Humboldt County
Department of Health and Human Services
Mental Health Branch

Mental Health Services Act
Prevention and Early Intervention Plan

December 2008

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EXPENDITURE PLAN FACE SHEET

Form No. 1

County Name: Humboldt	Date:12/04/08

COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	**Project Lead**
Name: Karolyn Rim Stein, RN Telephone Number: 707 268-2990 Fax Number: 707 476-4049 E-mail: kstein@co.humboldt.ca.us	Name: Karolyn Rim Stein, RN Telephone Number: 707 268-2990 Fax Number: 707 476-4049 E-mail: kstein@co.humboldt.ca.us
Mailing Address: Humboldt County Mental Health Branch Administration 720 Wood Street Eureka, Ca 95501	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature Karolyn Rim Stein, RN — December 5, 2008

County Mental Health Director — Date

Executed at Eureka, CA, California

INTRODUCTION: Humboldt County PEI Plan

County: Humboldt **Date:** December 4, 2008

The Mental Health Services Act (Proposition 63), passed by California voters in 2004, provides funds for counties to expand and transform mental health services. Transformation has been defined as more than just reorganizing, but a quantum change that reflects radical redesign and new strategic intent for an organization or system.

Humboldt County Department of Health and Human Services (DHHS) is a consolidated and integrated Health and Human Services Agency under the State's Integrated Services Initiative (AB 315 Berg) and includes the branches of Mental Health, Public Health and Social Services. Since its consolidation in 1999, DHHS has been engaged in true system transformation and redesign through numerous key strategies, including but not limited to:

- Establishing consolidated administrative support infrastructure(s)
- Establishing consolidated program support infrastructure(s)
- Developing governmental "rapid cycle" change management processes
- Importing or developing Evidence Based Practices and other outcomes-based approaches to services
- Developing integrated, co-located and decentralized services concurrently
- Establishing client and cultural inclusion structures/processes that will advise the department in terms of policy and programming
- Focusing on quality improvement and systems accountability in terms of outcomes linked to improved individual and family recovery and self-sufficiency, as well as improved community health
- Using a "3 x 5" approach to program design which spans:
    - Three service strategies
        - Universal
        - Selective
        - Indicated
    - Five target populations
        - Children, Youth and Families
        - Transition Age Youth

        - Adults
        - Older Adults
        - Community

- Working with State Health and Human Services Agency to reduce or eliminate barriers that impede effective service delivery at the county level.

It is through AB 315 and these transformational strategies that the Humboldt County DHHS has planned and implemented its Mental Health Services Act (MHSA) programming. Humboldt County's approved Community Services and Supports (CSS) workplans were developed and have been implemented with cross-departmental integration aimed at the delivery of holistic and transformational programs.

Consistent with the CSS, Humboldt County's MHSA Prevention and Early Intervention (PEI) Plan has also been developed in the context of AB 315, the Humboldt County DHHS AB 315 Strategic Plan and system transformation strategies.

In addition, as part of its strategic planning, DHHS has had a well articulated vision of the need for and role of prevention and early intervention since the adoption of the Humboldt County Strategic Prevention Plan in December 2002. This plan has guided DHHS in its efforts to move resources towards preventing problems and creating healthier communities.

Humboldt County's PEI Plan includes three main focus areas chosen after careful consideration of focused, ongoing stakeholder input, Mental Health Board participation, the department's AB 315 Strategic Plan, local and state data, evidence based strategies, community values and cultural competence:

- Suicide Prevention
    - Maintain a system of suicide prevention
    - Improve suicide prevention project effectiveness and system accountability

- Stigma and Discrimination Reduction
    - Maintain a system that uses external influence strategies to reduce stigma and discrimination
    - Educate communities to take action to reduce stigma and discrimination

- Transition Age Youth Partnership
    - Community outreach, education and training about the early identification of indicators for TAY who are at risk of or experiencing the onset of serious psychiatric illness

- The promotion of prevention and early intervention through support of TAY advocacy groups
- Comprehensive and coordinated services for TAY who are at risk of or experiencing the onset of a serious psychiatric illness.

The PEI Plan builds on Humboldt County's efforts to provide integrated, holistic and transformational strategies and services under AB 315, the AB 315 Strategic Plan, the Strategic Prevention Plan and the MHSA—and reflects Humboldt County DHHS' commitment to its Vision:

Humboldt County is a nurturing, supportive, healthy environment for its children, families, adults and communities.

Currently, in addition to MHSA PEI-proposed projects and the many prevention and early intervention programs being delivered by DHHS Public Health and Alcohol and Other Drugs divisions, DHHS is engaged in several cross-departmental prevention and early intervention initiatives in the areas of community capacity development, stakeholder support and early intervention for children in foster care:

- The Community/family Resource Center Initiative provides support for capacity-building within the diverse and geographically distant communities of Humboldt County towards the goal of decentralizing DHHS service delivery

- Mechanisms are also currently under development to promote partnerships with local Federally Qualified Health Clinics, Rural Health Clinics and Indian Health Clinics so that holistic healthcare may be provided in locations where the communities obtain services, close to home in decentralized environments

- The development of cross-branch rural, mobile outreach services is also underway

- DHHS has committed to systems and services delivery improvements for transition age youth through a long-term partnership with youth development and empowerment organizations to build a strong Humboldt County youth engagement process

- The Enhanced Mental Health/Foster Care Initiative will provide behavioral health assessment and referral to a variety of behavioral health services, when indicated, to all children in foster care in Humboldt County. It is anticipated that this initiative will result in up to $3 million dollars of new resources for this at-risk population, and lead to improved outcomes

including stability in placement, school and employment, as well as long-term self-sufficiency.

With a long history of successfully implementing and delivering prevention and early intervention services, and with our proven commitment to providing integrated, holistic and transformational programs across the department, Humboldt County DHHS looks forward to implementing the MHSA PEI projects/workplans described in the PEI Plan.

PREVENTION AND EARLY INTERVENTION
COMMUNITY PROGRAM PLANNING PROCESS

(Enclosure 3, Form No. 2)

County: Humboldt **Date:** December 4, 2008

Instructions: Please provide a narrative response and any necessary attachments to address the following questions. (Suggested page limit including attachments, 6-10 pages.)

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

- Mental Health Branch Administration, including the Branch Director and the MHSA Administrative Analyst

b. Coordination and management of the Community Program Planning Process

- Mental Health Branch Administration, including the Branch Director and the MHSA Administrative Analyst
- Humboldt County Department of Health and Human Services Senior Management Team

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

- Humboldt County Mental Health Board Mental Health Services Act Committee
- Mental Health Branch Administration, including the Branch Director and the MHSA Administrative Analyst

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations

The Humboldt County Mental Health Board, clients and family members, and Humboldt County Department of Health and Human Services (DHHS) staff

provided recommendations to identify opportunities for gaining input from diverse stakeholders, and served as liaisons with those communities.

An overall strategy was developed that included:

- The Mental Health Board MHSA Committee providing ongoing input and updates
- DHHS staff and Mental Health Board members contacting local community-based organizations and associations that represent or serve diverse stakeholders to request their participation in planning and gathering initial input
- DHHS sponsoring and conducting targeted MHSA PEI stakeholder planning meetings
- Conducting a stakeholder survey to verify diverse participation
- Planning for an ongoing process which will result in updates and discussions at least annually.

For example, youth involved with juvenile justice was identified as an underserved population. DHHS staff (including the Mental Health Branch Director and the Social Services Branch Director) regularly attend the Humboldt County Juvenile Justice and Delinquency Reduction Commission meetings. The Mental Health Branch Director requested that MHSA PEI be an agenda item at monthly commission meetings. The request was granted, MHSA PEI materials were presented at a meeting, a brief survey was distributed, and a discussion occurred including:

- The identification of key community mental health needs and related priority populations
- Assessment of community capacity and strengths
- Selection of PEI strategies to achieve desired outcomes
- Development of PEI projects with timeframes, staffing and budgets
- Implementation of accountability, evaluation, and program improvement activities.

All stakeholder comments and recommendations were recorded and brought back to the MHSA PEI workgroups and have provided guidance throughout this process.

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, race/ethnicity and language

The same overall stakeholder participation strategy was implemented to gain input from individuals reflecting the diversity of the demographics of the county, including but not limited to geographic location, age, gender, race/ethnicity and language.

For example, the Mental Health Board Chair is the Executive Director of a rural healthcare clinic in the southern part of the county. He recommended venues for stakeholder participation in groups with which he regularly participates, and requested time on their agenda for DHHS staff to present MHSA PEI and gather initial and ongoing input.

Regional meetings also were held in the eastern and northern parts of the county and were co-sponsored by both DHHS and a local Family/community Resource Center.

Another example was the request that MHSA PEI be an agenda item at a monthly Positive Indian Family Network meeting. The request was granted, MHSA PEI materials were presented at a meeting, a brief survey was distributed, and a discussion occurred including:

- The identification of key community mental health needs and related priority populations
- Assessment of community capacity and strengths
- Selection of PEI strategies to achieve desired outcomes
- Development of PEI projects with timeframes, staffing and budgets
- Implementation of accountability, evaluation, and program improvement activities.

All stakeholder comments and recommendations were recorded and brought back to the MHSA PEI workgroups and have provided guidance throughout this process.

c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate

The same overall stakeholder participation strategy was implemented to gain input from clients with serious mental illness and/or serious emotional disturbance and their family members. For example, the Mental Health Branch Director requested time at monthly National Alliance for Mental Illness (NAMI) meetings to discuss MHSA PEI.

Also, several input meetings occurred at the Hope Center, a client-run wellness and empowerment facility. The requests were granted, MHSA PEI materials were presented at a meeting, a brief survey was distributed, and a discussion occurred including:

- The identification of key community mental health needs and related priority populations
- Assessment of community capacity and strengths
- Selection of PEI strategies to achieve desired outcomes
- Development of PEI projects with timeframes, staffing and budgets
- Implementation of accountability, evaluation, and program improvement activities.

All stakeholder comments and recommendations were recorded and brought back to the MHSA PEI workgroups and have provided guidance throughout this process.

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including but not limited to:

- **Individuals with serious mental illness and/or serious emotional disturbance and/or their families**
- **Providers of mental health and/or related services such as physical healthcare and/or social services**
- **Educators and/or representatives of education**
- **Representatives of law enforcement**
- **Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families**

The PEI planning process was built upon knowledge gained from the Community Services and Supports component of the MHSA. Humboldt County conducted an extensive public planning process that included:

- Proposition 63 Steering Committee
- Six regional meetings (see Table 1 below)
- Thirteen targeted stakeholder meetings (see Table 2 below)
- Four age-specific advisory groups
  - Children and youth
  - Transition age youth
  - Adult
  - Older adult
- Community Strengths & Needs Survey
- Client interviews.

Table 1: Six regional meetings

Location	Number of participants
Eureka	30
Arcata	24
Willow Creek	9
Orick	15
Fortuna	8
Redway	15

Table 2: Thirteen targeted stakeholder meetings

Stakeholder Group	Number of participants
Client consumers	19
Families of clients	10
Education/schools	16
Law enforcement/courts/Probation	6
Native American community	15
Hispanic/Latino community	4
Asian/Pacific Islander community	4
DHHS Mental Health Branch organizational providers	8
Community and primary care providers/clinics	30
Transition-age youth	13
Gay/lesbian/bisexual/transgender community	5
Homeless community	23
DHHS Mental Health Branch staff	8

PEI-specific planning continued with thoughtful, deliberate planning efforts by the Humboldt County Mental Health Board, clients and family members, and Humboldt County DHHS staff to ensure inclusion of required stakeholders.

In addition to conducting demographically targeted regional stakeholder planning meetings, local community-based organizations and associations that represent or serve diverse stakeholders participated in the input process.

- **MHSA PEI education and stakeholder input collected from:**

    - DHHS Family/ Community Resource Center monthly meeting
    - Transition Age Youth, first onset of mental illness planning meeting
    - Juvenile Justice Commission
    - Domestic Violence Coordinating Council, Eureka
    - Domestic Violence Coordinating Council, Redway
    - The NET (Community Network)
    - NAMI (National Alliance on Mental Illness)
    - Fetal Infant Mortality Review/Child Death Review Team
    - CAST (Child Abuse Services Team)
    - Hope Center community meeting
    - Hope Center MHSA PEI input meeting
    - Paso a Paso meeting
    - AIDS Task Force
    - Community partners
    - In Home Support Services Public Authority Advisory Board
    - DHHS organizational provider meeting
    - Positive Indian Families Network
    - Willow Creek regional meeting
    - Redway regional meeting
    - McKinleyville regional meeting
    - Eureka MHSA PEI public hearing.

- **MHSA PEI education provided to:**

    - Alcohol Tobacco and Other Drug Prevention Committee
    - Mental Health Board
    - Mental Health Branch all-staff meetings
    - Alcohol and Drug Advisory Board
    - DHHS Human Services Cabinet meeting.

b. Training for county staff and stakeholders participating in the Community Program Planning Process

County DHHS staff received MHSA PEI training through multiple methods. First, staff who would be primarily responsible for plan development and ensuring

inclusion of diverse stakeholders participated in several MHSA PEI webcasts that had as a component PEI training sponsored by CiMH and DMH. Training included:

- PEI guidelines webcast
- Disparities in mental health access
- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Suicide prevention.

Second, MHSA PEI training-specific activities occurred where county staff were informed about the identification of key community mental health needs and related priority populations; assessment of community capacity and strengths; selection of PEI strategies to achieve desired outcomes; development of PEI projects with timeframes, staffing and budgets; and implementation of accountability, evaluation, and program improvement activities.

MHSA PEI training activities included:

- DHHS Mental Health Branch all-staff meetings
- Program-specific staff meetings
- DHHS Newsletter
- DHHS Trends reports
- Mental Health Branch “Branch Bits” newsletter
- Mental Health Branch Data Book
- Mental Health Board updates
- Local newspapers
- DHHS public education activities.

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how these were applied in the PEI process

Humboldt County conducted an extensive planning process for the CSS component of MHSA. Many of the individuals who participated in the CSS planning process as Mental Health Board members, clients and family members, and DHHS County staff provided insight and lessons learned for the PEI planning process.

Two significant changes were made to the PEI planning process since the CSS process. First, in addition to conducting targeted DHHS-sponsored MHSA PEI stakeholder planning meetings, requests were made for local community-based organizations and associations that represent and/or serve diverse stakeholders

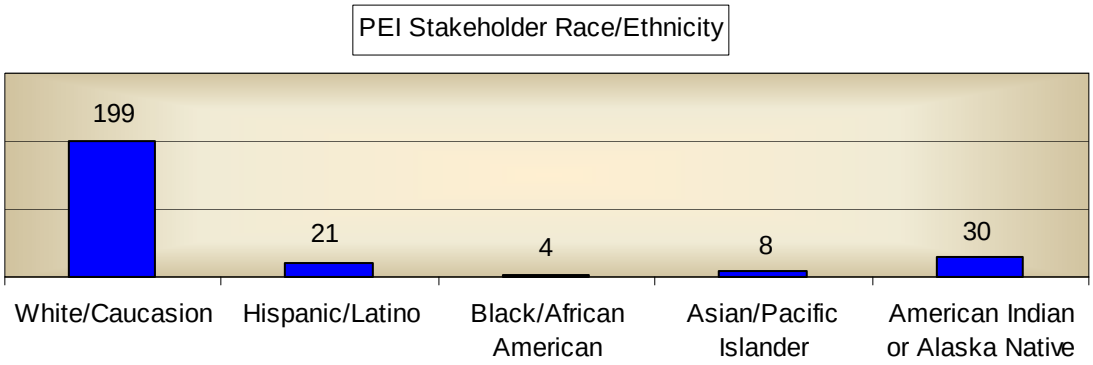
to include MHSA PEI at one of their regularly scheduled meetings. This dramatically increased the number of individuals providing input. Second, individuals who provided stakeholder input were asked to complete a voluntary and anonymous questionnaire that captures demographic information to verify diverse participation.

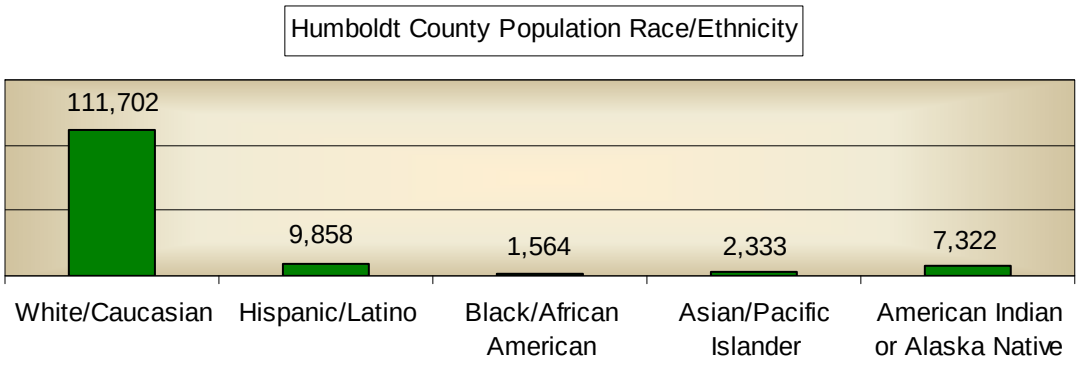
b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth

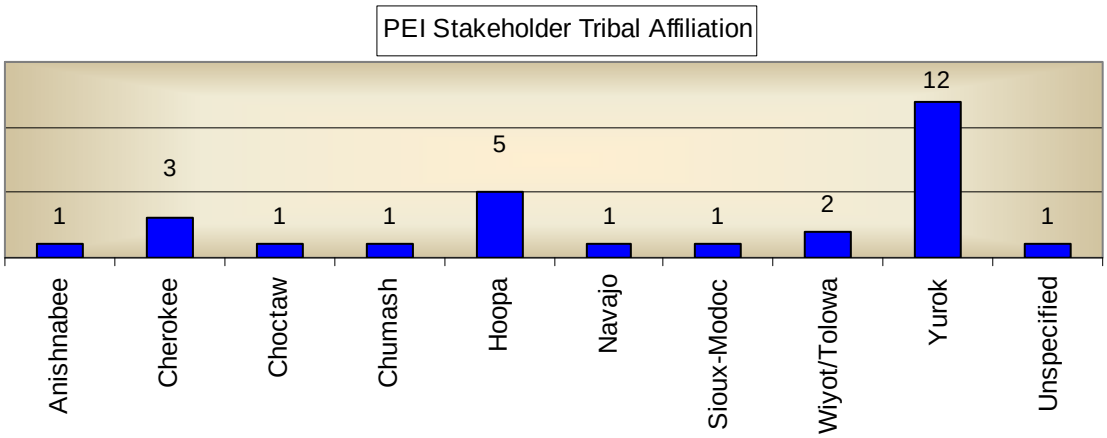
For the purpose of tracking and validating that the number of individuals participating in the stakeholder process represent different stakeholder groups, all participants were asked to complete a voluntary and anonymous demographic questionnaire.

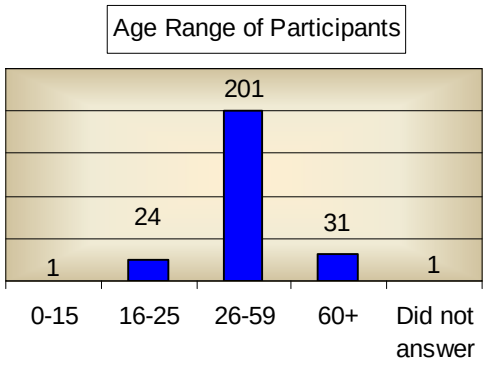
A total of 258 individual stakeholders who provided input completed the demographic questionnaire. The following graphs, compiled from the questionnaires, demonstrate broad-based input from a diversity of stakeholders.

