TRI-CITY MENTAL HEALTH SYSTEM'S
PREVENTION AND EARLY INTERVENTION PLAN

A Proposal to the Mental Health Services Oversight and Accountability Commission
in Accordance with the Mental Health Services Act

EXECUTIVE SUMMARY

February 2010

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INTRODUCTION

Tri-City Mental Health System is submitting this Prevention and Early Intervention (PEI) plan in accordance with California Department of Mental Health Letter 07-19, dated September 25, 2007, and subsequent related notices.

The Prevention and Early Intervention Plan is the second of five substantive plans Tri-City Mental Health Center will develop according to the Mental Health Services Act. The first plan, approved by CA DMH in June 2009, was the Community Services and Supports (CSS) plan. The CSS plan focuses on treatment for people who are seriously and persistently mental ill, or severely emotionally disturbed (SMI/SED). The Prevention and Early Intervention plan, however, focuses on a broad continuum of people who do not yet suffer from SMI/SED, from people in the general population to groups and individuals who may be more susceptible or at risk of mental illness. Specifically, the California Department of Mental Health guidelines identify six priority populations for the PEI plan:

- Individuals experiencing onset of serious psychiatric illness;
- Children and youth in stressed families;
- Trauma-exposed individuals;
- Children and youth at risk for school failure;
- Children and youth at risk of or experiencing juvenile justice involvement; and
- Underserved cultural populations.

Additionally, the state guidelines identify five priority issues that can be addressed by the plan:

- Prevention efforts and responses to early signs of emotional and behavioral health problems for children, youth, and young adults;
- Disparities in access to early mental health interventions;
- Suicide risk;
- Negative psycho-social impact of trauma for all ages; and
- Stigma and discrimination.

THE FUNDING

Given the global and national economic downturn, projections for Mental Health Services Act funding generally, and PEI funding in particular, have been highly volatile. Tri-City's actual PEI allocations have included:

- FY 2007-08: $702,900
- FY 2008-09: $1,386,881
- FY 2009-10: $1,881,300
- FY 2010-11: $1,232,500

According to projections by consultants for the California Institute of Mental Health and the California Mental Health Directors' Association, however, Tri-City's (and every other county's) projections over the next several years likely will decline significantly:

- FY 2011-12 estimated projection for Tri-City: $781,000
- FY 2012-13 estimated projection for Tri-City: $662,000

Given these projections, and the requirement that funds be expended within three years of their allocation date, we have developed a budget for the PEI plan that assumes:

- A beginning allocation for **on-going investments of $1 million**;
- A projected annual increase in expenses of 5%; and
- The worst-case revenue scenario for Tri-City continuing for several more fiscal years beyond FY 2012-13.

Under these assumptions, we project that Tri-City would be able to sustain its proposed PEI plan through FY 2015-16, and well-beyond FY 2015-16 if revenue projections improve. In addition to these on-going funds, the plan also includes projected non-recurring investments of $1,275,028 expended by June 30, 2013, and $61,600 in training and technical assistance funds.

SURVEY AND FOCUS GROUP DATA

PRIORITY POPULATIONS AND PRIORITY ISSUES DATA

Tri-City Mental Health Center staff and consultants engaged almost 3,000 community members in the PEI planning effort between June and December 2009, using four inter-related processes: focus groups, surveys, staff presentations, and stakeholder deliberations.

The data that emerged from these multiple conversations and engagement efforts revealed remarkable convergence among community members and leaders across the tri-city area on a range of questions, including the question about priority populations.

A more detailed description of the six priority populations, provided by the California Department of Mental Health for the PEI plan, includes the following:

- Individuals experiencing onset of serious psychiatric illness as identified by providers, including but not limited to primary health care, as presenting signs of mental illness or experiencing a first break, including those who are unlikely to seek help from any traditional mental health services;

- Children and youth in stressed families, including children and youth placed out-of-home or in families where there is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g. as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems;

- Trauma-exposed individuals—i.e., individuals who are exposed to traumatic events or prolonged traumatic conditions such as grief, loss or isolation, including those who are unlikely to seek help from any traditional mental health service;

- Children and youth at risk of or experiencing juvenile justice involvement, including children and youth exhibiting signs of behavioral/emotional problems who are at risk of having contact with, or have had any contact with, any part of the juvenile justice system, and who cannot be appropriately served through the Community Services and Supports plan;

- Children and youth at risk for school failure, including children at risk due to unaddressed emotional and behavioral problems; and

- Underserved cultural populations: those populations unlikely to seek help from any traditional mental health services whether due to stigma, lack of knowledge, or other barriers.

