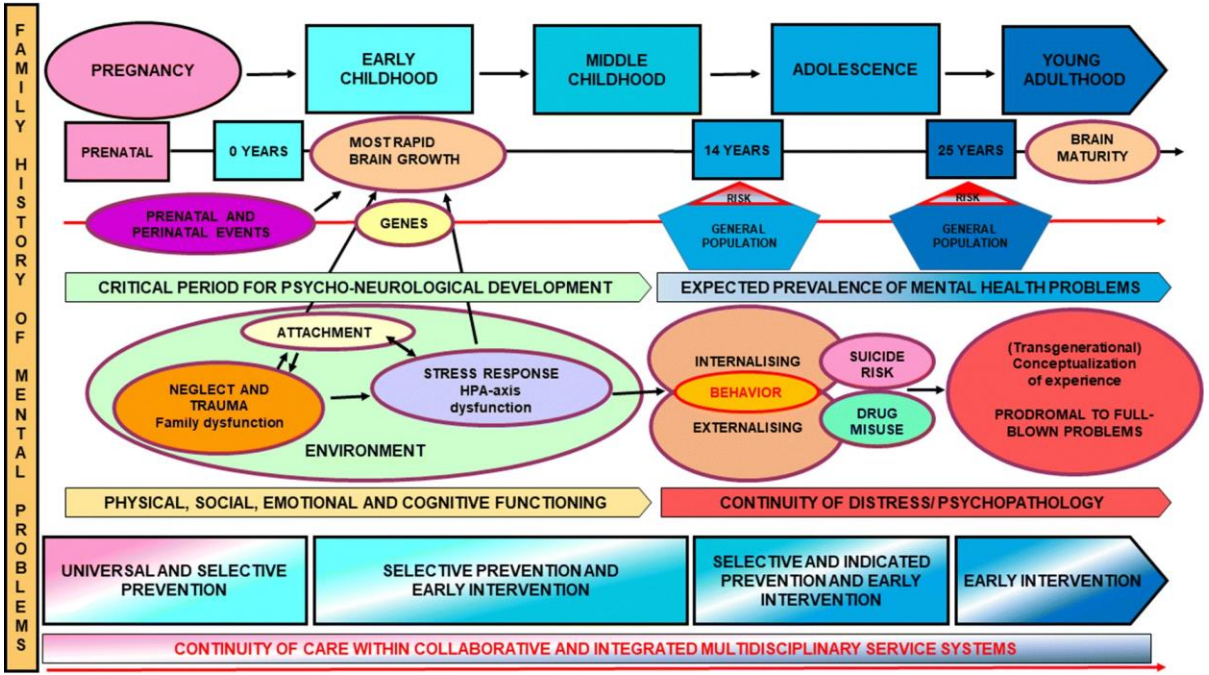
Paolo Fusar-Poli et al., "Preventive Psychiatry: A Blueprint for Improving the Mental Health of Young People," *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 20, no. 2 (June 2021): 200–221, https://doi.org/10.1002/wps.20869.

Summary of risk factors and pluripotent pathological trajectory for mental disorders