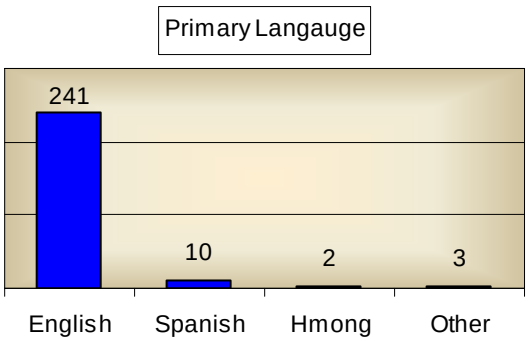
The first two graphs show that the ethnicity of participants in stakeholder meetings generally reflects that of Humboldt County's population.

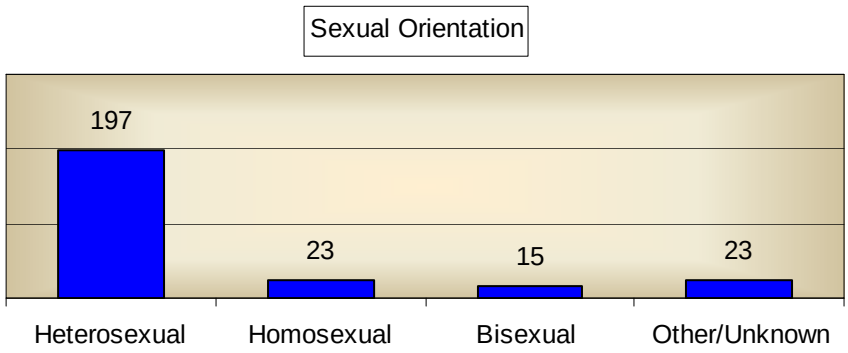


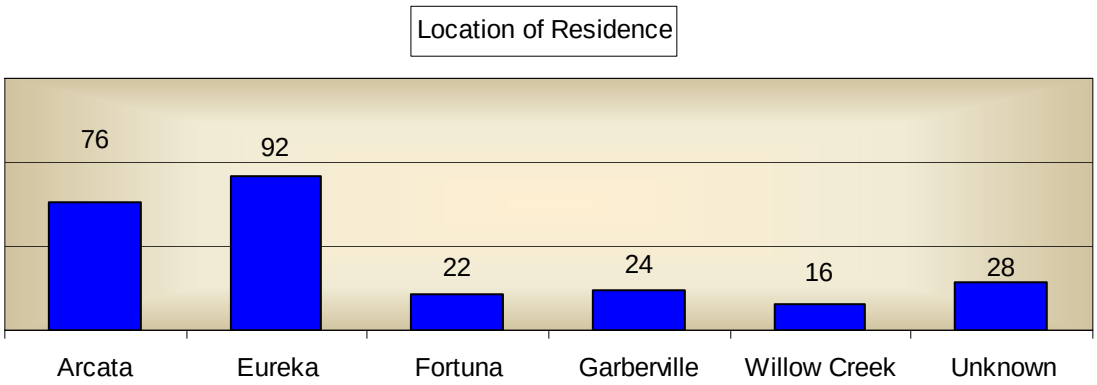


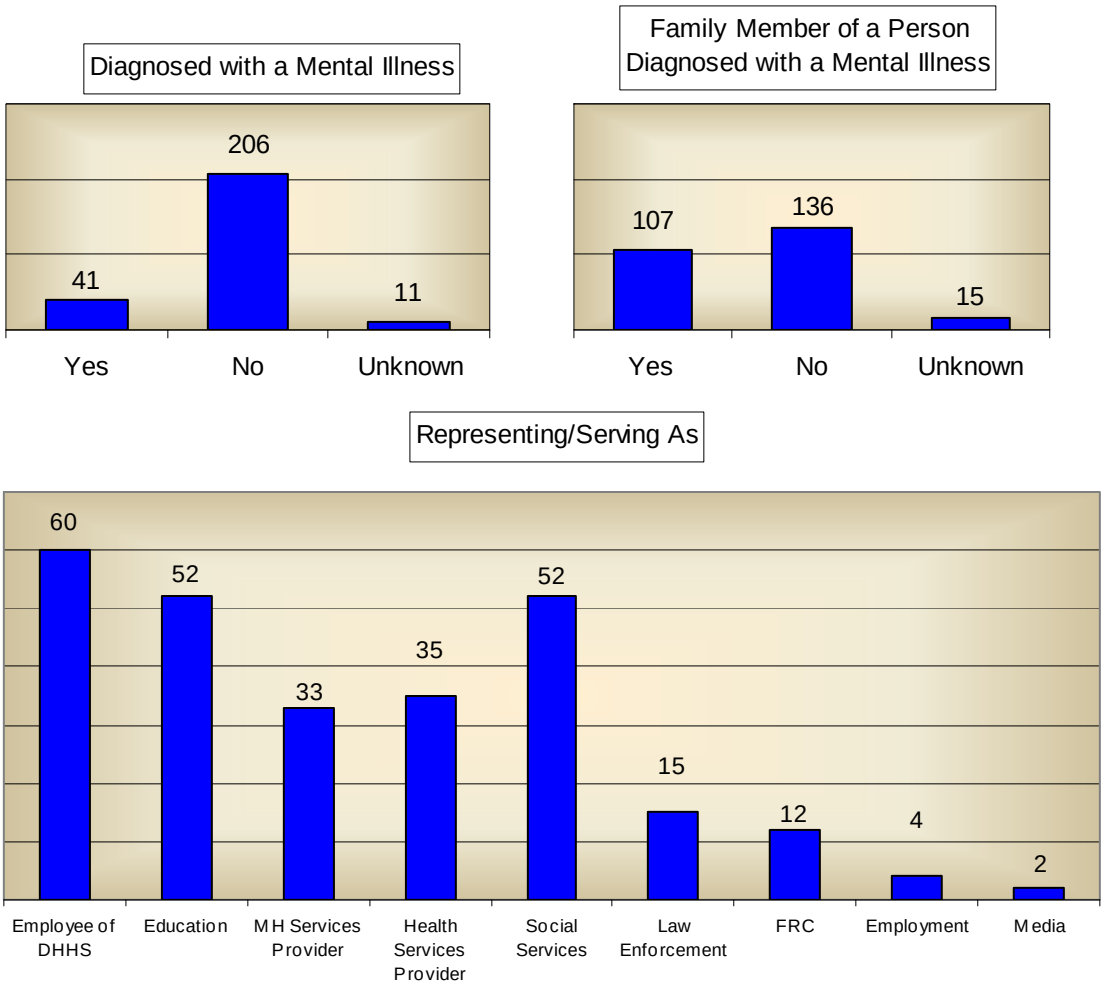

PEI Stakeholder Tribal Affiliation
1
3
1
1
5
1
1
2
12
1
Anishnabee
Cherokee
Choctaw
Chumash
Hoopa
Navajo
Sioux-Modoc
Wiyot/Tolowa
Yurok
Unspecified


Age Range of Participants
1
24
201
31
1
0-15
16-25
26-59
60+
Did not answer


Primary Langauge
241
10
2
3
English
Spanish
Hmong
Other


Sexual Orientation
197
23
15
23
Heterosexual
Homosexual
Bisexual
Other/Unknown


Location of Residence
76
92
22
24
16
28
Arcata
Eureka
Fortuna
Garberville
Willow Creek
Unknown



5. Information about the required county public hearing:

a. The date of the public hearing

November 17, 2008
5 p.m. to 6 p.m.
Humboldt County Department of Health and Human Services
Large Mezzanine Conference Room
507 F Street, Eureka, CA, 95501
(Attachment A)

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties requesting it

There was a 30-day Public Comment period from October 18th through November 17th, 2008.

Copies of the MHSA PEI Plan were made available to all stakeholders through the following methods:

- Electronic format: the Humboldt County Department of Health and Human Services, Mental Health Branch, Mental Health Services Act website: http://co.humboldt.ca.us/hhs/mh/mhsa.asp (Attachment B)

- Print format: Humboldt County Department of Health and Human Services (DHHS) Professional Building, 507 F Street, Eureka Ca, 95501; DHHS Mental Health Branch, 720 Wood Street, Eureka Ca, 95501; DHHS Children Youth and Family Services 1711 3rd Street Eureka Ca, 95501; and The Hope Center 2933 H Street Eureka Ca, 95501

- Flyers were mailed to over 30 locations around the county, including public libraries, health care clinics, tribes, and senior centers

- Flyers were e-mailed to recipients on more than 10 local e-mail distribution lists including family/community resource centers, organizational providers, and Latino Net

- Plans were e-mailed or mailed to all persons who requested a copy

- An informational flyer was sent to stakeholders regarding the Plan's availability, including where to obtain it, where to make comments, and where/when the public hearing would be held (Attachment C)

- Advertisements were placed in the local newspaper Oct. 25, Nov. 8 and Nov. 15, with the Plan's availability, including where to obtain it, where to make comments, and where/when the public hearing would be held (Attachment D)

- The Mental Health Branch Director and the MHSA Coordinator announced to DHHS staff, community-based organizations and partner agencies in various meetings the Plan's availability including where to obtain it, where to make comments, and where/when the public hearing would be held.

c. A summary and analysis of any substantive recommendations for revisions

During the public review period, comments from stakeholders were received in a variety of ways, including e-mail, public input meetings, comment boxes, phone calls, and at the public hearing.

A number of the comments received were outside of the scope of MHSA PEI planning and not substantive to this Plan. However, they are relevant and important to services provided in the community. All comments were carefully documented and used to inform planning and implementation of programs and activities throughout the Humboldt County DHHS.

The value and effectiveness of peer-to-peer activities was a recurring theme in many of the comments received and has resulted in a substantive change to the PEI projects. That change will be to enhance and support peer-to-peer activities such as peer counseling, peer support groups, peer mentors, peer support specialists, and peer educators are a component of PEI activities.

d. The estimated number of participants:

See attached copy of the Mental Health Board Public Hearing Agenda (Attachment E) and attendance sheet (Attachment F).

PEI PROJECT NAME: Suicide Prevention

County: Humboldt **Date:** December 4, 2008

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in access to mental health services	☐	☐	☐	☐
2. Psycho-social impact of trauma	☐	☐	☐	☐
3. At-risk children, youth and young adult populations	☐	☐		
4. Stigma and discrimination	☐	☐	☐	☐
5. Suicide risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma-exposed individuals	☐	☐	☐	☐
2. Individuals experiencing onset of serious psychiatric illness	☐	☐	☐	☐
3. Children and youth in stressed families	☐	☐		
4. Children and youth at risk for school failure	☐	☐		
5. Children and youth at risk of or experiencing juvenile justice involvement	☐	☐		
6. Underserved cultural populations	☐	☐	☐	☐
This project supports the statewide suicide prevention initiative.				

B. Stakeholder input and data analysis that resulted in the selection of the priority population (and age groups)

This Project will address suicide prevention on a population-wide basis, across the entire lifespan, utilizing universal prevention strategies as well as selective and indicated prevention strategies. The project supports the statewide suicide prevention initiative; priority population is not addressed.

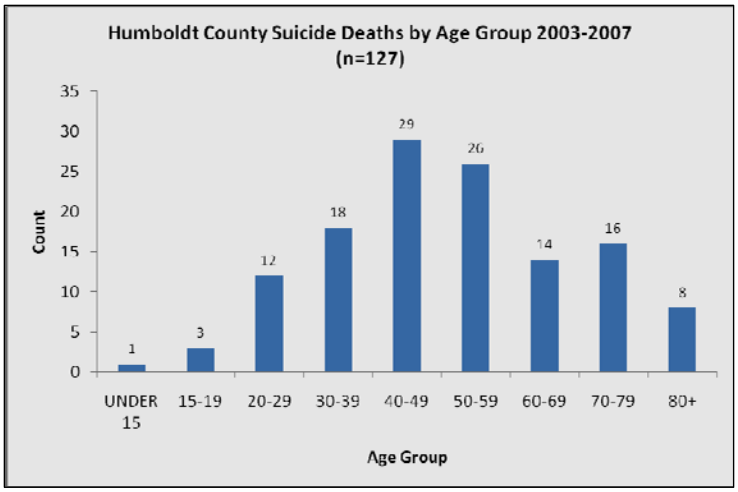
This Suicide Prevention Project recognizes suicide as a serious public health problem. The Humboldt County Department of Health and Human Services Public Health Branch worked closely with the Mental Health Branch to compile a 5-year suicide data report, released in June 2008.[1]

The report has been presented to and feedback collected from the Mental Health Board, the Human Services Cabinet, Domestic Violence Coordinating Council, community groups including Alternatives to Suicide and California Catalysts for Change, and the local media.

Further, as part of the Humboldt County Strategic Prevention Plan,[2] components of suicide prevention and integrated prevention strategies were identified which remain valid today. These include a well-coordinated community education campaign, including media, which can raise awareness about the issue and pave the way for action; support coalitions and collaboratives to build capacity in outlying communities; and development of a suicide death review team.

According to data from the "Suicide in Humboldt County" report:

- During 2007 in Humboldt County, there was a suicide rate of 21.8 per 100,000 total population. There were an additional 74 suicide attempts resulting in hospitalization during the same period



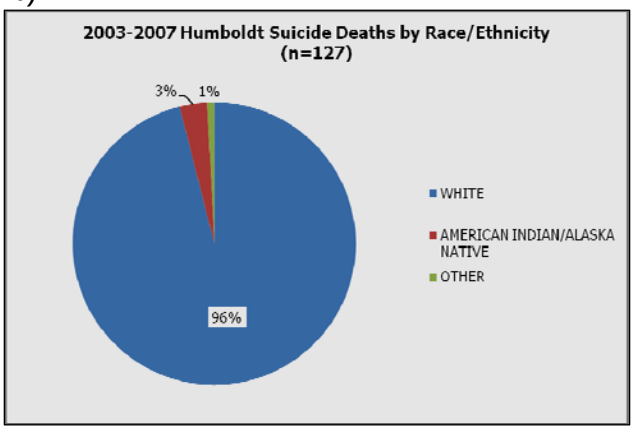
- Between 2003 and

[1] Attachment A: Humboldt County DHHS. (2008). *Suicide in Humboldt County, 2003-2007* (1st ed.) Eureka, CA: Mental Health and Public Health branches.

[2] Attachment B: Humboldt County Human Services Cabinet Consolidated Prevention Activities. (2002). *Humboldt county strategic prevention plan*. Eureka, CA: Humboldt County DHHS.

2007, suicide was the third-highest cause of death for county residents between the ages of 15 and 44

- The majority of hospitalized, nonfatal suicide attempts between 2003 and 2005 involved poisoning (82.2%)
- Firearms were used in the majority of suicide deaths between 2003 and 2007 (51.2%)
- Between 2003 and 2007, county residents between the ages of 40 and 49 accounted for the highest number of suicide deaths of any age group, with 29.



Between 2003 and 2007, whites were over-represented in fatal suicides with 96%, American Indian/Alaska Natives accounted for 3%, while those with a race/ethnicity indication of "other" accounted for 1%. According to recent census projections, the county population consisted of 82% whites, 5.7% American Indian/Alaskan Natives, with all other groups making up a total of 11.5% of the population.

3. PEI Project Description

Humboldt County DHHS conducted an extensive Community Planning Process as the initial component of the Mental Health Services Act. The process included the Mental Health Board, six regional meetings, 13 targeted stakeholder meetings, four age-specific advisory groups, a Community Strengths & Needs Survey, and client consumer interviews.

At specific phases of the planning process, each group was asked to articulate and prioritize mental health themes and needs. The need to address suicide prevention was a recurring theme. "Better suicide prevention and intervention" was a theme from all of the regional meetings and from the Transition Age Youth stakeholder meeting.

The gay/lesbian/bisexual/transgender/questioning stakeholder meeting included discussion of the need to "look at drug addiction and suicide." Attendees of the homeless community stakeholder meeting were concerned that "too many

people commit suicide." The Children and Youth Advisory Group included suicide prevention in an education and training recommendation.[3]

Once suicide prevention was identified as a key community mental health need, the prevention and early intervention planning process, including 22 meetings and more than 250 participants, further assessed the community's capacity and strengths and selected strategies to address desired outcomes and develop projects.

For example, at an MHSA stakeholder input discussion at a Fetal Infant Mortality Review/Child Death Review Team meeting, recommendations were made to form a similar team to review suicide deaths. That recommendation has been incorporated into this Project.

Identifying practices that would be most effective for specific populations was a strategy recommended a number of times, including at an MHSA PEI stakeholder discussion at a National Alliance on Mental Illness meeting. "We do not need to reinvent the wheel," one participant said. "There are some proven programs that work that we could use here." This Project proposes incorporation of a proven suicide prevention program.

Suicide prevention training and education was a recurring theme at all of the MHSA PEI stakeholder input meetings. As a result of this input, training and education are key components of this Project.

Suicide prevention education that would reach the entire community was also repeatedly recommended. Because of this input, media outreach and community-based education have been incorporated into this Project.

Stakeholders also recommended that ongoing accountability and program improvement were key strategies in the success of any suicide prevention projects. Both have been included in this Project.

In addition, stakeholders insisted throughout the MHSA PEI community planning process that local suicide prevention activities not overlap with or duplicate statewide efforts and initiatives. Therefore, as statewide initiatives develop and are implemented, local activities included in this plan will be reevaluated and adjusted to prevent redundancy.

The Suicide Prevention Project is built around a public health approach that defines the problem, identifies risk factors, develops and tests interventions to control or prevent the problem, implements interventions and monitors the effectiveness of employed interventions.

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[3] Attachment C: Humboldt County Mental Health Services Act. (2005) *Recommendations submitted by advisory groups to MHSA steering committee*.

This Project will address suicide prevention on a population-wide basis, across the entire lifespan, utilizing universal as well as selective and indicated prevention strategies.[4] Further, the Project will conform to MHSA and PEI policies and concepts, focusing on community collaboration, cultural competence, and programs that are individual- and family-driven. The Project will target underserved communities with an integrated and outcomes-based program design, focusing on wellness while encouraging resilience and recovery.

Humboldt County suicide data indicate that primary populations for selective and indicated prevention are 40- to 49-year-old white males who represent the demographic with the highest rate of suicide completions in the county, as well as 40- to 49-year-old white women and 20- to 29-year-old men, demographics with the highest rates of attempt.

Appropriate early intervention strategies will be employed that may include specific evidence based practices. The Project includes approaches which will remove barriers to receiving services, instill improved cultural and linguistic competency and cultivate broader community involvement in suicide prevention.

Further, suicide was the third-highest cause of death for transition age youth. We will continue to analyze data and trends to effectively employ early intervention strategies within this population.

The Project benefits from the integration of DHHS, assuring seamless service delivery and cross-branch coordination of community outreach. This Project contains plans to be delivered through collaborative strategies that provide integrated service experiences for individuals and their families. Such services are decentralized, culturally appropriate to the identified target populations and, when possible, delivered in natural community settings.

Collaboration with implementation partners and other DHHS programs will provide linkages with other services and supports, including substance abuse prevention and treatment, violence prevention and intervention, and assistance with basic needs such as food, employment and housing. Further, implementation partners will recognize the early signs of mental illness and can intervene or offer linkages to individuals and service providers that can recognize the early signs of mental illness and can intervene.