For the on-line survey, we asked respondents to identify their top 3 priority populations. Of the 635 survey respondents:

- 19.29% chose individuals experiencing onset of serious psychiatric illness;
- 22.88% chose children and youth in stressed families;
- 17.05% chose trauma-exposed individuals;
- 13.59% chose children and youth at risk of or experiencing juvenile justice involvement;
- 14.23% chose children and youth at risk for school failure; and
- 12.95% chose underserved cultural populations.

When the delegates went through their own exercise of prioritizing the top three populations, their percentages differed slightly from those of the online survey respondents. Specifically:

- 29.90% of delegates chose individuals experiencing the onset of serious psychiatric illness;
- 23.04% of delegates chose children and youth in stressed families;
- 20.59% chose trauma-exposed individuals;
- 9.80% chose children and youth at risk of or experiencing juvenile justice involvement;
- 8.83% chose children and youth at risk for school failure; and
- 7.84% chose underserved cultural populations.

Delegates also reviewed data for the past year that indicate discernible, and in many cases significant increases in domestic violence calls, violent crime, suicide attempts, and other indicators of mental and emotional distress within families and communities across the three cities. Delegates understood that these and other indicators of mental and emotional distress are increasing at precisely the time when local governments, schools, foundations, and service providers are suffering escalating and devastating budget cuts. Indeed, the funding streams that support this plan under the Mental Health Services Act have declined significantly, and will likely continue to do so over the next several fiscal years.

Ultimately, however, delegates concluded that many of the root causes affecting the mental wellbeing of these different populations are the same, and many of the strategies that could promote the mental wellbeing of these populations would also be similar. For example, delegates reasoned that children and youth in stressed families are likely to be at higher risk for experiencing juvenile justice involvement and school failure. They also assumed that the imperative to serve underserved cultural populations was a priority for all other priority populations. They therefore sought to create projects that could benefit as many of these populations as possible.

WELLNESS DATA

In addition to questions about priority issues and populations, we also asked survey participants, focus group participants, and delegates a series of questions about *wellness*, including:

- What does mental and emotional wellbeing mean for you and the people closest to you?
- What helps you maintain mental and emotional wellbeing?
- What helps people in your community meet challenges in their lives?

Regardless of the characteristics of the group—income level, race and ethnicity, geography, gender identity, immigrant status, and others—responses to these questions were extraordinarily consistent: the top responses to each of these open-ended questions remained consistent across virtually all sub-groups.

- What does mental wellbeing mean for me and the people I am closest to?
  - Healthy relationships with family and friends;
  - A sense of greater purpose and meaning through religion, church, spirituality, and/or nature; and
  - An ability to create and maintain supportive relationships with others.

- What helps me maintain mental wellbeing?
  - Support from family and friends;
  - A meaningful connection to church, religion, spirituality, and/or nature;
  - Exercise, recreation, and music; and
  - A sense of purpose through employment, volunteering, and/or school.

- What helps people in these communities meet these challenges?
  - Healthy relationships with family and friends;
  - A sense of greater purpose and meaning through religion, church, spirituality, and/or nature;
  - Meaningful work, employment, school and/or volunteer opportunities.

We also asked focus group and survey participants who some of the people were that they considered trusted leaders and healers in their communities, and some of the places they and others in their communities frequented for worship, health, recreation, shopping, and other purposes. What became clear from the responses to these questions was that while the *categories* of wellbeing and support were consistent across groups and communities, the actual *experience* of wellbeing and support is highly contextual: where people go and who they trust for support and care varies dramatically within and among families and communities.