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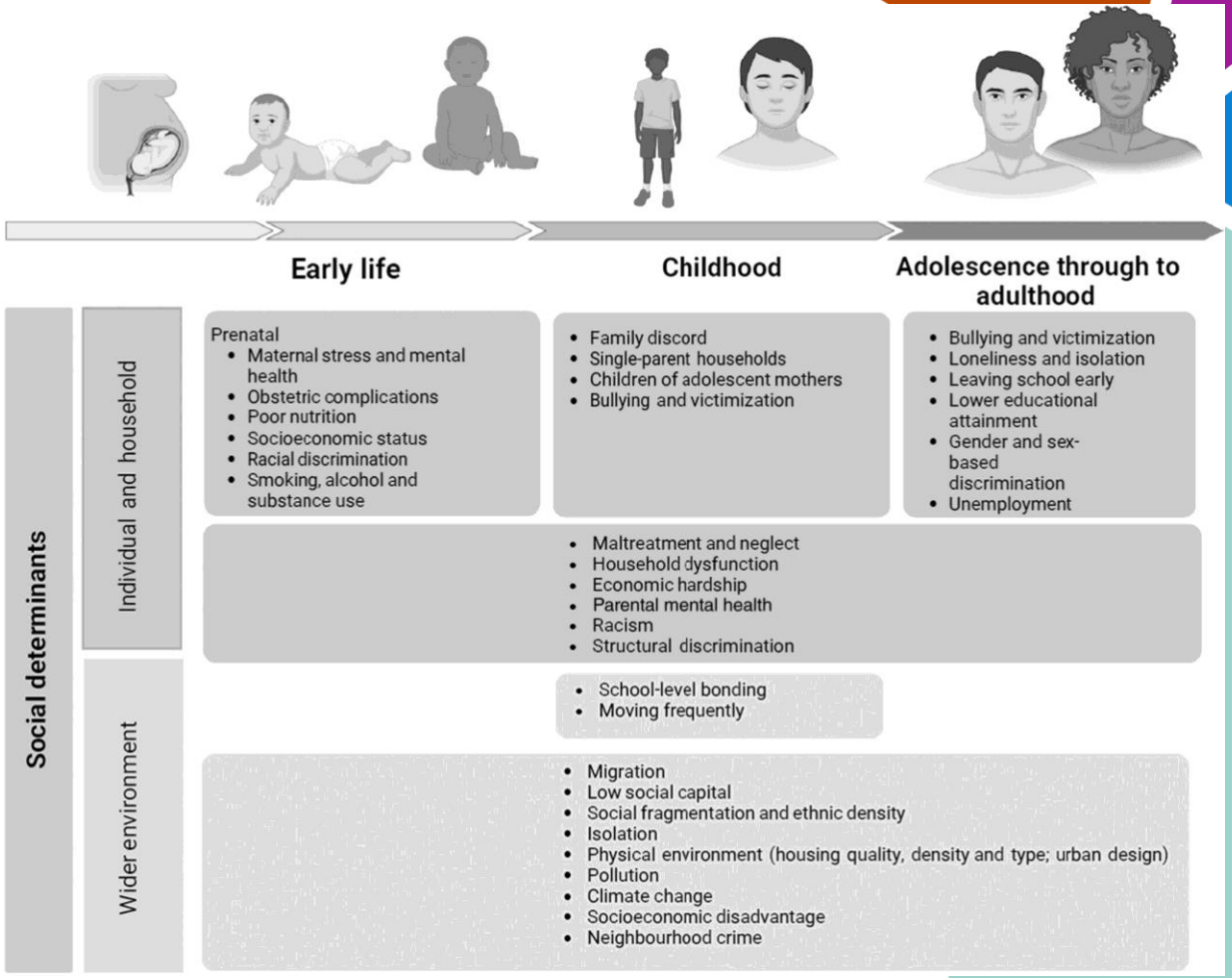
Marco Colizzi, Antonio Lasalvia, and Mirella Ruggeri, “Prevention and Early Intervention in Youth Mental Health: Is It Time for a Multidisciplinary and Trans-Diagnostic Model for Care?,” International Journal of Mental Health Systems 14 (2020): 23, https://doi.org/10.1186/s13033-020-00356-9.