For the Suicide Prevention Project, Humboldt County will collaborate with individuals, organizations, community groups and others to ensure impact within

[4] (2008, August 7). Proposed guidelines, Prevention and early intervention component of the three-year program and expenditure plan, Fiscal years 2007-08 and 2008-09. *California Department of Mental Health. Mental Health Services Act*, Retrieved September 2, 2008, from http://www.dmh.cahwnet.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/docs/Rev_PEI_Guidelines.

unserved and underserved racial, ethnic and cultural populations, as well as in remote, geographically underserved areas of the county.

When possible, programs and interventions will be delivered in natural, nontraditional mental health settings, including family and community resource centers, to facilitate easy access for all members of the community. Key to collaboration are partnerships which contribute to reducing mental health disparities across socioeconomic and racial groups.

Potential implementation partners include but are not limited to:

- Humboldt County Mental Health Board
- Individuals, groups and organizations representing unserved and underserved populations including the Native American and Latino communities
- Domestic Violence Coordinating Council
- Multi-Agency Juvenile Justice Coordinating Council
- Alcohol and Other Drug Death Review Team
- Family/community Resource Centers
- Local law enforcement
- Medical examiner and coroner
- Local media
- Schools and youth organizations
- Primary care and health clinics, primary healthcare providers
- Client and family member groups
- And others as specific program design may require or facilitate.

According to the U.S. Census Bureau's 2006 American Community Survey Data Profile for Humboldt County,[5] there are an estimated 128,330 people in Humboldt County.

- As a whole, the racial and ethnic identification of Humboldt County residents included 122,160 White including 9,858 Hispanic or Latino, 7,322 American Indian/Alaskan Native, 1,564 Black or African American, 2,333 Asian, and 4,660 identifying "some other race"

- There were seven federally recognized tribes and eight reservations or Rancherias including the Hoopa Valley Indian Reservation which is,

[5] (2006). 2006 American Community Survey, Data Profile Highlights. Retrieved September 3, 2008, from U. S. Census Bureau Web site: http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&geo_id =&_geoContext=&_street=&_county=humboldt&_cityTown=humboldt&_state=04000US06&_zip=&_lang=en&_sse=on&pctxt=fph&pgsl=010.

geographically, one of the largest in California, and the Karuk tribe which has one of the largest memberships, with 4,800 members

- 8.3% of households reported that a language other then English is spoken at home

- The median age was 35.9 years, with 26,198 under 18, 86,008 between 18 and 65,and 16,124 age 65 and older

- The median household income was $40,749
- There were approximately 28,663 families in Humboldt County, with a median family income of $52,182

- 17.9% of the population was at or below the federal poverty level, including 11.5% of families

- 106,908 people in the county were aged 15 years and older, 52,454 males and 54,454 females

- According to September 2008 data from the State of California, Humboldt County's unemployment rate continues to trend higher then the national average, with a rate of 7.4% in August 2008 outpacing the national rate of 6.1%. This represents an increase over the August 2007 rate in Humboldt County of 5.8% which exceeded the national rate of 4.6%.[6]

As illustrated in the report "Suicide in Humboldt County, CA, 2003-2007,"[7] suicide impacts every segment of Humboldt County. Initially, though, as part of the Suicide Prevention Project's universal prevention strategies, the project will focus on county residents 15 and older for targeted suicide prevention messages, education and outreach services.

One population identified for selective prevention strategy is the multi-branch workforce of Humboldt County DHHS. Training will include a strong component which will assist frontline staff in identifying individuals who may require mental health assessment or treatment, and suggest ways to facilitate those linkages and referrals to appropriate mental health service providers. Training will be delivered to personnel in the Public Health, Mental Health and Social Services branches. The multi-branch workforce is reflective of Humboldt County's

[6] (2008) Humboldt county industry employment and labor force. Retrieved September 22, 2008, from California Employment Development Department, Labor Market Information Division: http://www.calmis.ca.gov/file/lfmonth/humbopds.pdf'

[7] Attachment A: Humboldt County DHHS . (2008). *Suicide in Humboldt county, 2003-2007* (1st ed.) Eureka, CA: Mental Health and Public Health Branch.

population in its diversity as well as location, with employees stationed in outlying areas of the community.

The Suicide Prevention Project will expand upon existing, successful public health prevention programs including Alcohol and Other Drug Prevention, Violence Prevention, Injury Prevention, the North Coast AIDS Project and others. It will enhance the health education programs already proven successful in the delivery of integrated, culturally competent outreach services in the community, build upon established dialogue with underserved populations, and connect with geographically underserved areas.

This Project will enhance and support peer-to-peer activities such as peer counseling, peer support groups, peer mentors, peer support specialists, and peer educators.

Community priorities identified by research and stakeholder input will serve as the basis for directing local resources, based on the state's suicide prevention blueprint.[8] Humboldt County will implement this Project which includes and is not limited to strategies within the following policy directions.

Maintain a system of suicide prevention, which may include but not be limited to:

- Appoint a liaison to the State Office of Suicide Prevention

- Integrate suicide prevention programs, and identify resources and programs, including those for underserved populations, as well as a continued assessment of community capacity and strengths

- Establish linkages between Suicide Prevention, Stigma and Discrimination Reduction and TAY Partnership PEI projects with other DHHS programs and projects

- Implement an evidence based practice and/or promising program related to suicide prevention, which will be appropriate to our community and populations. This selection is tentative as we await selection of a statewide program and direction. Potential selection may include Air Force Suicide Prevention Program, with potential selection of a complimentary program with a strong education component such as Question, Persuade, Refer Training (QPR), and/or Applied Suicide Intervention Skills Training (ASIST).

[8] Attachment E: California Department of Mental Health. Based on the Recommendations of the Suicide Prevention Plan Advisory Committee (2008) *Draft California strategic plan on suicide prevention: Every Californian is part of the solution.*

Training and workforce enhancements to prevent suicide, which may include but not be limited to:

- Use an inclusive process for input from partners, stakeholders, members of underserved communities and the community to establish annual targets for suicide prevention training. The process will further identify the number of individuals and occupations to receive suicide prevention training (e.g., public health nurses, mental health clinicians, social workers, community health outreach workers, eligibility workers and others).

Educate communities to prevent suicide, which may include but not be limited to:

- A community education component which may focus on increasing awareness of protective factors including:
    - Restricting access to highly lethal means of suicide
    - Building strong connections to community and family support
    - Problem solving
    - Conflict resolution and nonviolent dispute resolution
    - Cultural and religious beliefs that discourage suicide and support self-preservation
- Identification and support of client, consumer and family groups
- Community education that is decentralized and integrated with outreach efforts, and includes partnerships within the Latino and Native American communities
- Engagement with and education of local media.

Improve suicide prevention effectiveness and system accountability, which may include but not be limited to:

- Building local capacity for data collection and dissemination to inform prevention and early intervention strategies, as well as evaluation of suicide prevention programs for use in program improvement
- Enhanced capacity for clinical and forensic review of suicide deaths, including working with Coroners Office staff and medical examiners to improve reporting consistency and accuracy
- A process for suicide death review.

Actions to be performed to carry out the PEI Project, including frequency or duration of key activities:

Maintain a System of Suicide Prevention	Frequency/Duration
Hire and/or identify staff sufficient to achieve outcomes, including health education staff and an interpreter/translator. Orient project staff to include knowledge about and identification of individuals needing mental health assessment and referral, and linkages to other services and supports	Early spring 2009
Appoint a Humboldt County liaison to the State Office of Suicide Prevention	Spring 2009
Integrate suicide prevention programs and identify resources and programs including those for underserved populations; provide links between Stigma and Discrimination Reduction, TAY Partnership and Suicide Prevention	Initial identification of resources to begin Spring 2009; program integration commencing Summer/ Fall 2009, then ongoing
Implement evidenced based practices and/or promising programs related to suicide prevention, that may include: • Air Force Suicide Prevention Program • Question, Persuade, Refer Training (QPR) • Applied Suicide Intervention Skills Training (ASIST) Include components of suicide prevention training with annual targets, community education that is decentralized and integrated with outreach efforts, and engagement and education of local media	Beginning Spring 2009. Annual Training targets include target occupations e.g.; primary care healthcare providers, public health nurses, mental health case managers, community health outreach workers, law enforcement, eligibility workers, and others.
Identify and support client, consumer and family groups; develop method to disseminate information and resources	Spring 2009 and ongoing
Improve Project Effectiveness and System Accountability	**Frequency/Duration**
Build local capacity for data collection, reporting, surveillance and dissemination to inform PEI strategies; build local capacity for evaluation of suicide prevention programs for use in program improvement	Begin data collection in Spring 2009; remaining components will be addressed in Project development beginning in Spring 2009 and begin in Fall 2009
Enhance capacity for clinical and forensic review of suicide deaths, work with coroners and medical examiners to improve data consistency and accuracy, create process for suicide death review	Beginning in Spring 2009, process in place by Fall/Winter 2009

4. Programs

Suicide Prevention Program	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Maintain a System of Suicide Prevention and Implementation of Evidence Based Practice	Individuals: not less then 500 Families:	Individuals: Families:	4 to 6 months
Improve Suicide Prevention Project Effectiveness and System Accountability	Individuals: Families:	Individuals: Families:	4 to 6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: not less then 500 Families:	Individuals: Families:	

5. Linkages to county mental health and providers of other needed services

Since 1999, through initiatives and legislation such as Assembly Bill 315,[9] Humboldt County Department of Health and Human Services has been an integrated Health and Human Services agency. Mental Health, Public Health and Social Services branches provide interrelated programs for children, families, and adults that deliver coordinated, efficient services and maximize available resources. Services continue to become decentralized and in closer proximity to clients to the maximum extent possible.

Through the Community Services and Supports component of the MHSA, Humboldt County has continued to implement integrated multidisciplinary program teams which have developed successful mechanisms for assessment and referral to appropriate services through both governmental and community providers.

Program implementation for the Suicide Prevention Project will rely upon and strengthen ongoing referral mechanisms to link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to public and community care providers, as well as to

[9]Attachment D: Humboldt County Department of Health and Human Services. (2008). *AB315 (Berg, 2007) Integrated services initiative 2007-2010 strategic plan*. Eureka, CA: Humboldt County Department of Health & Human Services.

other needed services. Such services will include those provided by community agencies not traditionally defined as mental health that have established or show capacity to establish relationships with at-risk populations.

Specific focus will be in the areas of:

- Substance abuse treatment
- Community, domestic or sexual violence prevention and intervention
- Provision for basic needs such as can be met at the family/community resource centers
- Outpatient treatment settings
- Community-based nonprofit organizations
- Supportive housing programs
- Clinics including rural, Federal Qualified Health Clinics, and Indian Health Clinics
- Schools
- Faith-based organizations.

All staff and community partners are or will be aware of community contact information and ways to access mental health services.

Programs within the Suicide Prevention Project will strive to bridge gaps in the community with new and existing partnerships that will implement and expand services, including to unserved and underserved populations. Partnerships will ensure that all members of these communities are aware of mental health issues and services.

Partnerships established and/or renewed as a result of the project will ensure that an organized system of referrals is developed between community-based organizations, county programs and services. The referral system will ensure that individuals served through these prevention and early intervention programs are able to access other support services as may be required by their individual needs.

This Project will leverage resources by maximizing existing partnerships and creating new ones. Partnerships within these programs consist of established members of the community including family/community resource centers, local clinics and hospitals, agencies and organizations representing unserved and underserved populations, client and family member groups, and others.

All program staff will be encouraged to participate in cultural competency and program- and system-level improvement training. Funded services within the Project will contribute to increased capacity among community and nonprofit partners. The media outreach component of the Suicide Prevention Project will

contribute to community-level improvements and reduction in suicides and attempts, as well as increased awareness of and access to services.

6. Collaboration and System Enhancements

DHHS, as a member of the California Family Resource Association, and in ongoing collaboration with Humboldt County Family/community Resource Centers (FRCs), Healthy Start Schools and Communities Partnership, is able to utilize 17 rural centers as proven and established linkages to outlying areas of the county.

FRCs are key partners in improving the health and safety of Humboldt County residents. In partnership with DHHS, the centers have identified numerous ways to collaborate for improved outcomes for families and individuals, including locating DHHS liaisons at centers, assigning public health nurses and child welfare social workers geographically to centers, cross-training staff, and participation by resource centers in DHHS-promoted evidence based practices.

Further, the FRCs are key collaborators in the DHHS rollout of the MHSA PEI programs, as previously mentioned, and as key informants in development of prevention services. DHHS personnel work with resource center staff on several existing programs such as Differential Response, an innovative approach to child abuse prevention established through the California Child Welfare System Redesign, and by attending regular meetings with center staff and stakeholders.

The Project will strengthen and build upon local community-based mental health and primary care systems by strengthening media outreach to increase community awareness, and by offering workforce training to frontline staff and implementation partners. Training will build cultural competence and reduce disparity among socioeconomic groups and underserved populations.

The Project will also leverage the considerable outreach of existing DHHS Public Health programs, including Family Violence Prevention, Injury Prevention and Alcohol and Other Drug Prevention, to ensure that suicide prevention messages and materials are shared with the greatest number of community members possible. Public Health's knowledgeable health education specialists have built successful community collaborations with clinics and healthcare providers, as well as with organizations and agencies trusted by and with access to underserved populations.

A key feature of the **"**Educate Communities to Take Action to Reduce Stigma and Discrimination" portion of the Project is outreach with local media. Humboldt County is an unusual media market which offers the Project opportunities as well as challenges.

- Print media: one daily newspaper in Eureka with a daily online edition; two weekly papers in the rural southern part of the county; a weekly paper in the eastern region of the county in Klamath-Trinity; weekly papers also in Arcata, McKinleyville, Fortuna, and Ferndale; one weekly that covers the entire North Coast region; and one monthly paper produced in Spanish.

- Television: several television stations with limited local programming or with offices located locally; one has local news staff and produces a newscast daily.

- Radio: multiple radio stations in Humboldt County including three commercial radio stations, two Public Radio stations, one Spanish station, one centered in the Hoopa Reservation and one low-powered station broadcasting on the Humboldt State University campus.

The project will be sustained by infusing a strong sense of community awareness about suicide prevention into all segments of the Humboldt community. The DHHS workforce and implementation partners will be trained in providing culturally competent suicide prevention strategies and effective identification and referral of individuals requiring mental health assessment and treatment.

7. Intended Outcomes

As documented during the community stakeholder process and consistent with community priorities and local data, the intended individual, system and program outcomes include:

- A reduction in deaths due to suicide

- An increase in the number of individuals and occupations receiving suicide prevention training

- Continued participation from underserved populations providing stakeholder input into PEI programs

- Increased outreach efforts within target populations and the community

- Increased community participation in suicide prevention activities

- Appointment of a liaison to the State Office of Suicide Prevention resulting in increased coordination between county and state suicide prevention activities and selection of suicide prevention program staff

- Provision of culturally competent suicide prevention training to DHHS staff, other agencies, and implementation and community partners

- Promotion of opportunities and settings to enhance resiliency, recovery, resourcefulness, respect and interconnectedness for individuals, families and communities.

As a Result of the Suicide Prevention Project, we expect the following changes to occur:

- Increased competency in all aspects of suicide prevention among DHHS staff, implementation partners and the community

- Creation and strengthening of linkages between Humboldt County DHHS and community partners

- Strengthened links between suicide prevention PEI and other Humboldt County MHSA components.

8. Coordination with Other MHSA Components

This PEI project will coordinate to the maximum extent possible with other MHSA components, including these projects which are a result of the community planning process and function within the context of Humboldt County DHHS integrated services:

- The Hope Center, which provides a safe, welcoming environment based on self-help recovery principles and the resources necessary for the underserved mentally ill and their families to be empowered in their efforts to achieve self-sufficiency. Coordination with the Hope Center will offer crucial training opportunities for staff. Staff members will be able to hear from clients who bring a set of values, beliefs and lifestyles that were molded as a result of their personal experiences with mental illness, the mental health system and their own cultures.

- Rural Outreach Services Enterprise (ROSE), providing mobile access to culturally appropriate services in the rural, remote, and outlying geographic areas of Humboldt County. ROSE links with and provides support to existing community organizations such as the Family/ community Resource Centers, community clinics and tribal organizations. ROSE will have the ability to bring the Suicide Prevention Project to Humboldt's outlying geographic areas.

- Integrated Program and Planning Support Structures, which represents a further integration and expansion of a newly developed division of DHHS. It includes the following infrastructure enhancements:

- The Office of Client and Cultural Diversity, which will assist with development and implementation of culturally competent programs

- The Research and Evaluation Unit, which will be facilitate the capacity-building focus areas of the Project

- The Training, Education and Supervision Unit, which continues to build system capacity to develop, coordinate and integrate educational resources.

At this time, the county is in the early planning stages of the Workforce Education and Training, and Capital Facilities and Technology components of the MHSA.

PEI PROJECT NAME: Stigma and Discrimination Reduction

County: Humboldt **Date:** December 4, 2008

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in access to mental health services	☐	☐	☐	☐
2. Psycho-social impact of trauma	☐	☐	☐	☐
3. At-risk children, youth and young adult populations	☐	☐		
4. Stigma and discrimination	☒	☒	☒	☒
5. Suicide risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma exposed individuals	☐	☐	☐	☐
2. Individuals experiencing onset of serious psychiatric illness	☐	☐	☐	☐
3. Children and youth in stressed families	☐	☐		
4. Children and youth at risk for school failure	☐	☐		
5. Children and youth at risk of or experiencing juvenile justice involvement	☐	☐		
6. Underserved cultural populations	☐	☐	☐	☐
This project supports the statewide stigma and discrimination reduction initiative.				

B. Stakeholder input and data analysis that resulted in the selection of the priority population (and age groups)

This project supports the statewide initiative addressing stigma and discrimination reduction; a priority population is not addressed.

The project description derived from the extensive Community Planning Process Humboldt County Department of Health and Human Services (DHHS) conducted as the initial component of the Mental Health Services Act. Included were six regional meetings, 13 targeted stakeholder meetings, four age-specific advisory groups, a Community Strengths and Needs Survey and numerous consumer interviews.[1]

At specific phases during the planning process, each group was asked to articulate and prioritize mental health themes. "Public education to alleviate discrimination" was the third highest-ranking theme for all of the targeted stakeholder meetings. Comments included:

- From the client stakeholder meeting—we need to "reduce stigma" and "learn to accept yourself by being respected," and "public education is needed to alleviate discrimination"

- From the Native American stakeholder meeting—"De-stigmatize services so people will apply for and use services. People want to maintain their pride and dignity"

- From the transition age youth stakeholder meeting—we need to "reduce feeling shunned by society"

- From the gay/lesbian/bisexual/transgender/questioning stakeholder meeting—we need "education for students in school regarding mental illness"

- And from the homeless community stakeholder meeting—we need "public education to foster compassion and reduce judgment."

Participants from the children and youth advisory group described their desired outcomes from addressing stigma and discrimination as follows: "The terms 'mental health' and 'mental illness' no longer make people nervous when mentioned in conversation. Acceptance of services aimed at prevention and intervention of mental illness is similar to society's acceptance of weight loss programs and treatments for medical diseases."

[1]Attachment C: Humboldt County Mental Health Services Act. (2005) *Recommendations submitted by advisory groups to MHSA steering committee*.