THE GUIDING VALUES

As delegates reflected on the purposes of the PEI plan, and on the data that emerged from the surveys, focus groups, and their own deliberations, several guiding values began to emerge:

- A focus on *communities*, defined as a groups of people who have sufficiently strong relationships that they provide tangible support to each other and can act together. Communities have strengths and assets that *already* support their members' health and wellbeing. With culturally appropriate support and encouragement, communities can leverage and extend these strengths and assets to improve and sustain the wellbeing of their members over time.

- A commitment to *strengthen the capacities of communities* to promote the mental and emotional wellbeing of their members. This commitment reflects an understanding that communities have the primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members. No service system, no matter how efficient and effective, can ever be a complete and permanent substitute for the care and nurturing that becomes available to individuals and families through their natural communities of support.

- A commitment to *sustainability*. Given the volatile and highly unstable economic environment, and the resulting uncertainty around MHSA funding, delegates committed to invest in strategies that would strengthen community capacity for caring and action that could continue regardless of future funding realities.

- A commitment to community-defined *results.* Too often data about effectiveness is unavailable, incomprehensible to anyone but program experts, or irrelevant to communities and families striving to decide on courses of action culturally appropriate to their contexts. Transformative action within communities will more likely emerge when community leaders can design their

own rigorous assessment plan, and access data they care about in a timely manner, to help them assess whether actions they are taking are having a positive impact.

- A commitment to *learning.* Too often within complex systems, data is used to enforce compliance with static and predetermined program guidelines, and/or to affix blame if something goes wrong. These two values—compliance and blame—profoundly diminish the capacity of communities to adapt to complex and shifting realities. Many of the challenges confronting local communities, including those that undermine their health and wellbeing, defy simple analyses and responses. What is needed are structures of support and learning that help communities learn from each other, even cross-culturally, to expand their respective repertoires of effective action.

We have designed every aspect of the Prevention and Early Intervention Plan to reflect our commitment to these values.

THE THREE PROJECTS

The Prevention and Early Intervention Plan is organized around three projects: the Community Capacity-Building Project, the Family Wellbeing and Peer Support Project, and the Student Wellbeing Project.

PEI PROJECT 01:
COMMUNITY CAPACITY-BUILDING

The Community Capacity-Building Project will engage partners in communities across the three cities, particularly unserved and under-served ethnic and other communities. These partners will include schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

The project includes two programs: the Community Wellbeing program and the Mental Health First Aid program.

- Community Wellbeing Program

The Community Wellbeing Program is a new program designed to help communities develop and implement community-driven plans to improve and sustain the mental and emotional wellbeing of their members. The program reflects several foundational premises, including:

- Families and communities have primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members;
- Families and communities have strengths and assets that already support their members' health and wellbeing; and

- With culturally appropriate support and training, communities can leverage and extend their strengths and assets to improve and sustain the wellbeing of their members over time.

In designing this program, delegates embraced a specific definition of *community* as a group of individuals who have sufficiently strong relationships that they are able to provide tangible support to each other and can act together.

Through the Community Capacity-Building Program, Tri-City Mental Health Center staff, with support from consultants in the first year, will identify a number of communities with strong community leadership and a commitment to improving the mental and emotional wellbeing of their members. The communities who partnered with us in the community planning process are obvious candidates for this effort.

Once identified, staff (and consultants in the first year) will work with community leaders to master the skills and frameworks needed to support their community's planning and action to promote mental health and wellbeing. The commitment each community will make will be to improve results of wellbeing for their community members. The community planning process will be based on the seven questions of the *Results-based Accountability* framework:

- What population are we concerned about? (Communities will be chosen to insure that most plans will, at minimum, address the needs of children, youth, and young adults in the chosen community.)
- What conditions of mental and emotional wellbeing do we want for this population in our community?
- How *will we know* if we are making progress toward these results? (The data specialist hired to support this program will work with the community to develop timely community-level data to help communities answer this question.)
- How are we doing on the most important of these measures, and why?
- Who are partners in our community (or elsewhere) who have a role to play in improving our conditions of mental and emotional wellbeing?
- What works, or can work, *in our community* to improve these conditions of mental and emotional wellbeing?
- What do we propose to do (including no-cost and low-cost ideas)?