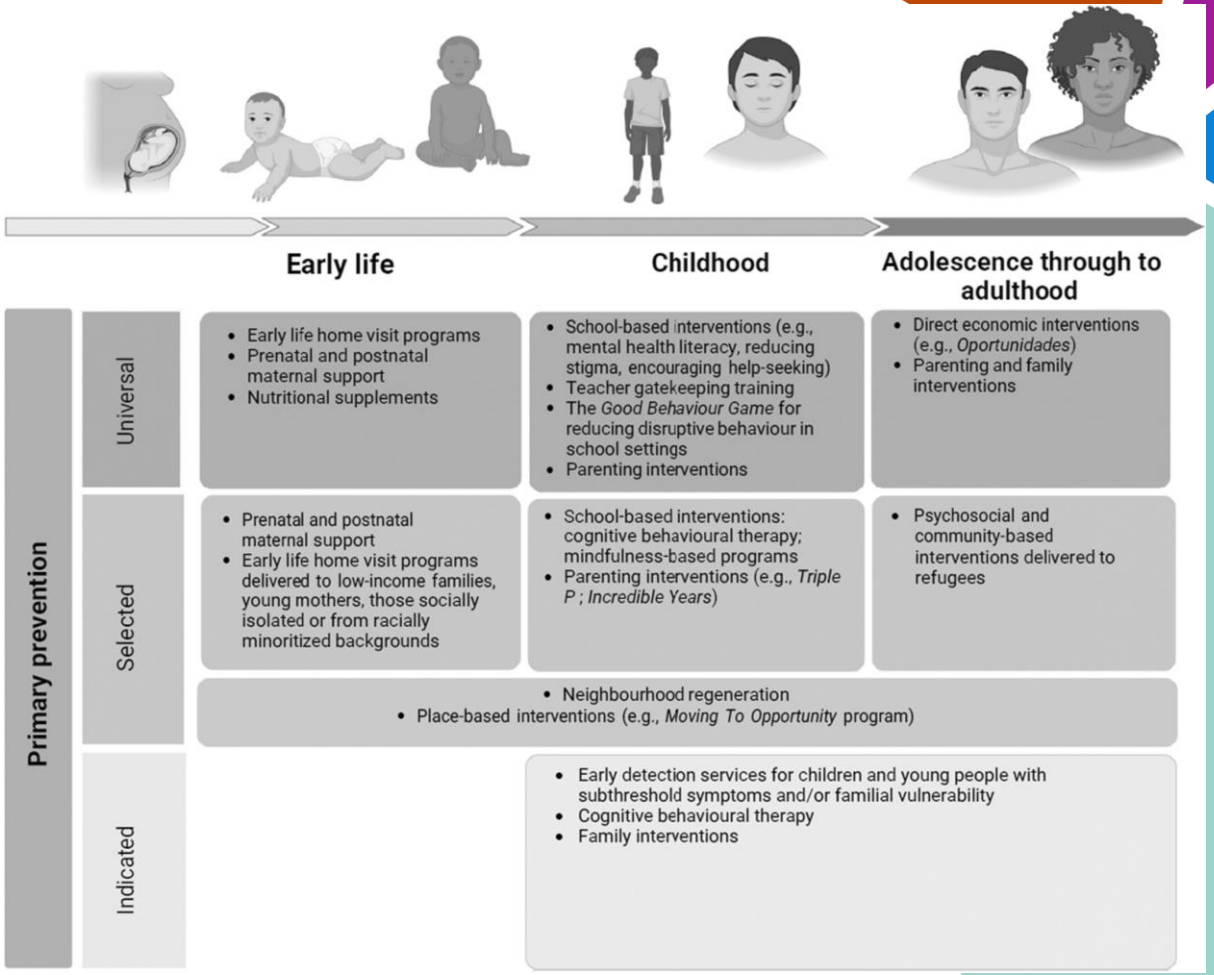
Summary of the social determinants of mental health and disorder and of the main primary prevention strategies (part 1 or 2)



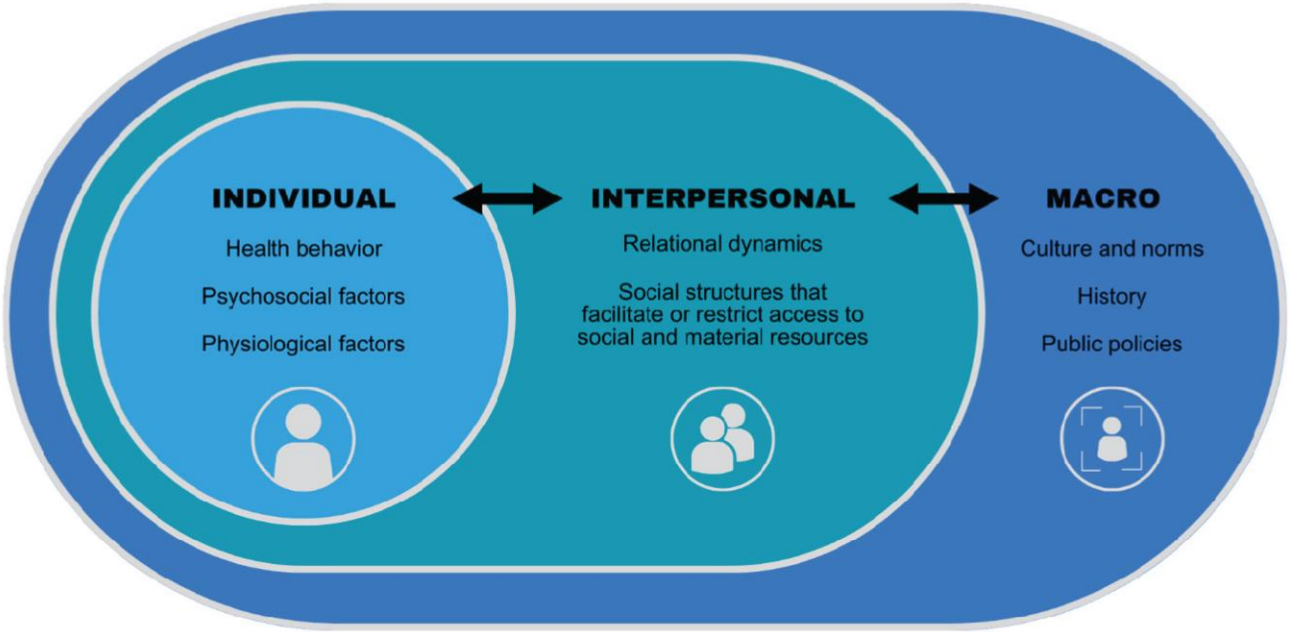
James B. Kirkbride et al., "The Social Determinants of Mental Health and Disorder: Evidence, Prevention and Recommendations," *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 23, no. 1 (February 2024): 58–90, https://doi.org/10.1002/wps.21160.