3. PEI Project Description

Humboldt County DHHS conducted an extensive Community Planning Process as the initial component of the Mental Health Services Act. Within that process, stigma and discrimination reduction was identified as a priority. Input identified goals which included increasing the level of interest in and discussion about mental health issues among the public, and engaging all mental health providers, including DHHS, in a common effort that will positively impact all involved.[2]

Once stigma and discrimination reduction was identified as a key community mental health need, the prevention and early intervention planning process, including 22 meetings and more than 250 participants, further assessed the community's capacity and strengths and selected strategies to address desired outcomes and develop projects.

Identification of programs that would be most effective for specific populations was a strategy recommended a number of times, including at an MHSA PEI stakeholder discussion at a Positive Indian Family Network meeting. The comment was made there that "there are different kinds of stigma for younger people and older people, and the approach should be different." As a result of this input, population-specific program design has been incorporated into this Project.

Stigma and discrimination reduction training and education was a recurring theme throughout the MHSA PEI stakeholder process. For example, at the Hope Center (a client-run wellness and recovery center) MHSA PEI stakeholder meeting, several "power groups," such as landlords and employers, were identified as sources of possible discrimination against people with mental illness. As a result, the training and education component of this Project will include outreach to these and other power groups.

Stigma and discrimination reduction that would reach the entire community was also a recommended project that would include both community-based education and media outreach. At a National Alliance on Mental Illness meeting, the comment was made that "in Crisis Intervention Training (with law enforcement officers) the client and family member panels are the most effective at changing the way people think." Another participant said that "we need to get the message out through advertising that mental illness is like any other illness." As a result of this input, the Project will outreach far beyond client and consumer groups.

Stakeholders also recommended that ongoing accountability and program improvement was a key strategy to the success of the suicide prevention projects. Both have been included in this Project.

[2] Attachment C: Humboldt County Mental Health Services Act. (2005) Recommendations submitted by advisory groups to MHSA steering committee.

In addition, stakeholders insisted throughout the MHSA PEI community planning process that local stigma and discrimination reduction activities not overlap with or duplicate statewide efforts and initiatives. Therefore, as statewide initiatives develop and are implemented, local activities included in this plan will be reevaluated and adjusted to prevent redundancy.

This Stigma and Discrimination Reduction Project incorporates prevention strategies consistent with the Institute of Medicine Spectrum of Mental Health Interventions.[3] Further, the Project will conform to MHSA and PEI policies and concepts and focus on wellness, community collaboration and cultural competence, with programs that are individual and family-driven with attention to underserved communities, and that encourage resilience and recovery, integrate services, and offer outcomes-based program design.

The Project benefits from the integrated service delivery of Mental Health, Social Services and Public Health branches, which were integrated beginning in 1999, through initiatives and legislation such as AB 315.[4] As a member of the California Family Resource Association, and in ongoing collaboration with Humboldt County Family/community Resource Centers, Healthy Start Schools and Communities Partnership, the 17 centers will provide a platform for decentralized service delivery which places transformational programs into natural, non-mental health settings and leverages community resources and partnerships.

While the Project will be carried out with a population-based perspective, there will be key components matched to the unique cultural and linguistic demands of Humboldt County's diverse, rural population, including Native American, Latino and non-English speaking community members.

For the Stigma and Discrimination Reduction Project, Humboldt County will collaborate with individuals, organizations, community groups and others to ensure impact within unserved and underserved racial, ethnic and cultural populations, and in geographically underserved areas of the county. Collaboration with implementation partners and other DHHS programs will provide linkages with other services and supports, including substance abuse prevention and treatment, violence prevention and intervention, and assistance with basic human needs such as food, employment and housing. Further,

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[3] (2008). Mental health services act. *Proposed guidelines. Prevention and early intervention component of the three-year program and expenditure plan. Fiscal years 2007-08 and 2008-09.* Retrieved September 2, 2008, from California Department of Mental Health Web site: http://www.dmh.cahwnet.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/docs/Rev_PEI_Guidelines.

[4] Attachment D: Humboldt County Department of Health and Human Services. (2008). *AB315 (Berg, 2007) Integrated services initiative 2007-2010 strategic plan*. Eureka, CA: Humboldt County Department of Health & Human Services.

implementation partners will offer linkages to individuals and service providers able to recognize early signs of mental illness and intervene.

When possible, programs and interventions will be delivered in natural, nontraditional settings, including Family/community Resource Centers, which provide easy access for all members of the community. Key to collaboration are partnerships which contribute to reducing mental health disparities across socioeconomic and racial groups.

Potential stakeholders and implementation partners include but are not limited to:

- The integrated branches of Humboldt County DHHS: Public Health, Mental Health and Social Services
- Humboldt County Mental Health Board
- Clinics and healthcare providers
- Community partners the Mental Health Branch contracts with
- Client, consumer and family groups
- Individuals, groups and organizations representing target and underserved populations, including the Native American Community, the Latino Community and others
- Family/community Resource Centers
- Local law enforcement
- Local media
- Schools and youth organizations
- Humboldt County nonprofits
- Other organizations that will delivery programs and interventions in natural, nontraditional mental health settings that facilitate access to the entire community.

According to the U.S. Census Bureau's "2006 American Community Survey Data Profile for Humboldt County,"[5] an estimated 128,330 people reside in Humboldt County.

As a whole, the racial and ethnic identification of Humboldt County residents included 122,160 White including 9,858 Hispanic or Latino, 7,322 American Indian/Alaskan Native, 1,564 Black or African American, 2,333 Asian, and 4,660 identifying "some other race." Approximately 8% of households reported that a language other then English was spoken at home.

[5] (2006). 2006 American Community Survey, Data Profile Highlights. Retrieved September 3, 2008, from U. S. Census Bureau Web site: http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&geo_id=&_geoContext=&_street=&_county=humboldt&_cityTown=humboldt&_state=04000US06&_zip=&_lang=en&_sse=on&pctxt=fph&pgsl=010

There were seven federally recognized tribes and eight reservations/Rancherias, including the Hoopa Valley Indian Reservation, which is geographically one of the largest in California, and the Karuk tribe which has one of the largest memberships, with 4,800 members.

The median age was 35.9 years, with 26,198 under 18, 86,008 between 18 and 65, and 16,124 who were 65 and over. There were 106,908 county residents aged 15 years and older, 52,454 males and 54,454 females.

There were approximately 28,663 families in Humboldt County, with a median family income of $52,182. The median household income was $40,749. Almost 18% of the population was at or below the federal poverty level, including 11.5% of families.

According to September 2008 data from the State of California, Humboldt County's unemployment rate continues to trend higher then the national average, with a rate of 7.4% in August 2008 outpacing the national rate of 6.1%. This represents an increase over the August 2007 rate in Humboldt County of 5.8%, which exceeded the national rate of 4.6%.[6]

Initially, the Stigma and Discrimination Reduction Project's universal prevention strategies will focus on county residents 15 and over, who will receive stigma and discrimination reduction messages, education or outreach services. Specific target populations for individual facets of the Project will be contingent upon guidance and selection of a statewide program but may include transition age youth, adults and older adults who are at high risk of having mental health issues, those experiencing discrimination, and key groups that have power in the lives of people with mental health issues, as well as the media.

One target population for selective prevention strategy is the multi-branch workforce of Humboldt County DHHS. Training intended to reduce stigma and discrimination will be delivered to personnel in the Public Health, Mental Health and Social Services branches. Such training will include a strong component to assist frontline staff in identifying individuals who require mental health assessment or treatment and in facilitating referrals to appropriate mental health service providers. The multi-branch workforce is reflective of the Humboldt County population in its demography and geography, with employees stationed in outlying areas of the community.

This Project will enhance and support peer-to-peer activities such as peer counseling, peer support groups, peer mentors, peer support specialists and peer educators.

[6] (2008) Humboldt county industry employment and labor force. Retrieved September 22, 2008, from California Employment Development Department, Labor Market Information Division. http://www.calmis.ca.gov/file/lfmonth/humbopds.pdf.

The Stigma and Discrimination Reduction Project will expand upon existing, successful public health prevention programs, including Alcohol and Other Drug Abuse Prevention, Violence Prevention, Injury Prevention, the North Coast AIDS Project and others. It will enhance the health education programs already proven successful in the delivery of integrated, culturally competent outreach services in the community, and build upon established dialogue with underserved populations in geographically remote areas of the county.

Community priorities identified through stakeholder input serve as the basis for directing local resources consistent with the recommendations from the state's 2007 report "Eliminating Stigma and Discrimination against Persons with Mental Health Disabilities."[7] Humboldt County will implement this Project, which includes and is not limited to strategies within the following policy directions.

- **Maintain a system utilizing external influence strategies to reduce stigma and discrimination:**

    - Work with the Humboldt County Mental Health Board to develop and implement a Humboldt County Stigma and Discrimination Reduction Plan with the continued input of diverse local stakeholders, addressing improved interaction between agencies, communities and service providers to reduce stigma and discrimination

    - Identify and support client, consumer and family groups

    - Integrate stigma and discrimination reduction programs, and identify resources and programs including those for underserved populations

    - Implement an evidenced based practice or promising program related to stigma and discrimination reduction which is appropriate to our communities and populations and consistent with the statewide program. This Project may work in collaboration with the Suicide Prevention PEI Project as the potential evidence based practice highlighted for its usage

    - Provide links between Stigma and Discrimination Reduction, Suicide Prevention, TAY Partnership PEIs with other DHHS programs and projects.

[7] Attachment F: (2007) *Eliminating stigma and discrimination against persons with mental health disabilities. A project of the California mental health services act.* Retrieved October 14, 2008 California Department of Mental Health Web site: http://www.dmh.ca.gov/MHSOAC/docs/Stigma And DiscriminationReport07Jun12.pdf.

- **Implement training and workforce enhancements to reduce stigma and discrimination, including but not limited to the following:**

    - Use an inclusive process for input, and establish annual targets for training that identify the number of individuals and occupations that will receive stigma and discrimination reduction training, including training for the DHHS multi-branch workforce (public health nurses, mental health clinicians, community health outreach workers, social workers, eligibility workers and others).

- **Educate communities to take action to reduce stigma and discrimination, including but not limited to the following:**

    - Identify and support client, consumer and family groups

    - Implement decentralized and integrated outreach efforts

    - Develop opportunities to promote greater understanding of stigma and discrimination related to mental health disabilities by engaging and educating local media about their role in promoting the reduction of stigma and discrimination

    - Use an inclusive and collaborative process for input, partnering with advocates and promoting access to programs and educational opportunities for the community to develop competencies that support reduction of stigma and discrimination

    - Develop a method to disseminate information and resources.

- **Stigma and discrimination reduction system accountability, which may include but not be limited to the following:**

    - Build local capacity for evaluation of stigma and discrimination reduction programs for use in program improvement, including input from underserved populations

    - With diverse input, consider strategies to reduce isolation and alienation, and foster and design programs that are culturally and linguistically appropriate.

Actions to be performed to carry out the PEI Project, including frequency or duration of key activities.

Plan Direction and Objectives	Frequency/Duration
Hire and/or identify staff sufficient to achieve outcomes, including health education staff and an interpreter/translator. Orient project staff to identify individuals needing mental health assessment and referral and linkages to other services and supports.	Early spring 2009
Maintain a system that uses external influence strategies to reduce stigma and discrimination	
Work with the Humboldt County Mental Health Board to develop and implement a Humboldt County Stigma and Discrimination Reduction Plan	To begin Spring 2009, full plan completion Fall 2009 and implementation to begin Fall/Winter 2009
Identify and support client, consumer and family groups; build decentralized and integrated outreach efforts; integrate stigma and discrimination reduction programs; and identify resources and programs for underserved populations. Provide links between Suicide Prevention, TAY Partnership, and Stigma and Discrimination Reduction Projects.	To begin Spring 2009, then ongoing
Implement an evidenced based practice or promising program	Beginning Spring 2009
Educate communities to take action to reduce stigma and discrimination	
Establish a workforce training program with annual targets, use an inclusive and collaborative process for input, partner with advocates, and promote access to programs and educational opportunities for the community to develop competencies that support reduction of stigma and discrimination	To begin Spring 2009; annual training targets determined annually based on consumer, client and community input
Engage and educate local media about their role in promoting stigma and discrimination reduction	To begin Spring 2009

4. Programs

Program Title **Stigma and Discrimination Reduction Project**	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Maintain a system that uses external influence strategies to reduce stigma and discrimination	Individuals: Families:	Individuals: Families:	4 to 6 months
Educate communities to take action to reduce stigma and discrimination	Individuals: not less then 500 Families:	Individuals: Families:	4 to 6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 500** **Families**:	**Individuals:** **Families**:	

5. Linkages to County Mental Health and Providers of Other Needed Services

Since 1999, through initiatives and legislation such as Assembly Bill 315,[8] Humboldt County DHHS has been an integrated health and human services agency. Mental Health, Public Health and Social Services branches provide interrelated programs for children, families and adults, and deliver coordinated, efficient services while maximizing available resources.

Services continue to decentralize and move geographically closer to the clients they support. Following the Community Services and Supports component of the Mental Health Services Act, Humboldt County has continued to implement integrated multidisciplinary program teams which have developed successful mechanisms for assessment and referral to appropriate services, available both through governmental and community providers.

Program implementation for the Stigma and Discrimination Reduction Project will strengthen and rely upon ongoing referral mechanisms to link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, primary care

[8] Attachment D: Humboldt County Department of Health and Human Services. (2008). *AB315 (Berg, 2007) Integrated services initiative 2007-2010 strategic plan*. Eureka, CA: Humboldt County Department of Health & Human Services.

providers or other appropriate mental health service providers as well as other needed services, including those provided by community agencies not traditionally defined as mental health that have established or show capacity to establish relationships with at-risk populations. Specific focus will be in the areas of:

- Substance abuse treatment
- Community, domestic or sexual violence prevention and intervention
- Provision for basic needs such as can be met at the Family/community Resource Centers
- Outpatient treatment settings
- Community-based nonprofit organizations
- Supportive housing programs
- Clinics including rural, Federal Qualified Health Clinics, and Indian Health Clinics
- Schools
- Faith-based organizations.

Programs within the Stigma and Discrimination Reduction Project will strive to bridge gaps in the community with new and existing partnerships that will implement and expand services, including to unserved and underserved populations. Partnerships will work to ensure that all members of our communities are aware of mental health issues and services.

Partnerships that are established and/or renewed as a result of the project will ensure that an organized system of referrals is developed between community-based organizations and county programs and services. The referral system will ensure that individuals served through these prevention and early intervention programs are able to access other support services, according to their individual needs.

Selected programs within this PEI Project will provide services on the individual/family level, as well as a strong component of mental health education at the community level. Partnerships within these programs consist of established members of the community, including Family/community Resource Centers, local clinics and hospitals, agencies and organizations representing unserved and underserved populations, client and family member groups, and others.

All program staff will be encouraged to participate in cultural competency and program- and system-level improvement training. Funded services within the project will contribute to increased capacity among community and nonprofit partners. The media outreach component of the Stigma and Discrimination Reduction Project will contribute to community-level improvements, especially in the area of reduction of stigma, and awareness of and access to services.

6. Collaboration and System Enhancements

DHHS, as a member of the California Family Resource Association, and in ongoing collaboration with 17 Humboldt County Family/community Resource Centers (FRCs), Healthy Start Schools and Communities Partnership, is able to utilize the centers as a proven and established linkage into outlying areas of the county.

FRCs are key partners in improving the health and safety of Humboldt County residents. In partnership with DHHS, the centers have identified numerous ways to collaborate for improved outcomes for families and individuals, including assigning DHHS liaisons to centers, geographically assigning public health nurses and child welfare social workers to centers, cross-training staff, and participating in DHHS-promoted evidence based practices.

Further, the FRCs are key collaborators in the DHHS rollout of the MHSA PEI programs, not only as previously mentioned but also as key informants in development of prevention services.[9] DHHS personnel work with FRC staff on several existing programs including Differential Response, an innovative approach to child abuse prevention established through the California Child Welfare System Redesign. Department staff additionally attend regular meetings with center staff and stakeholders.

The Project will strengthen and build upon local community-based mental health and primary care systems by strengthening media outreach to increase community awareness, and by offering workforce training to frontline staff and implementation partners. Training will build cultural competence and reduce disparity among a variety of socioeconomic groups and underserved populations.

The Project will also leverage the considerable outreach of existing DHHS programs, including Family Violence Prevention, Injury Prevention, and Alcohol and Other Drug Prevention, to ensure that stigma and discrimination reduction messages and materials are shared with the largest possible number of community members.

A key feature of educating communities to take action to reduce stigma and discrimination is outreach with local media. Humboldt County is an unusual media market which offers the Project opportunities as well as challenges. Local media outlets include:

- Print media: one daily newspaper in Eureka with a daily online edition; two weekly papers in the rural southern part of the county; a weekly paper in the eastern region of the county in Klamath-Trinity; weekly papers also in

[9] Attachment D: Humboldt County Department of Health and Human Services. (2008). *AB315 (Berg, 2007) Integrated services initiative 2007-2010 strategic plan*. Eureka, CA: Humboldt County Department of Health & Human Services.

Arcata, McKinleyville, Fortuna, and Ferndale; one weekly that covers the entire North Coast region; and one monthly paper that is produced in Spanish.

- Television: several television stations with limited local programming or with offices located locally, one has local news staff and produces a newscast daily.

- Radio: multiple radio stations in Humboldt County including three commercial radio stations, two Public Radio stations, one Spanish station, one centered in the Hoopa Reservation and one low-powered station broadcasting on the Humboldt State University campus.

The project will be sustained by infusing a strong sense of community awareness about stigma and discrimination throughout all segments of the local community. The DHHS workforce and implementation partners will be trained to provide culturally competent stigma and discrimination reduction strategies and effective identification and referral of individuals in need of mental health assessment and treatment.

7. Intended Outcomes

As documented during the community stakeholder process and consistent with community priorities and local data, the intended individual, system and program outcomes include:

- Development and implementation of a Humboldt County stigma and discrimination reduction plan

- Improved knowledge and attitudes relating to stigma and discrimination within target workforces

- Increased media coverage related to stigma and discrimination reduction

- Increased cultural competency through specialized training for DHHS, the communities it serves, and other organizations

- New partnerships and maintenance of existing partnerships between DHHS, other agencies, and implementation and community partners

- Promotion of opportunities and settings to enhance resiliency, recovery, resourcefulness, respect and interconnectedness for individuals, families and communities.

As a result of the Stigma and Discrimination Reduction Project, we expect these changes to occur:

- Development of resources, materials and training related to mental health disabilities and stigma and discrimination reduction

- Strengthened links between Stigma and Discrimination Reduction PEI and other Humboldt County MHSA components

- Creation and strengthening of linkages between DHHS and community partnerships

- Increased consumer and family member access to wellness, recovery and early intervention strategies

- Increased competency among implementation partners and the community in stigma and discrimination reduction

- Reduction of negative outcomes resulting from untreated mental illness, which may include prolonged suffering, school failure, removal of children from homes, incarcerations, chronic unemployment, homelessness, hopelessness and suicide.

8. Coordination with Other MHSA Components

This PEI project will coordinate to the best extent possible with other MHSA components, including the following projects which resulted from the Community Planning Process and function within the context of Humboldt County DHHS integrated services:

- The Hope Center, which provides a safe, welcoming environment based on recovery and peer empowerment principles, and the resources necessary for underserved people with mental health diagnoses and their families in their efforts to be self-sufficient. Coordination with the Hope Center will offer crucial training opportunities for staff, who will be able to hear from clients who bring a set of values, beliefs and lifestyles that were molded as a result of their personal experiences with mental illness, the mental health system and their own cultures.