Once the plans are completed, community leaders and partners will receive several forms of on-going support. First, communities can apply for funding for up to three years from a community grants fund to support community-driven actions focused on results of emotional wellbeing. Second, communities will receive support so that they are able to generate and analyze reliable and timely data to assess the effectiveness of their efforts. Third, communities will be able to participate in various learning circles and other structures that help them share and receive lessons learned with other communities who are also participating in this program.

- Mental Health First Aid Program

The Mental Health First Aid (MHFA) is a program to train scores of people in community-based settings to intervene quickly and effectively to offer support when someone is experiencing mental and emotional distress. This evidenced-based program begins with a premise that just as people can master basic first aid for physical injuries—e.g., the Heimlich maneuver, CPR— without being doctors, people can also master basic *mental health first aid* without being clinicians.

The components of this program are straightforward. An initial group of people successfully completes a five-day course to become certified MHFA instructors. We estimate that 25 people from the tri-city area will complete this instructor course in the first year: two will be new staff members from Tri-City Mental Health Center; the others will come from a range of community partners, including schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

Each of these 25 people will then be certified to offer the 12-hour MHFA course to members of their community. The course provides knowledge and skills to people to help them learn how to help someone struggling with mental or emotional distress, or developing a mental health problem or crisis. Specifically, First Aiders will learn:

- The potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, eating disorders, substance use disorders, self-injury, and psychosis and psychotic disorders;
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities;
- A 5-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate supports; and
- The self-help, social, peer, and professional resources available to help someone with a mental health problem.

The budget includes non-recurring funds to support the wide-ranging delivery of these 12-hour programs, including funds to purchase people's time—e.g., funds for substitutes so teachers can take the 12-hour first aid training—and stipends for food, space, childcare, and other support.

Our intention is to train over 1,000 Mental Health First Aiders within the first several years of the program. These First Aiders will know how to appropriately respond to a person they encounter who is struggling with a mental health issue, and how to help the person connect to their natural communities of support, and to other support structures and resources such as peer counseling, wellness activities, self-help programs, and others.

The two Tri-City Mental Health Center staff members who are trained as MHFA instructors will have additional responsibilities beyond delivering the basic MHFA course. One of their responsibilities will be to develop curriculum to augment the basic 12-hour first-aid training. We therefore expect these staff members to have expertise in curriculum and training design. The first two issues they will develop specialized training for will be: (1) recovering from trauma in response to violence (e.g., community violence, domestic violence, war); and (2) suicide awareness and prevention. They will deliver this training sometimes as an adjunct to the MHFA basic training, and sometimes as standalone training for high priority communities.

We also expect these two staff members to develop relationships with key community partners—e.g., primary care physicians and clergy. The focus of this work will be to understand these partners' needs to become more effective first responders for people having a mental health crisis, and identifying and securing experts or others who can provide specialized information, training, and support for these partners—e.g., training related to prescribing psychotropic medications for primary care physicians.

As trained First Aiders are available in their communities, we expect them to offer mental health first aid and support to perhaps thousands of people over time. For the people who *receive* mental health first aid, we anticipate that these individuals and families will report:

- Positive experiences with the First Aiders;
- Progress in responding to and resolving the immediate experience of mental and emotional distress; and
- Increased access to supports that can help them maintain their mental and emotional wellbeing going forward;
- Increased confidence that they will be able to maintain their mental and emotional wellbeing going forward.

We also expect that the presence of more than 1,000 First Aiders will have a positive impact on stigma and discrimination experienced by people who struggle with issues of mental and emotional distress, including those people who suffer from mental illness.

PEI PROJECT 02: PEER SUPPORT AND FAMILY WELLBEING

The Peer Support and Family Wellbeing Project will create a range of tailored structures of support and programming for older adults, older transition-aged youth and young adults, and for families of children and young transition-aged youth. The project includes two programs: The Peer Support Program and the Family Wellbeing Program.