Summary of the social determinants of mental health and disorder and of the main primary prevention strategies (part 2 or 2)

James B. Kirkbride et al., “The Social Determinants of Mental Health and Disorder: Evidence, Prevention and Recommendations,” *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 23, no. 1 (February 2024): 58–90, https://doi.org/10.1002/wps.21160.



Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies – Examples of Nested Level of Influence (figure)



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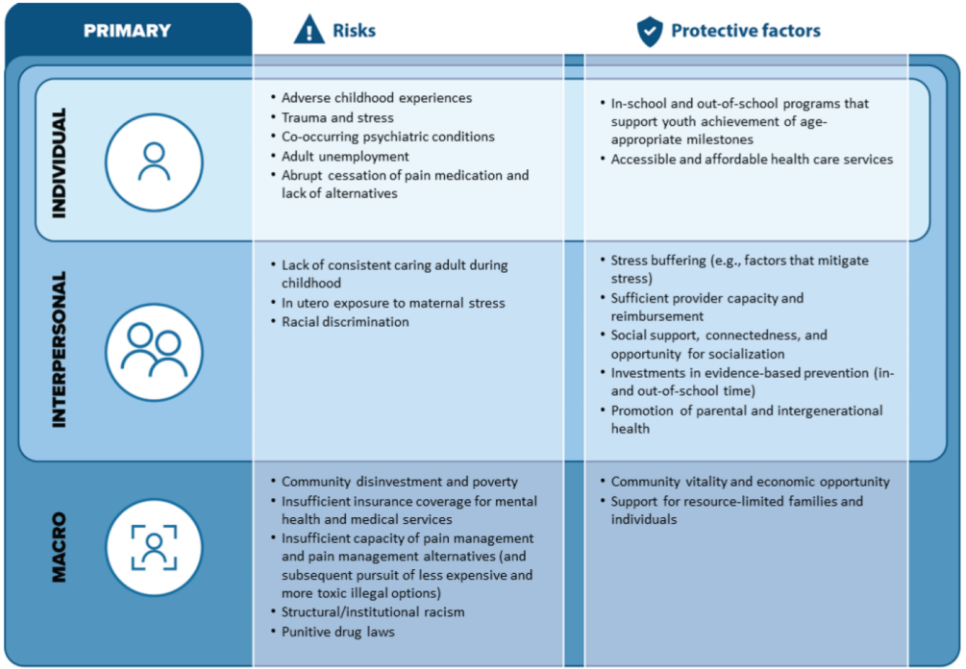
American Institutes for Research et al., "Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies," *NAM Perspectives* 9, no. 6 (September 6, 2023), https://doi.org/10.31478/202309b.

Primary Prevention: Examples of Risk and Protective Factors for Those at Risk of Developing Opioid Use Disorder



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American Institutes for Research et al., "Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies," *NAM Perspectives* 9, no. 6 (September 6, 2023), https://doi.org/10.31478/202309b.

Example: Overview of recommendations for action to intervene on social determinants to improve population behavioral health and reduce inequities in behavioral health problems

1. Make equity central to all public behavioral health interventions.
2. Support interventions that pay off in multiple domains.
3. Support interventions that prioritize critical windows of the life course to interrupt intergenerational transmission of behavioral health inequalities.
4. Prioritize interventions that focus on poverty alleviation.
5. Strengthen causal inference in research on social determinants of behavioral health and primary prevention.
6. Establish inclusive longitudinal population behavioral health monitoring.
7. Ensure parity between primary, secondary and tertiary prevention in mental health.