- Rural Outreach Services Enterprise (ROSE), which provides mobile access to culturally appropriate services in the rural, remote and outlying geographic areas of Humboldt County. ROSE links with and provides support to existing community organizations such as Family/community Resource Centers, community clinics and tribal organizations. ROSE will

have the ability to bring the Stigma and Discrimination Reduction Project to Humboldt County's outlying geographic areas.

- Integrated Program and Planning Support Structures, which is a further integration and expansion of a newly developed division of DHHS. It includes the following infrastructure enhancements:

    - The Office of Client and Cultural Diversity, which will assist with development and implementation of culturally competent programs

    - The Research and Evaluation Unit, which will facilitate the capacity-building focus areas of the Project

    - The Training, Education and Supervision Unit, which continues to build system capacity to develop, coordinate and integrate educational resources.

At this time, the county is in the early planning stages of the Workforce Education and Training, and Capital Facilities and Technology components of the MHSA.

PEI PROJECT NAME: Transition Age Youth Partnership Program

County: Humboldt **Date:** December 4, 2008

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in access to mental health services	☐	☐	☐	☐
2. Psycho-social impact of trauma	☐	☐	☐	☐
3. At-risk children, youth and young adult populations	☐	☒	☐	☐
4. Stigma and discrimination	☐	☐	☐	☐
5. Suicide risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma exposed individuals	☐	☐	☐	☐
2. Individuals experiencing onset of serious psychiatric illness	☐	☒	☐	☐
3. Children and youth in stressed families	☐	☐		
4. Children and youth at risk for school failure	☐	☐		
5. Children and youth at risk of or experiencing juvenile justice involvement	☐	☐		
6. Underserved cultural populations	☐	☐	☐	☐

B. Stakeholder input and data analysis that resulted in the selection of the priority population(s).

Stakeholder input and analysis of data clearly indicate that a priority for our community is comprehensive and coordinated support services for Transition Age Youth (TAY), including those who represent unserved and underserved racial/ethnic and cultural populations and who are at risk of or experiencing onset of psychiatric illness.

Humboldt County Department of Health and Human Services (DHHS) conducted an extensive Community Planning Process as the initial component of the Mental Health Services Act (MHSA).[1] Included were the Mental Health Board, attendees of six regional meetings and 13 targeted stakeholder meetings, four age-specific advisory groups, a Community Strengths & Needs Survey and client interviews. At specific phases of the planning process, each group was asked to articulate and prioritize mental health themes and needs.[2]

Comprehensive and coordinated early intervention for 16- to 25-year-olds experiencing the onset of a serious psychiatric illness was a high-ranking theme throughout the Community Planning Process. The Arcata community meeting's second-highest ranked theme was to "reduce the timeline between point of crisis and the point of intervention." The Willow Creek and Eureka community meetings' highest-ranked themes were early intervention in crises and ensuring "follow-up services, especially for those who are not system 'savvy.'" A theme at the Orick community meeting was that "early intervention works."

Key stakeholder input has come from DHHS's ongoing dialogue and partnership with TAY advocates, including both local youth and statewide TAY advocacy groups. DHHS initiated this focused input during the 2004-2005 Community Planning Process and has continued to sponsor and support the development of this group of young stakeholders.

These TAY have stated very clearly that it is critical to provide a comprehensive stakeholder-driven work plan that can sustain a strong and ongoing TAY voice in Humboldt County. Another theme is the need for a "one-system, all youth" approach to providing behavioral health services, as well as other TAY-specific services such as emancipation planning and advocacy.

Once a TAY youth partner program was identified as a key community need, the prevention and early intervention planning process, including 22 meetings and more than 250 participants, further assessed the community's capacity and

[1] California mental health services act (2004). *DMHC.ca.gov* . Retrieved: September 2, 2008, from http://www.dmh.ca.gov/Prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf

[2] Attachment C: Humboldt County Mental Health Services Act. (2005*) Recommendations submitted by advisory groups to MHSA steering committee.*

strengths and selected strategies to address desired outcomes and develop projects.

Education, training and outreach for TAY who are experiencing the onset of serious psychiatric illness was a consistent theme in the MHSA PEI community planning process. For example, at an MHSA PEI stakeholder discussion at a Community Partners (foster parents group) meeting, the comment was made that "education is needed for TAY and family members who are first diagnosed with a serious mental illness regarding medications, side effects, and what services are available." These recommendations have been incorporated into this Project.

The need for youth-driven advocacy for TAY was another consistent theme. At the MHSA PEI regional meeting in McKinleyville, the recommendation was made that "TAY with mental illness need other experiences, besides just mental health services, such as interpersonal skills training, and opportunities to engage with the community and learn that they can be successful in school." This recommendation has been incorporated into this Project.

Another common theme was the need to implement a project that will deliver intensive services from consistent providers for TAY and their family members from the first onset of a serious psychiatric illness. At a MHSA PEI planning discussion at a Domestic Violence Coordinating Council quarterly meeting, one participant said TAY "need to get to know the people working with them to build trust." This recommendation has been incorporated into this Project.

According to the literature, the earlier a comprehensive and coordinated intervention occurs, the better the outcomes for TAY experiencing the onset of serious psychiatric illness. The Early Diagnosis and Preventative Treatment of Psychotic Illness Clinic reports that longer duration of untreated psychosis is associated with poorer outcomes.[3] The report also indicates that reduced functioning and increased treatment resistance follow repeated relapses. Recommended treatment models are family-focused and include a multifunctional team that provides rapid responses in conjunction with medication management.

In addition, there is evidence that youth development programs promote positive outcomes[4] which:

[3] Attachment G: Carter, C. S. MD. (n.d.). *Early intervention for transitional age populations* [PowerPoint slides]. From http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/docs/Meetings/2008/Apr/OnsetFinalPresentation_DrCarter.pdf.

[4] Social Development Research Group, (1998, November 13). *Positive youth development in the United States: research finding on evaluations of positive youth development programs*. Seattle, Washington.

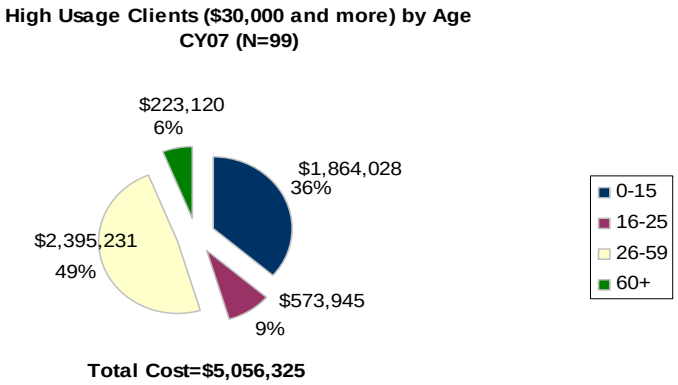
- Foster resilience, self determination, spirituality, self-efficacy, clear and positive identity, hope for the future, and pro-social norms
- Promote bonding and social, emotional, cognitive, behavioral and moral competencies
- Provide recognition for positive behavior
- Provide opportunities for pro-social involvement.

In California, youth who have experienced foster care have a higher incidence of poor outcomes.[5] The data show that 70% are incarcerated during their lifetime, with one in four in jail within two years of leaving foster care. Half to 80% have mental health needs. Less than half complete high school, and only 3% attend college. By age 21, less than 50% are employed, and 20% are homeless.

The data in Humboldt County support the need for comprehensive and coordinated services for TAY who are at risk or experiencing onset of a serious psychiatric illness, including those who represent unserved and underserved racial, ethnic and cultural populations.

According to Medi-Cal paid claims data for Calendar Year 2007, compiled by California's External Quality Review Organization (CAEQRO), Humboldt County's penetration rate of mental health services to the TAY population is ninth in the state, higher than both the statewide and small county averages.

The graphic below shows that as of May 2008, of 99 identified high service users, about 9% of the individuals in Humboldt County who utilize $30,000 or more per year were TAY between 16 and 25 years old.



[5] Bass, K. (n.d.). *leginfo.ca.gov*. AB 2216 - assembly bill chaptered. Retrieved September 15, 2008, from http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_2201-2250/ab_2216_bill_20060922_chaptered.html.

3. PEI Project Description: The TAY Partnership Project

The Community Planning Process identified TAY, at-risk of or experiencing the onset of serious psychiatric illness, particularly those who have experienced foster care, as an unserved and/or underserved priority population for our community.

The Community Planning Process further expressed that the goals for this population include reducing psychiatric hospitalization, psychiatric emergency services, incarceration, suicide attempts and substance abuse, while increasing their ability to succeed in school and employment, define their own recovery, and participate fully with their families and in their community.

This Project will enhance and support peer-to-peer activities such as peer counseling, peer support groups, peer mentors, peer support specialists, and peer educators.

The purpose of this Project is to provide supportive services that will contribute to the achievement of these goals. As a result of the Community Planning Process and an assessment of community capacity and strengths, three Programs were developed for the TAY Partnership Project.

Program #1: Education, Training and Outreach

In partnership with the Stigma and Discrimination Reduction Project, Suicide Prevention Project, and the TAY Advocacy Program, and in coordination with DHHS Public Education staff, this program utilizes a universal approach that will provide education and training throughout Humboldt County about:

- The early identification of indicators for TAY who are at risk of or experiencing the onset of serious psychiatric illness
- The importance of family and community in supporting mental health wellness and recovery
- Ways to access behavioral health services within local communities.

These efforts will raise community awareness about psychoactive illness and the importance of early intervention. Outreach efforts will specifically include historically unserved and underserved rural areas, as well as diverse racial, ethnic and cultural groups.

As a result of this Project, the TAY Plus team will be implemented and ensure youth and their families will receive ongoing education and support for the

development and application of culturally appropriate activities for transition age youth at-risk of or experiencing the onset of serious psychiatric illness.

Their natural supports such as family members, teachers, friends, and employers will receive education to increase their knowledge of the early challenges created by psychiatric illness, the types of assistance and services available, and ways to access those services. This outreach, training and education project will generate optimism and expectations of positive outcomes and recovery so that all TAY at risk of or experiencing symptoms of severe mental illness and their families can achieve optimal levels of support and services.

Program #2: TAY Advocacy

A wide variety of resources and collaborations will contribute to a DHHS-wide TAY Advocacy commitment. This PEI TAY Advocacy Program will bring a selective approach as one component of that larger DHHS-wide commitment, and will provide multiple opportunities to promote prevention and early intervention for serious mental illness.

This program will build on the concepts of Youth Development as used by the DHHS Alcohol and Other Drug Prevention Programs. By providing a safe environment with an approach that is youth-driven and congruent with youth culture, TAY participants will experience opportunities for community engagement, leadership and meaningful and caring relationships with peers and adults. These protect against risk factors of serious mental illness by promoting development of relevant personal and interpersonal skills, healthy personal attitudes and behaviors toward violence prevention, academic completion and minimization of the use of drugs, tobacco and alcohol.

Similar to other counties in California, Humboldt County is home to a population of transition age youth who are unserved or underserved and are in need of county system assistance. As part of our commitment to serve these youth in the best possible ways, Humboldt County will begin a five-year process to increase transition age youth input into systems improvement by ensuring the ongoing contribution of TAY-driven influences on DHHS policies and programs, and to provide strength-based advocacy and training to local TAY.

DHHS is engaged in an ongoing, department-wide collaboration with statewide community-based groups that advocate for the unique needs of TAY. Youth in Mind (YIM),[6] California Youth Connection (CYC),[7] and Youth Offering Unique

[6] (2008)Youth in mind: youth inspiring leadership and advocacy in mental health. Retrieved October 10, 2008 from *CMHACY California mental health advocates for children and youth* Web site http://www.cmhacy.org/conf-yla.html

Tangible Help (Y.O.U.T.H.)[8] are currently involved. TAY advocacy groups initially will develop and, with DHHS assistance as needed, implement a comprehensive work plan that may include but not be limited to:

- Development of digital stories from Humboldt County youth who have experienced the foster care, mental health and other systems. Those stories may be utilized in trainings and for departmental staff development

- Recruitment and hiring of a small team of Humboldt County Youth Advisory Board members to serve on a workgroup

- Planning and implementation of a countywide youth leadership program to support and prepare youth for strong youth engagement throughout Humboldt County DHHS

- Development of ongoing mechanisms for youth concerns and recommendations, to be incorporated into various county initiatives such as foster care, mental health, and housing

- Creation of ongoing opportunities for youth to exercise their leadership and expand their learning through conference presentations and participation.

Program #3: TAY Plus

This is an indicated approach that will include a comprehensive, coordinated and multifunctional team to provide an integrated service experience through culturally appropriate support services to TAY who are at risk of or experiencing the onset of serious psychiatric illness, their families, and their other significant supports. Those services may include but are not limited to:

- Comprehensive diagnostic assessment

- Tailored treatment pathways and therapies for early treatment and rehabilitation, with targeted pharmacological therapies, if indicated

- Treatment and planning in conjunction with a multifunctional team, to include the youth and their natural supports

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[7] (2002-2003). CYC foster youth building a foundation for the future *California youth connection*. Retrieved: October 10, 2008, from http://www.calyouthconn.org/site/cyc/

[8] Youth training project: about us (n.d.). Retrieved: October 10, 2008, from *Y.O.U.T.H. training project overview*. http://www.youthtrainingproject.org/article.php?list= type &type=3&printsafe=1

- Emergency outreach intervention to address immediate needs
- Individual and group therapies (psycho-educational, motivational, therapeutic)
- Advocacy (school, vocational, insurance, disability, housing)
- Independent living skills training and support
- Modified peer support therapeutic groups with involvement of mental health professionals
- Engagement of the family, and support to the family in its role in the individual's recovery
- Inclusion in a multifamily support group
- Education on the role of the family and community in supporting mental health wellness and recovery
- Information about how to access behavioral health services within the community.

The core team will consist of two case managers to serve as navigators and one mental health clinician, who will work together to provide consistent, ongoing relationships with program participants. The goal of this program is to engage the youth and the parent/support systems in sustained treatment focused on stabilizing and supporting recovery of function and developmental trajectory.

During the Community Planning Process, TAY and their family members prioritized the need for ongoing, consistent relationships with service providers in order to build trust with providers who know their stories. A recurring concern has been the difficulty TAY face when they are forced to start new relationships with multiple new providers.

A community strength identified in the Community Planning Process is DHHS's increasing ability to provide services within communities, where individuals and families can access and participate in those services in their natural settings. The TAY Plus team will continue to build on this strength by providing recovery-based, culturally competent services in the community, where such services are most effective. For example, when requested, TAY Plus team members may accompany program participants to locations such as homes, schools, work sites and doctors offices to support their recovery goals.

As youth and families served in this program define their own needs and preferences, the core team will provide, partner or link with services that will be

most effective. A community strength identified in the Community Planning Process is the successful collaboration with partners currently servicing the community. As youth and family needs are identified, the TAY Plus team will engage with those partnerships to meet the individual needs of those served in the program. These will include but not be limited to:

- Department of Health and Human Services integrated Public Health, Mental Health and Social Service branches
- TAY advocacy groups
- Mental Health Board
- Primary healthcare providers
- Probation Department
- Law enforcement
- Youth and family education and advocacy community groups
- Family/community Resource Centers
- Individual and organizational providers of mental health services
- Schools
- Substance abuse providers
- Vocational training providers.

Evidence Based Practices (EBPs)[9] currently provided in conjunction with DHHS are another community strength identified during the Community Planning Process. As appropriate, TAY Plus youth will be referred to and enrolled in DHHS EBPs which may include but not be limited to Aggression Replacement Therapy (ART) or Functional Family Therapy (FFT).

The TAY Plus team will gain proficiency in Trauma Focused Cognitive Behavioral Therapy (TF-CBT). This EBP has been selected for the TAY Plus program in order to provide knowledge and skills related to processing trauma by managing distressing thoughts, feelings and behaviors, and enhancing safety, parenting skills and family communication for TAY and their significant supports.

TF-CBT has the flexibility to achieve the desired outcomes for this population. This approach can be used in a variety of settings in the community, such as homes, schools, clinics, or hospitals. It can be offered individually or in groups, and can be provided using a brief intervention model. When appropriate, it is inclusive of parents and caretakers and has been shown to be appropriate for unique rural and diverse racial, ethnic and cultural populations.

To be eligible for participation in this program, TAY must be at risk of or experiencing (within the past 12 months) the onset of a serious psychiatric

[9] County of Humboldt (n.d.). *County of Humboldt Department of Health and Human Services*. Retrieved September 15, 2008, from http://co.humboldt.ca.us/HHS/Administration/Evidence Based Practices.asp

illness. There will be specific outreach and engagement to TAY from unserved and underserved racial, ethnic and cultural populations, as well as to TAY in foster care. Eligibility will be based on a combination of several symptoms, some of which may include:

- Impaired cognition which threatens academic performance and decision making[10]
- Anxiety or suspiciousness which impairs social function and increases risk for substance abuse, hostility and aggression
- Loss of interest and motivation which negatively impacts social functioning.

Onset of a serious psychiatric illness is defined as the first time an individual meets full DSM-IV criteria for a psychotic illness. If onset of a serious psychiatric illness has occurred, eligibility will be met when diagnosed by a qualified mental health professional.

Referrals to the TAY Plus program may come from a variety of sources, including family members, primary healthcare providers, psychiatric emergency services, hospital emergency rooms, family resource centers, schools, community-based agencies, county agencies, faith-based organizations, and/or the youth themselves.

Selection of participants will be made by a multifunctional committee comprised of Mental Health, Social Services, and Public Health representatives. When appropriate, the youth and/or their family may be included. A component of the referral and selection process may include the Strategic Assistance for Adult Recovery Intervention (SAFARI) committee which routinely reviews and authorizes services.

This committee, which includes DHHS management and clinical staff, provides an intensive and highly responsive review process to ensure that participants in the mental health system of care are being cared for in the least restrictive setting possible. The goal of SAFARI is to maximize opportunities for recovery for individuals served by the mental health system.

Similarly, the Children's System of Care's referral process will coordinate with TAY Plus. These referral mechanisms will also be utilized when additional or increased intensity of services is required for TAY Plus youth.

[10] Attachment G: Carter, C. S. MD. (n.d.). *Early intervention for transitional age populations* [PowerPoint slides]. Retrieved from http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/docs/Meetings/2008/Apr/OnsetFinalPresentation_DrCarter.pdf.

Actions to be performed to carry out the PEI Project, including frequency or duration of key activities

Education, Training and Outreach	Frequency/Duration
Identify and/or hire public education staff	Fall '08
Develop and implement training program	Spring '09 and then ongoing
TAY Advocacy	
Develop and implement work plan in coordination with DHHS representatives	Early Spring '09
Develop evaluation mechanism to monitor and report on progress	Mid Spring '09
Implement a countywide youth leadership program	Spring '09 and then ongoing
Implement communication mechanism for youth concerns and recommendations	Spring '09 and then ongoing
TAY Plus	
Hire and/or identify TAY Plus core team members	Winter/Spring '09
Develop program policies and procedures including referral and selection mechanisms	Winter '09
Identify eligible TAY Plus youth	Spring '09 and ongoing
Initiate services to five TAY Plus participants	Spring '09

4. Programs

Transition Age Youth Partnership Program	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Education, Training and Outreach	Individuals: at least 500 Families:	Individuals: Families:	4-6 months
TAY Advocacy	Individuals: 20 Families:	Individuals: Families:	4-6 months
TAY Plus	Individuals: Families:	Individuals: 5 Families:	4-6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: not less than 500 Families:	Individuals: 5 Families:	4-6 months

5. Linkages to County Mental Health and Providers of Other Needed Services

Since 1999 and through initiatives and legislation such as Assembly Bill 315,[11] Humboldt County Department of Health and Human Services has been an integrated health and human services agency. Mental Health, Public Health, and Social Services branches provide integrated programs for children, families, and adults which deliver coordinated, efficient services and maximize available resources.