➢ Peer Support Program

Building on the success of the senior peer counseling model from the Center for Healthy Aging in Santa Monica, California, the Peer Support Program will recruit and train

volunteer peer counselors for two age groups: older adults, and older transition-aged youth and young adults. These volunteers will be trained to assess the mental health and well-being of age group peers, to provide 1-1 peer counseling, and to lead age- and issue-based peer support groups. Groups organized under this program will focus on providing support *and* creating opportunities for members to engage in projects that serve their communities and other wellness activities.

Communities who have implemented the peer counseling program have implemented ratios of counselors to group members as low as 1-4 (Contra Costa county) and as high as 1-75 (Marin County). Our targets are to recruit up to 25 volunteers for each of our two priority age groups, and for each volunteer to support up to 25 peers each through a combination of groups and 1-1 counseling. We expect that supports offered through this program will focus both on targeted prevention and early intervention.

Volunteer counselors (who likely will also be trained as Mental Health First Aiders) will receive part-time supervision from Tri-City Mental Health Center clinical staff, and will meet regularly to receive support and share lessons learned. They will be recruited from communities across the three cities, including unserved and under-served communities; some will be fluent in languages other than English, and will conduct groups and 1-1 counseling sessions in these languages.

Potential recipients of these peer supports will be identified by, among others:

- Mental Health First Aiders trained under the Mental Health First Aid Program under the Community Capacity-Building Project, who will be located in non-traditional mental health settings across the three cities;
- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (also under the Community Capacity-Building Project);
- CSS Community Navigators;
- Tri-City Mental Health Center staff funded under the CSS Field Capable Services for Older Adults program; and
- Tri-City Mental Health Center staff funded through the CSS Wellness Center program, particularly staff members supporting the transition-aged programming in the Wellness Center.

➢ Family Wellbeing Program

The Family Wellbeing Program will be located at the CSS-funded Wellness Center, and will identify existing community resources—e.g., the NAMI Parents and Teachers as Allies program, parent support groups, and others—and develop new programming to support families of children and young transition-aged youth struggling with mental and emotional distress.

As with the Peer Support program, potential recipients of these supports will be identified by, among others:

- Mental Health First Aiders trained under the Mental Health First Aid Program under the Community Capacity-Building Project, who will be located in non-traditional mental health settings across the three cities;
- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (also under the Community Capacity-Building Project); and
- CSS Community Navigators.

Programming will reflect the culture and traditions of families who seek support from the program, and as with the Peer Support Program, will include a range of wellness activities—e.g., exercise, music, cultural awareness activities, and others.

PEI PROJECT 03:
STUDENT WELLBEING

The tri-city area is served by three public school districts. These are:
- Bonita Unified School District, with 10,000 K-12 students;
- Claremont Unified School District, with 6,300 K-12 students; and
- Pomona Unified School District, with 32,000 Pre-K-12 students.

A number of colleges are also located in the tri-city area, including:
- California State Polytechnic University, Pomona, better known as Cal Poly Pomona, serving 21,000 students;
- Claremont Colleges, including 7 independent colleges serving a total of 6,300 students; and
- University of La Verne, serving over 4,200 students.

The PEI guidelines require that at least 51% of a county's funding address the needs of children, youth, and young adults ages 0-25. From the beginning of the planning process, delegates knew that the schools, colleges, and universities would have vital roles to play in the PEI efforts.

Data from the focus groups made clear the essential role for these institutions to play in this process. Through our conversations with teachers, students, families of school- and college-aged students, school personnel, and others, we heard numerous and detailed stories of the increased stress and emotional challenges confronting students and their families as they struggle to cope with the chaos of the economic downturn.

At the same time, the school districts, as well as the colleges and universities, are experiencing devastating budget cuts to both core education and support programs, including mental health programs for students. These institutions are scrambling to discover new ways to support students under increasing and often debilitating stress,

even as they have to dismantle programs they have relied on for years—e.g, Student Assistance Programs, counseling programs, and others.