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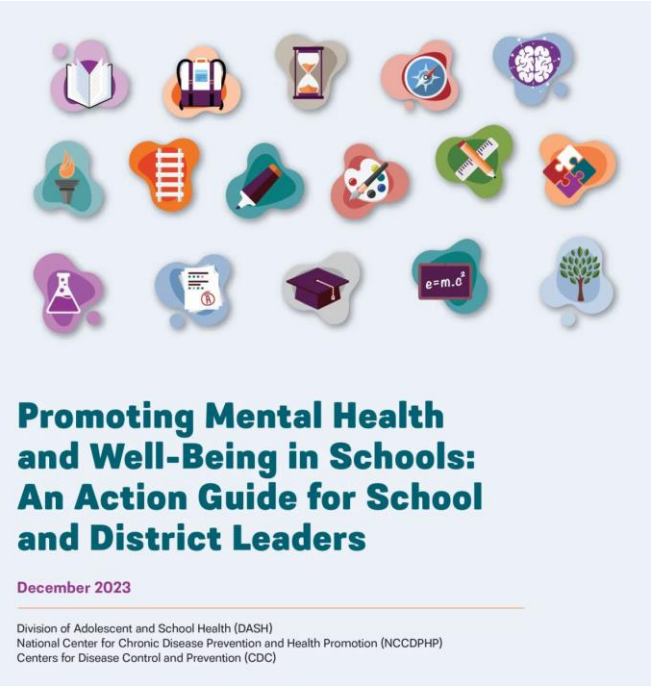
James B. Kirkbride et al., “The Social Determinants of Mental Health and Disorder: Evidence, Prevention and Recommendations,” *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 23, no. 1 (February 2024): 58–90, https://doi.org/10.1002/wps.21160.

Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders, CDC 2023



- Schools are prioritizing students' mental health, and there are many tools and resources to choose from. CDC created this action guide as a place to start. It can help school and district leaders build on what they are already doing to promote students' mental health and find new strategies to fill in gaps.
- The action guide describes six in-school strategies that are proven to promote and support mental health and well-being. For each strategy, the guide also describes approaches, or specific ways to put the strategy into action, and examples of evidence-based policies, programs, and practices.

https://www.cdc.gov/healthyyouth/mental-health-action-guide/index.html

“… adolescent mental health is getting worse and has brought national attention to the important role schools play in promoting mental health and well-being.” CDC, Dec 2023

- In 2021, 42% of high school students reported having felt so sad or hopeless for at least two weeks in the past year that they couldn’t engage in their regular activities, and 22% of high school students reported that they had seriously considered suicide.
- The data for female students, lesbian, gay, bisexual, queer or questioning students, and students who have experienced racism in school shows they are even more likely to experience poor mental health.
- When youth experience poor mental health, they are also at increased risk of school absence and dropout, risky sexual behavior, and illicit substance use.

https://www.cdc.gov/healthyyouth/mental-health-action-guide/index.html

Promoting Mental Health and Well-Being in Schools - Action Guide Strategies and Approaches

Strategy	Approach
Increase Students' Mental Health Literacy	▪ Deliver classroom-based mental health education curricula ▪ Implement peer modeling programs
Promote Mindfulness	▪ Deliver classroom-based mindfulness education ▪ Dedicate time for students to independently practice mindfulness ▪ Offer small group mindfulness activities
Promote Social, Emotional, and Behavioral Learning	▪ Provide classroom instruction focused on building social skills and emotional development ▪ Offer targeted education focused on teaching social skills and emotional development
Enhance Connectedness Among Students, Staff, and Families	▪ Provide relationship-building programs
Provide Psychosocial Skills Training and Cognitive Behavioral Interventions	▪ Promote acceptance and commitment to change ▪ Provide cognitive behavioral interventions ▪ Engage students in coping skills training groups
Support School Staff Well-Being	▪ Offer mindfulness-based training programs ▪ Provide therapeutic resources

https://www.cdc.gov/healthyyouth/mental-health-action-guide/index.html

Suicide Risk Is Tied to Local Economic and Social Conditions - Rates are lower in counties with more health insurance, internet access, and income

Suicide rates were **26% lower** in counties with the most health insurance coverage compared to counties with the least coverage.