Services continue to become increasingly decentralized and in closer proximity to local communities to the maximum extent possible. Throughout the Community Services and Supports component of the Mental Health Services Act, Humboldt County has continued to implement integrated, multidisciplinary program teams which have developed successful mechanisms for assessment and referral to appropriate services, available through county and community providers.

[11] Attachment D: (2008). *AB315 (Berg, 2007) Integrated services initiative 2007-2010 strategic plan*. Retrieved September 3, 2008, from Humboldt County Department of Health and Human Services Web site: http://co.humboldt.ca.us/HHS/Administration/Documents/AB%20315%20Strategic%20Plan%20June%202008.pdf.

This project will both strengthen and rely upon ongoing referral mechanisms to link individual participants who need assessment, services or treatment to primary care providers or other appropriate service providers. Included are those provided by community agencies not traditionally defined as mental health, agencies which have established or show capacity to establish relationships with TAY at-risk populations.

Specific focus will be in the areas of:

- Substance abuse treatment
- Community, domestic or sexual violence prevention and intervention
- Provision for basic needs such as can be met at the family/community resource centers
- Outpatient treatment settings
- Community based nonprofit organizations
- Supportive housing programs
- Clinics including rural, Federally Qualified Health Clinics, and Indian Health Clinics
- Schools
- Faith-based organizations.

Programs within the TAY Partnership Project will bridge gaps in the community with new and existing partnerships which will help implement and expand prevention and early intervention services, including those for unserved and underserved at-risk TAY. Partnerships that are established, expanded and/or renewed as a result of the project will better ensure that both an organized system of referral and early response to intervention are developed between the community organizations, county programs and services that are youth- and family-driven.

The project will leverage resources by maximizing existing partnerships and creating new ones. Partnerships within these programs may consist of established community infrastructure, including Family/community Resource Centers, local clinics and hospitals, statewide and local TAY advocacy groups, agencies and organizations representing unserved and underserved populations, client and family member groups, and others.

All programs will be encouraged to participate in trainings created and facilitated by TAY advocacy groups and program-/system-level improvement trainings. Funded services within the project will contribute to an increased capacity among community partners to meet the special needs of TAY who are at risk of or experiencing the onset of serious psychiatric illness.

6. Collaboration and System Enhancements

The TAY Partnership Project is built upon multiple partnerships among numerous stakeholders. As a result of targeted, collaborative efforts, the entire community will be strengthened.

DHHS, as a member of the California Family Resource Association, and in ongoing collaboration with Humboldt County Family/community Resource Centers, is able to utilize 17 existing centers as proven and established linkages to outlying areas of the county. Resource centers are key partners in improving the health and safety of the people of Humboldt County.

In partnership with DHHS, the centers have identified numerous ways to collaborate for improved outcomes for individuals and their natural supports. The suggestions include locating DHHS liaisons in the centers, and assigning public health nurses, social service workers and behavioral health clinicians to geographically-based centers; cross-training staff; center participation in evidence based practices; and Casey's Family-to-Family Initiatives, such as Team Decision Making and family-finding activities.

Resource Centers have also collaborated with Public Health, Child Welfare and Mental Health with Differential Response, an innovative approach established through the California Child Welfare System Redesign. This project will further enhance an already strong partnership among DHHS and the resource centers, and provide the focus and prioritization necessary to address the special needs of this target population.

DHHS, as an integrated health and human services agency, has several forums in place to share information and sustain strong working relationships with community-based mental health and primary care systems. Monthly Community Service Provider meetings have enabled both the community and multi-disciplinary DHHS staff to engage in ongoing dialogue to best meet the needs of the community.

Examples include quarterly clinics meetings with the local consortium of Federally Qualified and Rural Health Clinics. The project, in partnership with the Stigma Reduction and Suicide Prevention projects, will strengthen and build upon local community-based mental health and primary care systems by providing more opportunity for cross-training and coordination on behavioral health issues specific to the target population.

DHHS is also a founder of Humboldt County's Children's Health Initiative, Healthy Kids Humboldt, whose goal it is to assure access to healthcare for all Humboldt County children and youth.

DHHS enjoys an ongoing collaborative relationship with Humboldt County educational institutions to meet the educational needs of our community. Specifically for the TAY foster care population, the Independent Living Skills Program through Child Welfare Services coordinates with school liaisons to provide advocacy and support for TAY exiting foster care and bridging to higher education. This partnership continues to generate positive outcomes for TAY. Humboldt County's foster youth receive priority and assistance in class selection and scheduling, as well as homework assistance and counseling services.

Of particular note is the expansion of the residential housing program at a local community college, which now provides year-round service to foster youth, rather than closing during holidays and other academic breaks. This change in program allows foster youth to have stable housing when they may not otherwise have a place to go.

Additionally, the formation of a former foster youth club on a local community college campus provides successful, peer-to-peer advocacy and support that has been supported through the partnership.

The local university also supports a former foster youth club on campus. The TAY Partnership Project will expand upon the current advocacy and support structures to meet the needs of the participants who may or may not be former foster youth, but who are equally, if not more, vulnerable.

7. Intended Outcomes

Education Training and Outreach (Universal)

- Program/System: Provide education, training and outreach to 500 individuals

TAY Advocacy (Selective)

- Person/Family: Build youth capacity to self-advocate
- Program/System: Digital storytelling workshop and screening completed

TAY Plus (Indicated)

- Person/Family: Increased engagement in TAY recovery activities, maintenance of healthy and stable living environment, achievement of personal recovery goals, and increased access to family member support services
- Program/System: Improved methods for assessing TAY outcomes, and implementation of an EBP to improve outcomes.

8. Coordination with Other MHSA Components

Benefiting from the "lessons learned" of already established programs, it is anticipated that consultation and training with other MHSA programs will be invaluable during planning and implementation of the TAY Partnership Project, as well as on an ongoing basis. TAY Plus, TAY Advocacy, and Education, Training and Outreach will be significantly stronger programs and provide better outcomes by linking to such programs as:

- Rural Outreach Services Enterprise (ROSE), which provides mobile access to services in the rural, remote and outlying geographic areas as well as to the homeless populations throughout Humboldt County. ROSE links with and provides support to existing organizations such as the family and community resource centers, community clinics and tribal organizations. ROSE will have the ability to bring the TAY Partnership program to Humboldt's outlying geographic areas.

- The Hope Center, which provides a safe, welcoming environment based on recovery and peer empowerment principles, and the resources necessary for underserved people with mental health diagnoses and their families in their efforts to be self sufficient. The Hope Center provides a foundation of peer-to-peer activities that the TAY partnership program can build upon.

- Comprehensive Community Treatment (CCT), providing intensive community services and supports including housing, medical, dental, educational, societal, vocational, rehabilitative and other community services. Peer clients and peer family members, whenever possible, provide services to partners in their natural settings. TAY Plus youth may be referred to CCT when appropriate.

- Outpatient Medication Services Expansion, providing medication support via video conferencing equipment to people with serious mental illness residing in remote rural areas. This service strategy enhances existing collaborative efforts with primary healthcare providers, and TAY Plus youth residing in remote rural areas will have access to this resource.

- Crisis Intervention Services (CIS) staff, who respond to intervene in the community and prevent hospitalizations and incarcerations. CIS staff provide crisis support to emergency rooms and primary care settings, as well as during potential or actual critical incidents in the community involving individuals who may have a mental illness. CIS and TAY Plus staff will collaborate when TAY Plus youth are involved.

- Integrated Program & Planning Support Structures, including the Office of Client & Cultural Diversity. OCCD provides cross-branch leadership to

DHHS in the areas of policy and program development related to culturally competent client- and family-driven services and the reduction of racial, ethnic, and geographic disparities. The OCCD will provide resources and technical assistance that will increase TAY Partnership program's ability to be culturally competent and client- and family-driven.

- The Research and Evaluation (R&E) Unit, which includes a full spectrum of evaluation services from data management, data verification, statistical analysis and interpretation, to written progress reports. The unit increases DHHS's capacity for outcomes-based program planning and improvement. R&E will provide resources and technical assistance to increase the TAY Partnership program's ability to evaluate and improve services and activities.

- The Training, Education and Supervision (TES) Unit, which continues to build system capacity to develop, coordinate, and integrate resources to provide education and training opportunities to staff, clients, parents, families, community partners, and providers. TES will provide resources and technical assistance to increase the TAY Partnership program's ability to develop and coordinate training and education opportunities.

At this time, Humboldt County is in the early planning stages of the Workforce Education and Training and the Capital Facilities and Technology components of MHSA.

Prevention and Early Intervention Budget Narratives

County: Humboldt

Project: Suicide Prevention

Fiscal year: 2008-09

PEI project budgets for FY 2008-09 are calculated for six months of operation.

Personnel expenditures include Salaries and Wages for the following staff positions:

Health Education Specialist 1.50 FTE; Senior Health Education Specialist .05 FTE; Public Education Officer .15 FTE; Administrative Analyst .20 FTE; Translator / Interpreter .01 FTE. Benefits and taxes are calculated at 41% for these Public Health Branch positions. **Total Personnel Expenditures are budgeted at $57,539.**

Operating expenditures include facility cost for leased space and utilities calculated at $5,079 annually per FTE.

Other operating expenses include the following:

Media and materials, including production and promotion of Suicide Prevention messages, education or outreach services $37,593.

DHHS multi-branch staff development and training $6,987; Professional and Special services $5,000.

Workers Compensation, Liability Insurance $1,495 annually per FTE

Recruiting costs estimated at $405

Communications $1,289; Office supplies $3,502; copier equipment and postage $1,500; books and periodicals $1,080

Mileage $2,984; out of county travel $2,525

Computer equipment and software – 2 personal computers $4,180

Total Operating Expenditures are budgeted at $73,322

Total proposed Suicide Prevention project budget / funding requested is $130,861.

In-Kind Contributions include $33,933 for DHHS personnel providing discussion of Suicide Prevention activities in forums such as Domestic Violence Coordinating Council, Alcohol and Drug Advisory Board, AIDS Task Force, and Human Services Cabinet.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: Humboldt Date: 10/15/08
PEI Project Name: Suicide Prevention
Provider Name (if known): DHHS - Public Health Branch
Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	500
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	500
Months of Operation:	FY 07-08	0	FY 08-09	6

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 07-08	FY 08-09	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages	FTE			
Health Education Specialist	1.50	$0	$30,612	$30,612
Senior Health Education Specialist	0.05	$0	$1,210	$1,210
Public Education Officer	0.15	$0	$4,521	$4,521
Administrative Analyst	0.20	$0	$4,301	$4,301
Translator / Interpreter	0.01	$0	$164	$164
b. Benefits and Taxes @ 41 %		$0	$16,731	$16,731
c. Total Personnel Expenditures		$0	$57,539	$57,539
2. Operating Expenditures				
a. Facility Cost		$0	$4,850	$4,850
b. Other Operating Expenses		$0	$68,472	$68,472
c. Total Operating Expenses		$0	$73,322	$73,322
3. Subcontracts/Professional Services (list/itemize all subcontracts				
		$0	$0	$0
		$0	$0	$0
		$0	$0	$0
a. Total Subcontracts		$0	$0	$0
4. Total Proposed PEI Project Budget		$0	$130,861	$130,861
B. Revenues (list/itemize by fund source)				0
		$0	$0	$0
		$0	$0	$0
			$0	$0
1. Total Revenue		$0	$0	$0
5. Total Funding Requested for PEI Project		$0	$130,861	$130,861
6. Total In-Kind Contributions		$0	$33,933	$33,933

Prevention and Early Intervention Budget Narratives

County: Humboldt

Project: Stigma and Discrimination Reduction

Fiscal year: 2008-09

PEI project budgets for FY 2008-09 are calculated for six months of operation.

Personnel expenditures include Salaries and Wages for the following staff positions:

Health Education Specialist .50 FTE; Senior Health Education Specialist .05 FTE; Public Education Officer .10 FTE; Administrative Analyst .10 FTE; Translator / Interpreter .01 FTE. Benefits and taxes are calculated at 41% for these Public Health Branch positions. **Total Personnel Expenditures are budgeted at $23,608.**

Operating expenditures include facility cost for leased space and utilities calculated at $5,079 annually per FTE.

Other operating expenses include the following:

Media and materials, including production and promotion of Stigma Reduction and Anti-Discrimination messages, education or outreach services $36,188.

DHHS multi-branch staff development and training $4,658; Professional and Special services $5,000.

Workers Compensation, Liability Insurance $1,495 per FTE; Recruiting costs estimated at $270

Communications $513; Office supplies $1,393; copier equipment and postage $1,500; books and periodicals $475

Mileage $1,989; out of county travel $1,683

Computer equipment and software – 1 personal computer $2,090

Total Operating Expenditures are budgeted at $58,257

Total proposed Stigma and Discrimination Reduction project budget / funding requested is $81,865.

In-Kind Contributions include $22,622 for DHHS personnel providing discussion of Stigma and Discrimination Reduction activities in forums such as Domestic Violence Coordinating Council, Alcohol and Drug Advisory Board, AIDS Task Force, and Human Services Cabinet.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: HUMBOLDT Date: 10/15/08
PEI Project Name: Stigma and Discrimination Reduction
Provider Name (if known): DHHS - Public Health Branch
Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	500
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	500
Months of Operation:	FY 07-08	0	FY 08-09	6

Proposed Expenses and Revenues		Total Program/PEI Project Budget FY 07-08	FY 08-09	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages	FTE			
Health Education Specialist	0.50	$0	$10,204	$10,204
Senior Health Education Specialist	0.05	$0	$1,210	$1,210
Public Education Officer	0.10	$0	$3,014	$3,014
Administrative Analyst	0.10	$0	$2,151	$2,151
Translator / Interpreter	0.01	$0	$164	$164
b. Benefits and Taxes @ 41 %		$0	$6,865	$6,865
c. Total Personnel Expenditures		$0	$23,608	$23,608
2. Operating Expenditures				
a. Facility Cost		$0	$1,930	$1,930
b. Other Operating Expenses		$0	$56,327	$56,327
c. Total Operating Expenses		$0	$58,257	$58,257
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
		$0	$0	$0
		$0	$0	$0
		$0	$0	$0
a. Total Subcontracts		$0	$0	$0
4. Total Proposed PEI Project Budget		$0	$81,865	$81,865
B. Revenues (list/itemize by fund source)				0
		$0	$0	$0
		$0	$0	$0
			$0	$0
1. Total Revenue		$0	$0	$0
5. Total Funding Requested for PEI Project		$0	$81,865	$81,865
6. Total In-Kind Contributions		$0	$22,622	$22,622

Prevention and Early Intervention Budget Narratives

County: Humboldt

Project: Transition-Age Youth (TAY) Partnership

Fiscal year: 2008-09

PEI project budgets for FY 2008-09 are calculated for six months of operation.

Personnel expenditures include Salaries and Wages for the following staff positions:

Public Education Officer .75 FTE; Supervising Mental Health Clinician .25 FTE; Mental Health Clinician 1.0 FTE; Case Managers 2.0 FTE. Benefits and taxes are calculated at 41% for these Mental Health Branch positions. **Total Personnel Expenditures are budgeted at $150,488.**

Operating expenditures include facility cost for leased space and utilities calculated at $5,079 annually per FTE.

Other operating expenses include the following:

DHHS multi-branch staff development and training $33,562. This expenditure includes cost of participation in evidence-based practice Trauma Focused Cognitive Behavioral Therapy training.

Workers Compensation, Liability Insurance $1,806 per FTE; Recruiting costs estimated at $900

Communications $2,700; Office supplies $2,493; copier equipment $1,500; books and periodicals $2,400

Mileage $7,800; out of county travel $11,028

Two mid-sized vehicles for staff liaisons to provide direct service and client transportation $60,000

Computer equipment and software – 4 personal computers $8,360

Total Operating Expenditures are budgeted at $148,125

Subcontracts/Professional Services budget includes $75,000 for TAY Advocacy Groups. These expenditures are intended to provide funds for recruitment and hiring and to establish an office where staff and youth advisory board leaders can work and meet throughout the year.

Total proposed Transition-Age Youth (TAY) Partnership project budget is $373,613.

Revenue estimates for TAY project include cost reimbursement for the provision of Specialty Mental Health Services to Medi-Cal beneficiaries: $26,437 State General Fund (EPSDT) and $26,437 Medi-Cal Federal Financial Participation FFP).

Total proposed funding request for TAY Partnership Project is $320,739

In Kind Contributions include $75,000 DHHS – Social Services Branch funds for local office space, staffing, training and project development process for improved services to transition-age youth. TAY Advocacy Groups have proposed in kind contributions from San Francisco State University for maintenance and operations of Oakland based office to assist with TAY Partnership project collaboration.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: HUMBOLDT Date: 10/15/08
PEI Project Name: Transition-Age Youth (TAY) Partnership Project
Provider Name (if known): DHHS - Mental Health Branch & Youth Advocacy Groups
Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	500
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	500
Months of Operation:	FY 07-08	0	FY 08-09	6

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 07-08	FY 08-09	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages	FTE			
Public Education Officer	0.75	$0	$22,606	$22,606
Supervising Mental Health Clinicia	0.25	$0	$9,219	$9,219
Mental Health Clinician	1.00	$0	$32,717	$32,717
Case Manager	2.00	$0	$42,187	$42,187
		$0	$0	$0
b. Benefits and Taxes @ 41 %		$0	$43,759	$43,759
c. Total Personnel Expenditures		$0	$150,488	$150,488
2. Operating Expenditures				
a. Facility Cost		$0	$10,158	$10,158
b. Other Operating Expenses		$0	$137,967	$137,967
c. Total Operating Expenses		$0	$148,125	$148,125
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
TAY Advocacy Groups		$0	$75,000	$75,000
		$0	$0	$0
		$0	$0	$0
a. Total Subcontracts		$0	$75,000	$75,000
4. Total Proposed PEI Project Budget		$0	$373,613	$373,613
B. Revenues (list/itemize by fund source)				0
SGF (EPSDT)		$0	$26,437	$26,437
Medi-Cal FFP		$0	$26,437	$26,437
			$0	$0
1. Total Revenue		$0	$52,874	$52,874
5. Total Funding Requested for PEI Project		$0	$320,739	$320,739
6. Total In-Kind Contributions		$0	$75,000	$75,000

Prevention and Early Intervention Budget Narratives

County: Humboldt – Administration Budget

Fiscal year: 2008-09

PEI Administration budget for FY 2008-09 is calculated for six months of operation.

Personnel expenditures include Salaries and Wages for the following staff positions:

PEI Coordinator / Analyst 1.0 FTE; Office Assistant .75 FTE; Fiscal Assistant .50 FTE. .50 FTE position is proposed to be client or family member. Benefits and taxes are calculated at 41% for these Administrative positions. **Total Personnel Expenditures are budgeted at $53,087.**

Operating expenditures include facility cost for leased space and utilities calculated at $5,079 annually per FTE.