We also learned through the focus groups, and from the delegates' deliberations, that the school districts have little experience engaging in collaborative planning and programming, despite their close proximity and the frequent movement of students and families among the school districts. Similarly, the area colleges have little experience engaging in collaborative planning and programming, either among themselves or with the school districts.

Given this data and analysis, we have designed the Student Wellbeing Project to support the three school districts in developing an integrated plan to promote the emotional and mental and emotional wellbeing of K-12 students across the three cities. Similarly, we will support the area colleges in developing coordinated plans that promote the mental and emotional wellbeing of area college students.

- K-12 Student Wellbeing Program

The K-12 Student Wellbeing Program will engage leadership from the three school districts to develop an *integrated* plan to promote the mental and emotional wellbeing of their students. This program will provide professional facilitation to the school districts to support their planning process, and up to three years of non-recurring funds to jumpstart the implementation of the plan.

The planning process for the school districts, like the community planning efforts funded under the Community Capacity-Building Project, will be based on the seven questions of the *Results-based Accountability* framework:

- What population are we concerned about? (K-12 students across the three cities)
- What conditions of mental and emotional wellbeing do we want for this population in our community?
- How will we know if we are making progress toward these results?
- How are we doing on the most important of these measures, and why?
- Who are partners in our communities (or elsewhere) who have a role to play in improving the conditions of mental and emotional wellbeing for our students?
- What works, or can work, to improve these conditions of mental and emotional wellbeing?
- What do we propose to do (including no-cost and low-cost ideas)?

Once the school districts complete their integrated plan and it is reviewed and approved by a joint staff-delegates' committee, they will receive additional levels of support. First, they will receive up to $600,000 in non-recurring funds (spread over two or more fiscal years) to jumpstart the implementation of their plan. Second, we will work to facilitate partnerships between the school districts and colleges in order to generate additional resources for the schools—e.g., student interns, research support, and other potential resources available through the colleges. Third, we will work to facilitate appropriate

partnerships between the communities participating in the Community Capacity-Building Project and the school districts based on the convergence among their respective plans. Fourth, we will invite the school districts to have significant numbers of their teachers and staff trained as Mental Health First Aiders. Fifth, as the school districts move toward implementation of their plan, staff members, students, and others will be able to participate in various learning circles and other structures that help them share and receive lessons learned with the colleges and communities who are also implementing plans to promote the mental and emotional wellbeing of their members.

- College Student Wellbeing Program

The College Student Wellbeing Program will engage leadership from the area colleges to participate in a joint planning process to develop campus-based plans to promote the emotional and mental wellbeing of their students. This program will provide professional facilitation to the area colleges to support their planning process, and up to three years of non-recurring funds to jumpstart the implementation of their plans.

The planning process for the colleges will be based on the same seven questions of the *Results-based Accountability* framework that will be used for the K-12 Student Wellbeing Program, and the community planning efforts under the Community Capacity-Building Project.

Once the colleges complete their planning process, and their respective plans are reviewed and approved by a joint staff-delegates' committee, they will receive levels of support similar to those provided to the school districts under the K-12 Student Wellbeing Program. First, they will receive up to $230,000 in non-recurring funds (spread over two or more fiscal years) to jumpstart the implementation of their plans. Second, we will work to facilitate appropriate partnerships between the communities participating in the Community Capacity-Building Project and the colleges based on the convergence among their respective plans. Third, we will invite the colleges to have significant numbers of their faculty members and staff trained as Mental Health First Aiders. Fourth, as the colleges move toward implementation of their plans, staff members, students, and others will be able to participate in various learning circles and other structures that help them share and receive lessons learned across the various campuses, and with the school districts and communities who are also implementing plans to promote the mental and emotional wellbeing of their members.

CONCLUSION

We believe the mental health system now emerging in the tri-city area is becoming stronger and more effective than anything that has gone before. We eagerly await the approval of the Mental Health Services Oversight and Accountability Commission so we can continue transforming the mental health system in the tri-city area by implementing the Prevention and Early Intervention plan.