Suicide rates were **44% lower** in counties where the most homes had internet access compared to counties where the fewest homes had internet.

The suicide rate for American Indian/Alaska Native people in counties with the highest income was half the rate of the lowest income counties.

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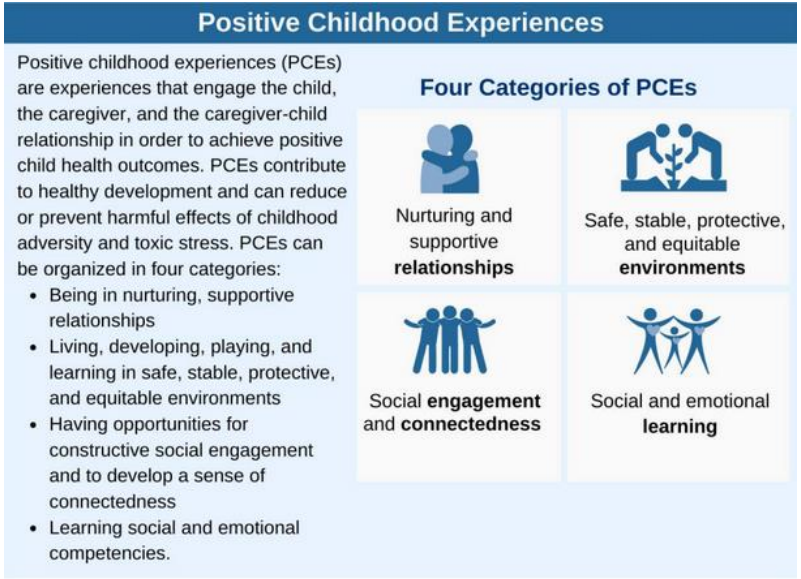
https://www.cdc.gov/vitalsigns/prevent-suicide/index.html
https://www.cdc.gov/mmwr/volumes/73/wr/mm7337e1.htm?s_cid=mm7337e1_e

Protective Factors and Resilience

- Inequities in early life exposures and community conditions contribute to inequities in behavioral health outcomes
- Positive childhood and community experiences are protective factors that can:
  - Support healthy development
  - Reduce or prevent the harmful effect of cumulative adversity and build resilience
  - Impact behavioral health disparities
- Examples: connectedness, positive relationships, cultural activities, community traditions, supports for basic needs, safe spaces, family support, belonging at school
- Population-level prevention includes improving equitable access to protective factors for all communities



Source: CDPH, Injury and Violence Prevention Branch; California Department of Social Services, Office of Child Abuse Prevention; California Essentials for Childhood Initiative; All Children Thrive, California. (2023, October). *Adverse and Positive Childhood Experiences Data Report: Behavioral Risk Factor Surveillance System (BRFSS), 2015-2021: An Overview of Adverse and Positive Childhood Experiences in California.*; CDC. (2024 May 16). Adverse Childhood Experiences: Risk and Protective Factors. https://www.cdc.gov/aces/risk-factors/index.html.; Prevention Institute. (2016). *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma*. https://www.preventioninstitute.org/publications/adverse-community-experiences-and-resilience-framework-addressing-and-preventing.

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CDPH Examples of Primary Prevention in Action: Addiction and Overdose

- Individual level:
  - Statewide Prevention and Education Campaign to raise awareness about the harms of fentanyl and prevent overdose
- Interpersonal level:
  - Strengthen child/parent bonding, healthy relationships, social supports and promotion of parent/caregiver health
  - Community defined, culturally and linguistically competent prevention activities responsive to the priorities and strengths of specific populations aimed at building connection, reducing stigma, and preventing substance misuse and addiction
- Macro level:
  - Policy partnership across departments and health systems to resolve barriers to access for addiction treatment and naloxone
  - Address poverty and food insecurity through improving access to WIC, CalFresh, Medi-Cal, TANF
  - Promote expanded utilization of the Earned Income Tax Credit to support economic security
- Examples from: Substance Use and Addiction Prevention Branch, Overdose Prevention Initiative, California Home Visiting Program, Black Infant Health Program, Adolescent Family life Program, Local MCAH, Cal-InSPIRE, California Reducing Disparities Project, and Essentials for Childhood Program