Other operating expenses include the following:

Workers Compensation, Liability Insurance $1,806 annually per FTE; Recruiting costs estimated at $225

Communications $1,519; Office supplies $1,875; copier equipment and postage $1,500; books and periodicals $400

Mileage $600; out of county travel $1,650; staff development and training $500

Computer equipment and software – 1 personal computer $2,090

Total Operating Expenditures are budgeted at $20,134

Total County Allocated Administration cost is calculated at $1,607.19 annually per FTE for a total of $7,168

Total proposed PEI Administration budget / funding requested is $80,389.

Form No. 5

County: HUMBOLDT Date: 10/15/2008

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator / Analyst		1.00		$21,506	$21,506
b. PEI Support Staff	0.50	1.25		$16,144	$16,144
c. Other Personnel (list all classifications)					$0
					$0
					$0
					$0
					$0
d. Employee Benefits				$15,437	$15,437
e. Total Personnel Expenditures			$0	$53,087	$53,087
2. Operating Expenditures					
a. Facility Costs				$5,714	$5,714
b. Other Operating Expenditures				$14,420	$14,420
c. Total Operating Expenditures			$0	$20,134	$20,134
3.County Allocated Administration					
a. Total County Administration Cost			$0	$7,168	$7,168
4. Total PEI Funding Request for County Administration Budget			$0	$80,389	$80,389
B. Revenue					
1 Total Revenue			$0	$0	$0
C. Total Funding Requirements			$0	$80,389	$80,389
D. Total In-Kind Contributions			$0	$0	$0

Form No. 6

Instruction: Please provide a listing of all PEI projects submitted for which PEI funding is being requested. This form provides a PEI project number and name that will be used consistently on all related PEI project documents. It identifies the funding

County:	HUMBOLDT
Date:	revised - 01/06/2009

		Fiscal Year			Funds Requested by Age Group			
#	List each PEI Project	**FY 07/08**	**FY 08/09**	**Total**	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Suicide Prevention	$ -	$ 130,861	$ 130,861	$ 32,715	$ 32,715	$ 32,715	$ 32,715
2	Stigma and Discrimination Reduction	$ -	$ 81,865	$ 81,865	$ 20,466	$ 20,466	$ 20,466	$ 20,466
3	Transition-Age Youth (TAY)	$ -	$ 320,739	$ 320,739		$ 320,739		
	Administration	$ -	$ 80,389	$ 80,389				
	Total PEI Funds Requested:	$ -	$ 613,853	$ 613,853	$ 53,181	$ 373,920	$ 53,181	$ 53,181

County requests that funds be distributed from the following PEI planning estimates:

FY 2007-08 $ 293,200

FY 2008-09 $ 320,653

Form No. 7

County: Humboldt Date: October 18, 2008

☐ Check this box if this is a "very small county" (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name: TAY Partnership Project

1. a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.

- TAY Plus
- TAY Advocacy
- Education Training and Outreach

1. b. Explain how this PEI project and its programs were selected for local evaluation.

Stakeholder Input identified coordinated TAY services as a priority.

The TAY project encompasses approaches that are universal, selective, and indicated.

Using one or more EBPs provides the opportunity to measure individual, family, and program outcomes.

2. What are the expected person/family-level and program/system-level outcomes for each program?

<u>Education Training and Outreach (Universal)</u>

Program/system

- Provide education training and outreach to 500 individuals

<u>TAY Advocacy (Selective)</u>

Person/family

- Build youth capacity to self advocate
- Build youth leadership development

Program/system

- Digital story telling workshop and screening completed

TAY Plus (Indicated)

Person/Family

- Increased engagement in TAY recovery activities
- Maintaining healthy stable living environment
- Meeting personal recovery goals
- Increased access to family member support services

Program/System

- Improved methods for assessing TAY outcomes
- Implementation of an EBP to improve outcomes

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For "other", provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION
Education Training and Outreach

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American		25					
Asian Pacific Islander		25					
Latino		50					
Native American		50					
Caucasian		350					
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)							
Transition Age Youth (16-25)		500					
Adult (18-59)							
Older Adult (>60)							
TOTAL		500					

Total PEI project estimated ***unduplicated*** count of individuals to be served ____500_____

Form No. 7

TAY Advocacy

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American		1					
Asian Pacific Islander		1					
Latino		2					
Native American		2					
Caucasian		14					
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)							
Transition Age Youth (16-25)		20					
Adult (18-59)							
Older Adult (>60)							
TOTAL							

Total PEI project estimated ***unduplicated*** count of individuals to be served ____20_____

Form No. 7

TAY Plus

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American							
Asian Pacific Islander							
Latino		1					
Native American		1					
Caucasian		3					
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)							
Transition Age Youth (16-25)		5					
Adult (18-59)							
Older Adult (>60)							
TOTAL							

Total PEI project estimated ***unduplicated*** count of individuals to be served _____5___

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

Education Training and Outreach (Universal)

Program/system

- Conduct education and outreach at Humboldt County public events monitored through number of events and number of brochures shared.

- DHHS Trainings will be tracked through number and frequency of presentations, trainings, and number of people in attendance as well as through the completed evaluations.

TAY Advocacy (Selective)

Person/family

- Build youth capacity to self-advocate: Number of youth participating and frequency of events.

- Build youth leadership development: Number of youth participating and frequency of events.

Program/system

- Digital story telling workshop completed: Monitor number completed for new and updated information over time.

- Digital story telling screening completed: Monitor number completed for new and updated information over time.

TAY Plus (Indicated)

Person

- Engagement in the community such as volunteering, participating in TAY Advocacy Group activities, attending school, and/or employment: monitored through periodic feedback by youth and TAY Plus Team toward progress of community participation goals.

- Maintaining healthy stable living environment: monitored through periodic feedback by youth and TAY Plus Team toward progress of healthy stable living environment goals.

- Meeting personal recovery goals: monitored through periodic reviews of progress toward meeting personal recovery goals.

Family

- Increased access to family member and natural support services monitored through program and utilization reports.

5. How will data be collected and analyzed?

   Data will be collected from the current mental health data system, program reports, pre and periodic standardized assessments, referral forms, surveys, sign-in sheets, counts, and training/event evaluations. Consolidation and reporting out of data will be performed by mental health analysts on at least an annual basis.

6. How will cultural competency be incorporated into the programs and the evaluation?

   In conjunction with DHHS overall commitment to cultural competency, the Office of Client and Cultural Diversity and the TAY Advocacy Groups will provide guidance and technical assistance on program development, implementation, and on-going monitoring.

7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

   Through EBP evaluation process Humboldt County will use normal fidelity practices in-house by the Research & Evaluation Unit.

8. How will the report on the evaluation be disseminated to interested local constituencies?

   The report on the evaluation of outcomes will be disseminated through current mechanisms such as:
   - Humboldt County Department of Health and Human Services Monthly Newsletter
   - Humboldt County Department of Health and Human Services Quarterly Trend Reports

- Mental Health Branch Data Book
- Mental Health Board
- Presentations at Mental Health Board
- MHSA Stakeholder meetings
- All Staff meetings
- Human Services Cabinet

Attachment A

Humboldt County Department of Health and Human Services

Mental Health Services Act

Provides funding to expand and develop innovative and integrated mental health services

What do you think?

Public Comment
October 18 - November 17

Prevention and Early Intervention Plan, Assignment Letter, and the Community Services and Supports Fiscal Year 2008-09 Update.

Documents are available and comments may be placed in the

"MHSA Comment Box"

- **Humboldt County DHHS Professional Building: 507 F Street, Eureka**
- **Humboldt County DHHS Mental Health Branch Children Youth and Family Services: 1711 3rd Street, Eureka**
- **Humboldt County DHHS Mental Health Branch: 720 Wood Street, Eureka**
- **Hope Center: 2933 H Street, Eureka**
- **website:** http://co.humboldt.ca.us/HHS/MHB/MHSA/

Public Hearing on November 17

Humboldt County Department of Health and Human Services Professional Building

507 F Street in Eureka from **5:30 to 6:30pm**

To request documents be sent to you or to make a comment please contact us at:

Phone: (707) 441-3770

Toll free: (866) 320-8911

Email: mhsacomments@co.humboldt.ca.us

Address: Department of Health and Human Services, Mental Health Branch
Attn: Jaclyn Culleton
720 Wood Street
Eureka, Ca 95501

Attachment B

County of Humboldt
Department of Health & Human Services

Mental Health Branch

Karolyn Stein, RN, Branch Director

Mental Health Services Act (MHSA)

"Maggie and Jane"
Maggie had found a home
~ Louise Hope ~

About The Mental Health Services Act

The Mental Health Services Act (MHSA) provides funding to counties to expand and develop innovative and integrated mental health services for children, youth, adults, and older adults. California voters passed Prop 63 in November 2004 as the result of a grassroots coalition intending to transform public mental health care.

The intent of this website is to inform and invite you to participate in the implementation of the MHSA.

- Full text of the Mental Health Services Act
- Acta de Servicios de Salud Mental

The Mental Health Services Act addresses a broad continuum of prevention, early intervention, and service needs.

- Older / Dependent Adult Services provides co-located, integrated mental health services by a clinician, with the Adult Protective Services (APS) and In-Home Supportive Services (IHSS) Program.
- Crisis Intervention Services (CIS) provides the coordination of crisis intervention services in partnership with law enforcement.
- The Alternative Response Team (ART) is an innovative, multi-agency program aimed at those at-risk families that would benefit from early intervention and services.
- Comprehensive Community Treatment (CCT) is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness.
- Hope Center is a client and family member center, that provides peer-to-peer education, support, prevention services, wellness activities, and system navigation. To contact the Hope Center, call **(707) 441-3723**.
- Rural Outreach Services Enterprise (ROSE) provides Mental Health, Alcohol and Other Drug, Social Services, and Public Health mobile outreach services to outlying communities.
- Telemedicine services provide medication support to outlying areas.
- Support to Transitional Age Youth (TAY) Organizations.
- The Mental Health Liaison works with families and individuals in the community who have mental health questions, concerns, or need support.

Public Comment! Participate! Be informed!

Mental Health Services Act Plans and Updates are available for a 30-day comment period before they are submitted to the State Department of Mental Health. When a Plan or Update is available for Public Comment it will be located in the **MHSA Documents Open for Public Comment** section.

MHSA Plans or Updates may be obtained in several ways:

- Click on the name of the document below to view or print.
- Click on document below to view and on the last page will be listed the locations hard copies are available during the 30-day Comment Period.
- E-mail or call with your mailing address or email address and request the document.

Submitting a Public Comment during the 30-day Comment Period may be done in several ways:

Click on the document below to view it and on the last page of the document will be listed the locations "MHSA Comment Boxes" are available during the 30-day Comment Period.

- Email: mhsacomments@co.humboldt.ca.us
- Comment line phone number: **(707) 441-3770**
- Toll Free number: **(866) 320-8911**

MHSA Documents Open for Public Comment!

- MHSA Prevention and Early Intervention Plan
  - Attachment A: Suicide in Humboldt County 2003-2007
  - Attachment B: Humboldt County Strategic Prevention Plan
  - Attachment C: Recommendation Submitted by Advisory groups to MHSA Steering Committee
  - Attachment D: Integrated Services Initiative 2007-2010 Strategic Plan
  - Attachment E: California Strategic on Suicide Prevention: Every Californian is part of the Solution
  - Attachment F: Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities. A Project of the Mental Health Services Act
  - Attachment G: Early Intervention for Transitional Age Populations
- MHSA Prevention and Early Intervention Assignment Letter
- MHSA Community Services and Supports Fiscal Year 2008-2009 Update

Previous MHSA Documents

2008

- MHSA Housing Assignment Letter

2007

- Community Services and Supports Implementation Progress Report
- Community Services and Supports FY05/06 Remaining Funds Plan
- Community Services and Supports One-Time Augmentation Plan
- Community Services and Supports Expansion Plan

2006

- Community Services and Supports Implementation Progress Report

2005

- Community Services and Supports Plan
- Executive Summary Community Services and Supports Plan
- Framework for Community Input
- MHSA Advisory Group Recommendations

Site Links

- Comprehensive Community Treatment Program
- Crisis Intervention Services
- Mental Health Liaison

Web Links

- California Department of Mental Health (MHSA)
- California Network of Mental Health Clients (CNMHC)
- National Alliance for the Mentally Ill (NAMI)

Attachment C

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHILLIP R. CRANDALL, DIRECTOR

MENTAL HEALTH BRANCH
720 Wood Street Eureka, CA 95501-4482
(707) 268-2900 Fax: (707) 476-4049

Administration (707) 268-2990 | Children, Youth & Family Service (707) 268-2800 | Adult/24 Hour Services (707) 268-2900 | Alcohol & Other Drug Programs (707) 476-4054

October 15, 2008

To whom it may concern,

Humboldt County Department of Health and Human Services is committed to stakeholder participation in the development of Mental Health Services Act programs.

The Mental Health Services Act, legislation passed in 2004, provides funding to counties to expand and develop innovative and integrated mental health services.

Currently there are Humboldt County Mental Health Services Act documents available for Public Comment from October18th through November 17th, 2008.

There will also be a Public Hearing on November 17th, 2008 from 5:30-6:30pm at the Department of Health and Human Services Professional Building at 507 F Street in Eureka.

Enclosed please find a flyer that contains information on where to access these documents and how to make comments.

If possible and appropriate please make these materials available to your staff and the people you serve. Also, please remove the materials after the Public Comment period ends on November 17th, 2008.

Please contact us with any questions you may have.

Thank you in advance for your help in this effort,

Jaclyn Culleton

Jaclyn Culleton
Administrative Analyst
Mental Health Services Act
Humboldt County Mental Health Branch
720 Wood Street, Eureka, CA 95501
Phone: 707 268-2923
Email: jculleton@co.humboldt.ca.us

Culleton, Jaclyn

From: Culleton, Jaclyn
Sent: Friday, October 17, 2008 11:47 AM
To: Culleton, Jaclyn
Subject: MHSA PEI Public Comment and Hearing
Attachments: PEI Public Comment-Hearing flyer.pdf

Hello,

Please forward to interested parties!

The Mental Health Services Act

- Prevention and Early Intervention Plan
- Assignment Letter
- Community Services and Supports FY 2008-09 Update

Are open for

Public Comment

October 18 - November 17

Public Hearing

November 17
5:30 to 6:30pm
Humboldt County Department of Health and Human Services
Professional Building
507 F Street in Eureka

Documents are available and comments may be placed in the "MHSA Comment Box"

- DHHS Professional Building
  507 F Street, Eureka
- DHHS Mental Health Branch
  720 Wood Street, Eureka
- DHHS Children Youth and Family Services
  1711 3rd Street, Eureka
- Hope Center
  2933 H Street, Eureka

- website: http://co.humboldt.ca.us/HHS/MHB/MHSA/

To request documents be sent to you or to make a comment please contact us at:

Phone: (707) 441-3770

Toll free: (866) 320-8911

Email: mhsacomments@co.humboldt.ca.us

Address: Department of Health and Human Services, Mental Health Branch
Attn: Jaclyn Culleton
720 Wood Street
Eureka, Ca 95501

Thanks,
~jaclyn

Jaclyn Culleton
Administrative Analyst
Mental Health Services Act
Humboldt County Mental Health
Phone: 707 268-2923
Fax: 707 476-4049

Humboldt County Department of Health and Human Services

Mental Health Services Act

Provides funding to expand and develop innovative and integrated mental health services

What do you think?

Public Comment
October 18 - November 17

Prevention and Early Intervention Plan, Assignment Letter, and the Community Services and Supports Fiscal Year 2008-09 Update.

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Public Hearing on November 17

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720 Wood Street
Eureka, Ca 95501

Attachment D

Humboldt County Department of Health and Human Services

Mental Health Services Act

Provides funding to expand and develop innovative and integrated mental health services

What do you think?

Public Comment
October 18 - November 17

Prevention and Early Intervention Plan, Assignment Letter, and the Community Services and Supports Fiscal Year 2008-09 Update.

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Public Hearing on November 17

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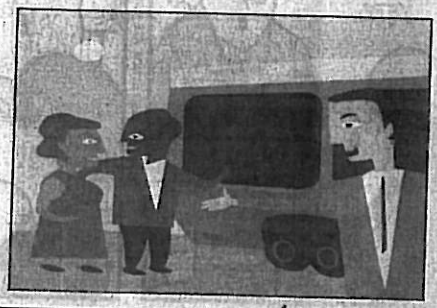
720 Wood Street
Eureka, Ca 95501



Times Standard 11/8/08 Page A3

Attachment E

COUNTY OF HUMBOLDT
MENTAL HEALTH BOARD
SPECIAL MEETING
AGENDA

Monday November 17, 2008

5:30-6:30 pm

Professional Building- Large Mezzanine Room
507 F Street, Eureka

I. Call to Order

II. Roll Call & Introductions

III. Adjustments to the Agenda

IV. Reports
A. MHSA Prevention and Early Intervention Plan

V. Public Comments - 3 minute time limit

VI. Adjournment

x = Enclosure
DHHS=Department of Health and Human Services, 507 F Street, Eureka
HCMH = Humboldt County Mental Health, 720 Wood Street, Eureka
CYFS = Children Youth and Family Services, 1711 Third Street, Eureka

Attachment F

HUMBOLDT COUNTY
DEPARTMENT of HEALTH and HUMAN SERVICES
PROFESSIONAL BUILDING
MEZZANINE MAIN CONFERENCE ROOM
ATTENDEE ROSTER

MEETING: MHSA Public Hearing (4:00 - 7:00)

2008 Date	Time In	Time Out	Please Print Name	Work-Phone Number	Office Use
Mon. Dec. 11/17	5:00		Jaclyn Culleton	268-2923	
11/17	5:00		Kris Huschke	441 5554	
11-17	5:00		Mike Goldsby	268-2195	
11-17	5:00		John Hill		
"	5:20		Mariane Penne Ramos	442-6212	
11-17	5:20		Ken Nagy	268-2919	
11-17	5:20		ERIC FIMBRES		
11/17	5:25		Pam Brown	8264564	
11/17	5:30		Tim Ash	826 0323	
11/17	5:30		Robin Wolff	443-9747 x259	
11/17	5:30		Ruth Needham	725-4406	
11-17	5:30		SARA TURNER	822-0235	
11-17	5:30		Candice Campbell	268-2800	
11/17	5:30		Linda Souza	826-9598	
11/17	5:30		Maralyn Lem Stein	268 2990	

EVACUATION PROCEDURES:
PRIMARY EVACUATION ROUTE is via of the main stairs by the elevator, to the first floor, and then out the front door to "F" Street. If this route is not useable, then use the SECONDARY EVACUATION ROUTE, go out the door marked "EXIT ", on the 5th street side of the Mezzanine Conference Room, down the stairs and out the door to 5th street. From either exit route, once outside proceed to the County Parking Lot at the corner of 5th and F street and assemble in the center of the Parking Lot.

Cited Documents

Suicide in Humboldt County, CA

2003-2007

Prepared by
Department of Health and Human Services
Mental Health and Public Health Branches
June 2008

Suicide and attempted suicide continue to be an issue of concern for Department of Health and Human Services (DHHS). This report is intended to provide information as part of the ongoing public discussion of this important topic.

The report compiles data to look at two important areas:

- What does the data tell us about suicide in Humboldt County?
- What steps can we take to prevent future suicides?

Did you know?