CDPH Example of Primary Prevention in Action: Suicide Death

- There are many factors the contribute to suicide. The goal of suicide prevention is to reduce factors that increase risk and increase factors that promote resilience.
- CDPH Youth Suicide Prevention Media and Outreach Campaign - *Never a Bother*
  - Includes 34 CBOs and tribal grantees implementing local youth suicide prevention projects. Activities include:
    - Provide resources and education that address the importance of reducing access to lethal means (e.g., safe storage of medication and firearms).
    - Teach coping and problem-solving skills through social-emotional learning programs.
    - A youth-led project to identify and implement stigma-reduction and peer support strategies.
    - Implement school-based initiatives, such as a youth-led, cross-cultural coalition to address safe-suicide messaging among youth and/or identify school-based prevention/support programs or policy changes.
- Additional examples include culturally and linguistically responsive outreach and education to reduce stigma and promote well-being through increased community connectedness and sustainment of cultural values and practices.

More than 50 different programs across CDPH focus on improving behavioral health outcomes:

Examples include:

- California Reducing Disparities Project advancing community-defined, culturally responsive approaches
- Office of Suicide Prevention
- Substance and Addiction Prevention Branch
- Office of School Health
- Essentials for Childhood
- Maternal, Child and Adolescent Health Program
- CDPH programs collect and provide data to understand behavioral health impacts, progress and opportunities for improvement
- Multiple CDPH programs are involved leading initiatives as part of the statewide Children and Youth Behavioral Health Initiative

Behavioral Health Planning

Informing strategies for population-based prevention in the context of Behavioral Health Services Act (BHSA)/Prop 1

BHSA Overview

- Statutory requirements mandate that a minimum of 4 percent of the total funds be directed to CDPH for **population-based** mental health and substance use disorder **prevention** programs.
- A significant portion of these funds, 51 percent, will be reserved for programs addressing behavioral health prevention for populations who are 25 years or younger.
- SB 326 outlines that these programs should encompass evidence-based practices or promising community defined evidence practices and meet one of the following:
  1. Benefit the entire population of the state, county, or particular community;
  2. Serve identified populations at elevated risk for a mental health or substance use disorder;
  3. Aim to reduce stigma associated with seeking help for mental health challenges and substance use disorders;
  4. Serve populations disproportionately impacted by systemic racism and discrimination; and
  5. Prevent suicide, self-harm, or overdose.

BHSA Overview

- SB 326 also stipulates school-based prevention supports and programs and early childhood population-based prevention programs shall be provided in a range of settings.
- **Implementation of all population-based prevention programs may be statewide or in a community setting**. Funding should also be used to strengthen population-based strategies and not be used for early intervention, diagnostic services, or treatment for individuals or supplant funding for services or supports provided by current initiatives.
- CDPH will collaborate with the Department of Health Care Services (DHCS) and the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) on implementation of the overall BHSA initiative.

Upcoming Engagement Opportunities

Expert Advisory Panel

CDPH will convene a group of equity-focused subject matter experts to refine and help prioritize policy, systems, and environmental (PSE) change strategies that support behavioral health and upstream prevention.

This input will be used to develop an overarching framework for broader collective action on behavioral health prevention, with roles across multiple sectors, initiatives, and funding streams.

BHTF Presentation

CDPH will provide updates on planning for BHSA population prevention activities and obtain input.

Date	Engagement Opportunity
Late October	Expert Advisory Panel Meeting #1
November 13th	Behavioral Health Task Force (BHTF) Presentation
Early December	Expert Advisory Panel Meeting #2

Discussion

- What aspects of primary prevention strategy resonate with your experience working to improve behavioral health?
- What are gaps or challenges in addressing prevention?
- What else would you add to help describe the opportunity for population-based prevention?

Visit the CDPH Behavioral Health webpage for updates on planning and engagement.

Questions or comments? Email us at bhsainfo@cdph.ca.gov.

Questions & Discussion

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Next Steps & Closing

Ariel Ambruster, Lead Facilitator, Sacramento State University

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California Health & Human Services Agency

Next Steps

- November 13th Hybrid Behavioral Health Task Force Quarterly Meeting, in Sacramento: 10 a.m.-3 p.m.
  - In-depth discussion on this issue and Proposition 1

- Email BehavioralHealthTaskForce@chhs.ca.gov to sign up for the Task Force listserv and send any questions/ comments

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Thank you for joining us today!

For information about the Behavioral Health Task Force, please visit the CalHHS website at https://www.chhs.ca.gov/home/committees/behavioral-health-task-force/

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