- Suicide is related to depression, which is treatable through medicine and psychotherapy/counseling.
- Suicide is a national public health concern, especially in rural areas and in the Western States.
- Fifty percent of elderly suicide victims in the United States consult a physician within a month or less of their death.
- "Problems are complex and go beyond the capacity, resources or jurisdiction for any single person, program or organization to change or control." Lasker & Weiss, Broadening Participation in Community Problem Solving. Journal of Urban Health, March 2003
- More Americans die by suicide each year than by homicide (2005); Suicide 32,637 vs. Homicide 18,124
- More Californians die by suicide each year than by homicide (2005); Suicide 3,206 vs. Homicide 2,540

How does Humboldt County compare with other counties and communities?

- While Humboldt County is not ranked highest in suicide rates in California, it ranks among the top 10 counties in California with the highest rates.
- Counties with high rates of suicide and demographically similar to Humboldt include Trinity, Plumas, Tuolumne, Siskiyou, Calaveras, Yuba, Amador, Mendocino and Butte.
- In a review of counties across the United States with population base under 250,000 and at least 20 suicides per year, the suicide rates ranged from Douglas County, Oregon at 19.7 per 100,000 population, to Carson City, Nevada at 39.8 per 100,000[1].

[1]Suicide mortality and vital statistic data from all 50 states and D.C. was accessed from each state's respective Public Health, Heath Statistics, or Vital Statistics website(s) from 3/11 to 3/18/2008.

- In a review of the 13 counties on the Pacific Northwest coast, the suicide rates ranged from 16.0 per 100,000 population in Del Norte County, California to 34.0 per 100,000 in Curry County, Oregon. All counties in this comparison are largely rural, have lower median household income and 85% of counties had a higher proportion of people living in poverty as compared to the national percentage. All of these counties have a white non-Hispanic and Native American population greater than the national proportion[2] [3].

While trying to objectively measure the burden of suicide on Humboldt County compared to other communities, is important to recognize that focusing solely on rankings can obscure that locations with similar population and demographic characteristics to Humboldt also share a similar burden of suicide mortality.

What can we do?

- Utilize a collaborative approach to develop a Suicide Prevention Plan.
- Work to eliminate stigma of mental illness and increase the number of depressed persons who receive treatment
- Reduce substance abuse.
- Promote healthy connections with others and prevent social isolation.
- Train physicians and other health care providers to identify and address depression.

How can we utilize a Public Health Approach to Suicide Prevention?[4]

- Promote awareness that suicide is a public health problem that is preventable
- Develop broad-based support for suicide prevention
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
- Develop and implement suicide prevention programs
- Promote efforts to reduce access to lethal means and methods of self-harm
- Implement training for recognition of at-risk behavior and delivery of effective treatment
- Develop and promote effective clinical and professional practices
- Improve access to and community linkages with mental health and substance abuse services
- Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the Entertainment and News Media
- Promote and support research on suicide and suicide prevention
- Improve and expand surveillance systems

The word suicide evokes strong emotional reactions, ranging from fear and anger to disbelief. People are often silent about suicide because they are afraid they will say the wrong thing. Talking about this community problem in a public forum can help us all be in a better position to help people in their moment of need.

[2] 2006 CA County Health Profiles, AVSS, US individual state Health/Vital Statistics website(s).
[3] American FactFinder. US Census Bureau website. http://factfinder.census.gov/home/saff/main.html?_lang=en. Accessed 3/18/2008.
[4] 1999 U.S. Surgeon General's Call to Action to Prevention Suicide, National Strategy for Suicide Prevention Goals.

Definition:
Number of suicides and suicide rate (age-adjusted deaths per 100,000 population), and number of uncompleted suicide attempts resulting in hospitalizations, and hospitalization rate for Humboldt County residents (This suicide definition includes all fatal, self-inflicted injuries)

Healthy People 2010 National Objectives[5]:

Reduce suicide rate* to no more than 5 per 100,000 population

California Suicide Rate[6]:

California average annual suicide mortality rate per 100,000 population, 2002-2004: **9.4**

Humboldt County 2003-2007 Age-Specific Mortality By Cause

KEY
---: Signifies that there were less than 5 deaths from a particular cause within the age range for 2003-2007 or not applicable

Rate per 100,000 for leading causes of mortality by age group, 2003-2007[7]

ALL RACE/ETHNICITY 2003-2007 WITH AVERAGE ANNUAL AGE-SPECIFIC RATE PER 100,000 PERSONS
(Note: 2003-2007 average annual infant mortality (under age 1) from all causes for Humboldt County is 6.0 per 1000 live births)
(*The 2003-2007 average annual mortality rate for ages 1 to 14 is 13.0 per 100,000)

AGE RANGE	#1 CAUSE	#2 CAUSE	#3 CAUSE	#4 CAUSE	#5 CAUSE
<1 (see above note)	---	---	---	---	---
1 to 14*	---	---	---	---	---
15 TO 24	MOTOR VEHICLE INJURIES (18.5)	FATAL UNINTENTIONAL INJURIES (9.7)	SUICIDE (8.8)	HOMICIDE (6.2)	---
25 TO 44	UNINTENTIONAL AOD OVERDOSE (43.4)	CANCER, ALL (22.9)	SUICIDE (21.7)	MOTOR VEHICLE INJURIES (19.9)	CARDIOVASCULAR DISEASE (19.3)
45 TO 64	CANCER, ALL (211.8)	CARDIOVASCULAR DISEASE (150.5)	LIVER DISEASE & CIRRHOSIS (65.9)	UNINTENTIONAL AOD OVERDOSE (57.2)	COPD & EMPHYSEMA (48.4)
65+	CARDIOVASCULAR DISEASE (1560.1)	CANCER, ALL (1106.9)	STROKE (548.5)	COPD & EMPHYSEMA (403.6)	PNEUMONIA (314.5)

[5] Healthy People Objectives and Measures. http://wonder.cdc.gov/data2010/obj.htm
[6] 2006 County Health Status Profiles. CADPH. Center for Health Statistics. Office of Health Information and Research
[7] AVSS

Humboldt County Baseline Data:

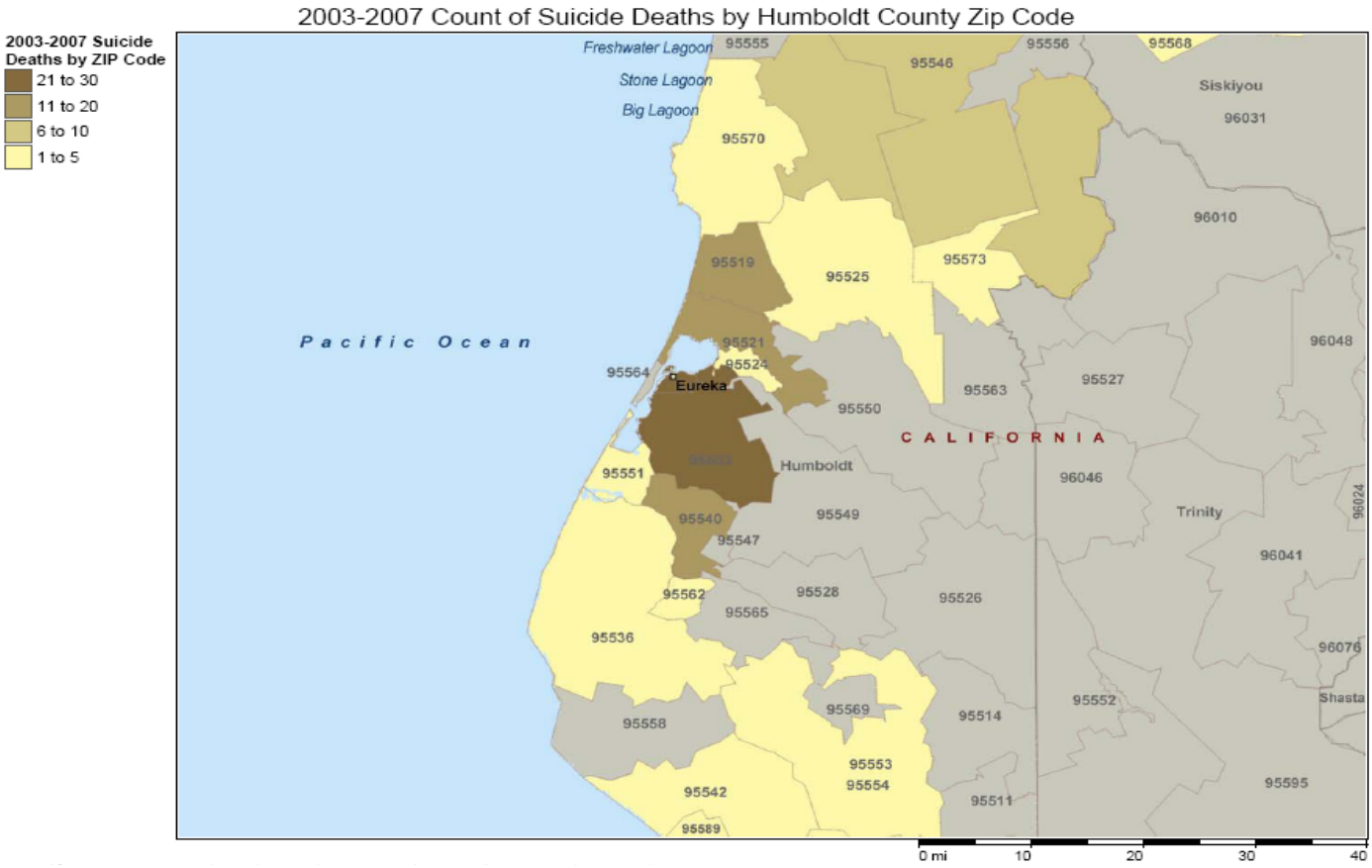
21.8 suicides per 100,000 total population during 2007[8]. The numbers of deaths represents Humboldt County residents only; Out-of-county residents who died as a result of intentional self-harm in Humboldt County are not included.

74 suicide attempts resulted in hospitalization in 2005.

Deaths and Hospitalizations for Self-Inflicted Injury, Humboldt County and California

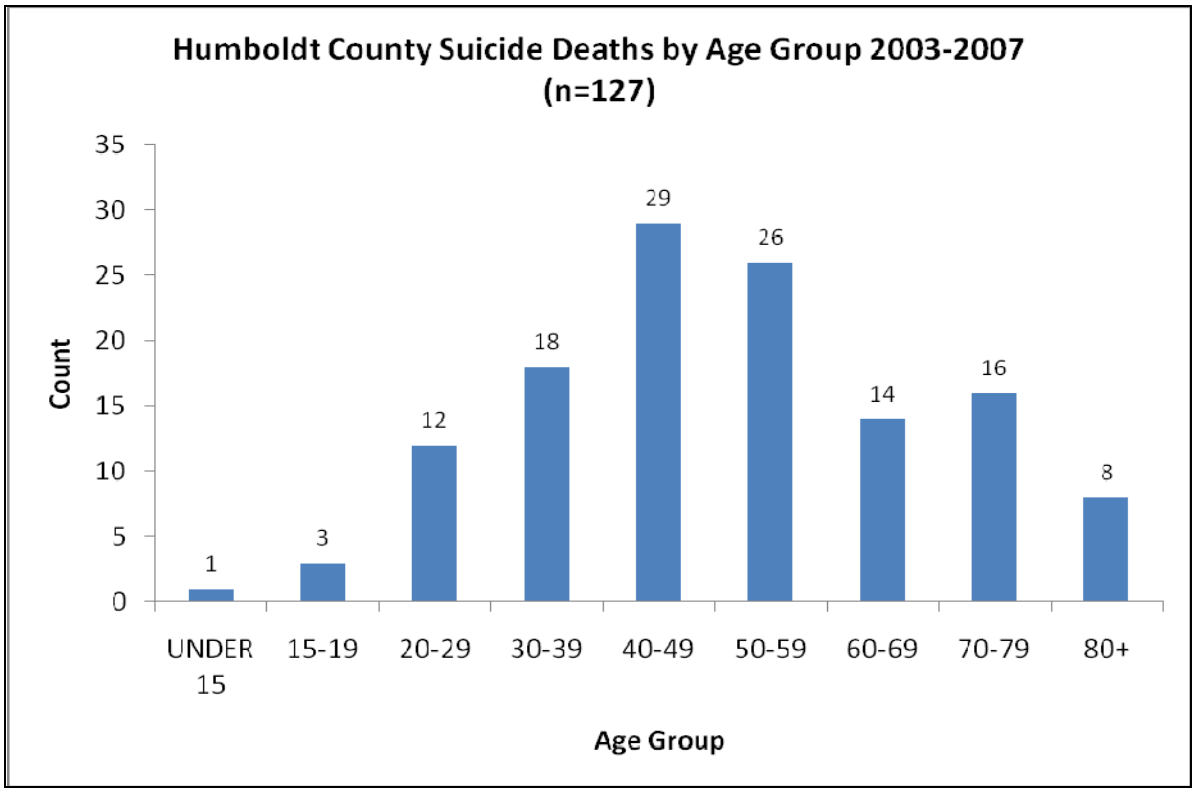
	Humboldt County		California
Result of Injury	**2007 Suicide Deaths & Hospitalizations (Humboldt Residents only)**	**Rate per 100,000**	**2002-2004 Rate per 100,000 for Deaths & Hospitalizations**
Deaths	29	21.8	9.4
Hospitalizations[9]	74	55.3	46.5

*All Rates are age-adjusted to the 2000 US Census.

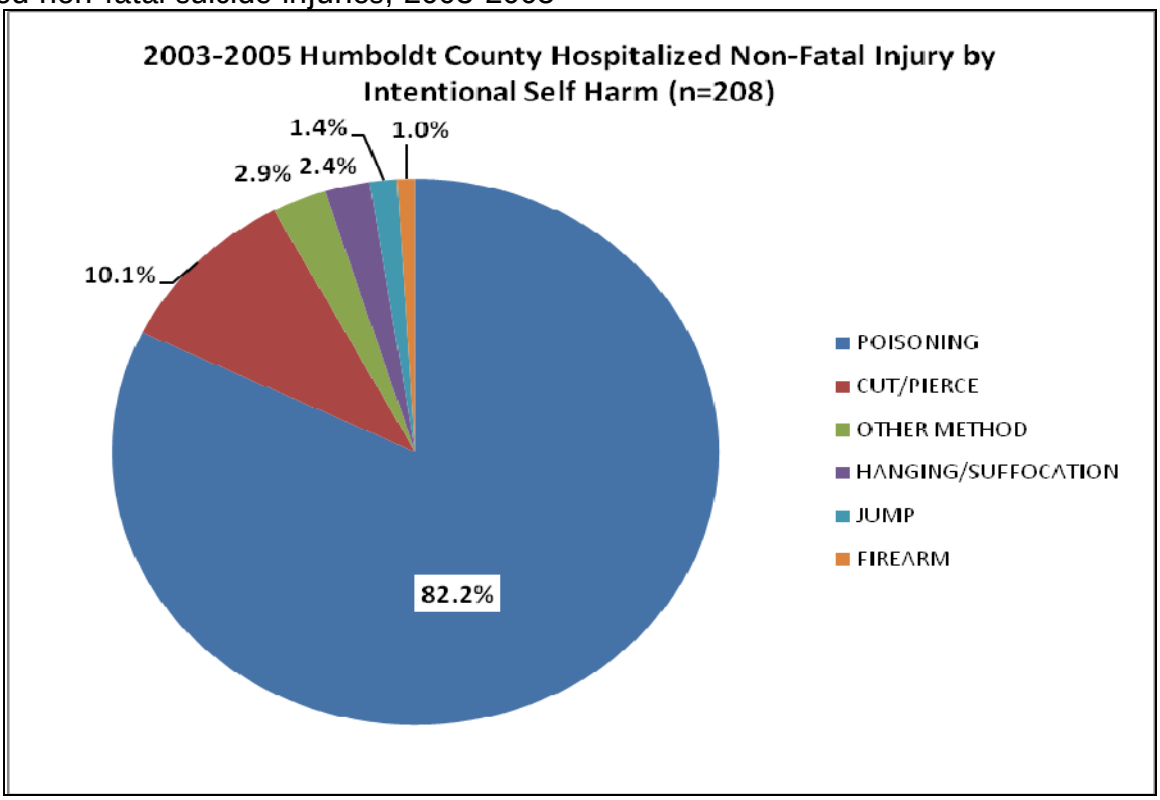


[8]Humboldt County Automated Vital Statistics System (AVSS)
[9]EPICenter-California Injury Data Online. http://www.applications.dhs.ca.gov/epicdata/default.htm. Accessed 3/18/2008.

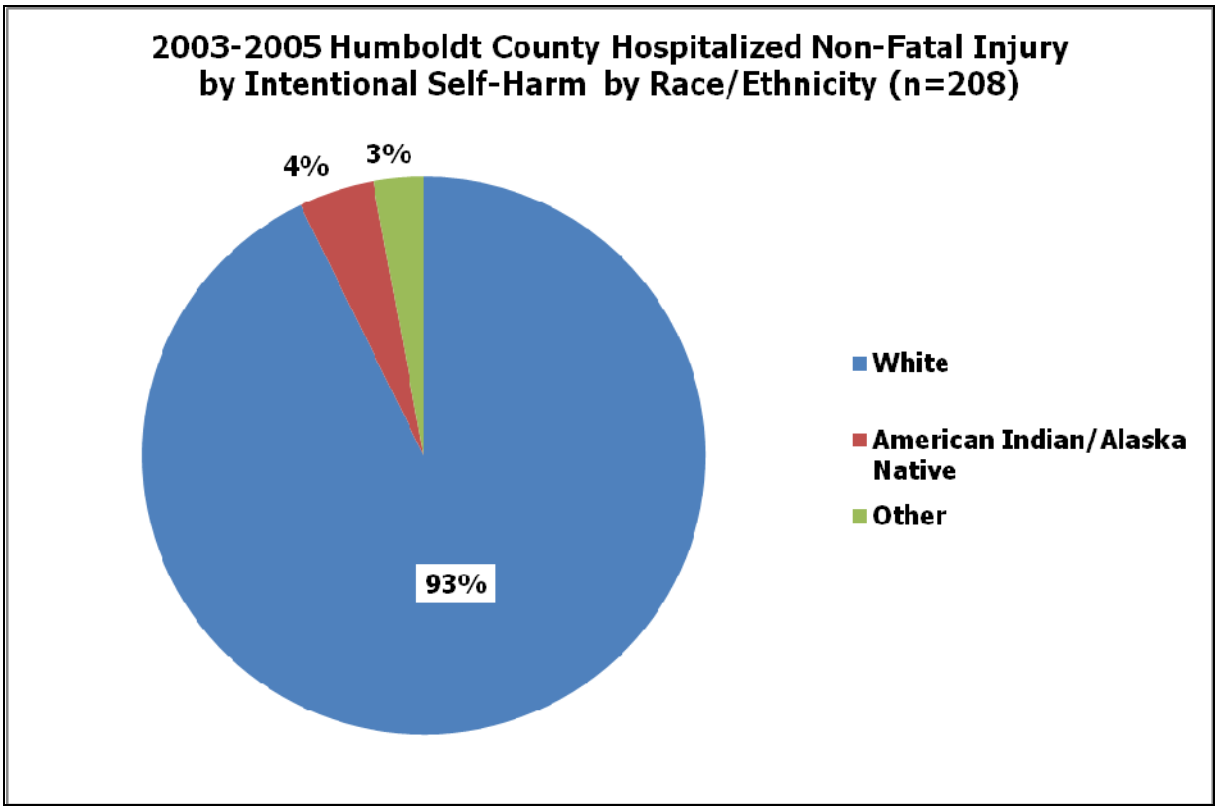
2003-2007 Suicides by age group[10]

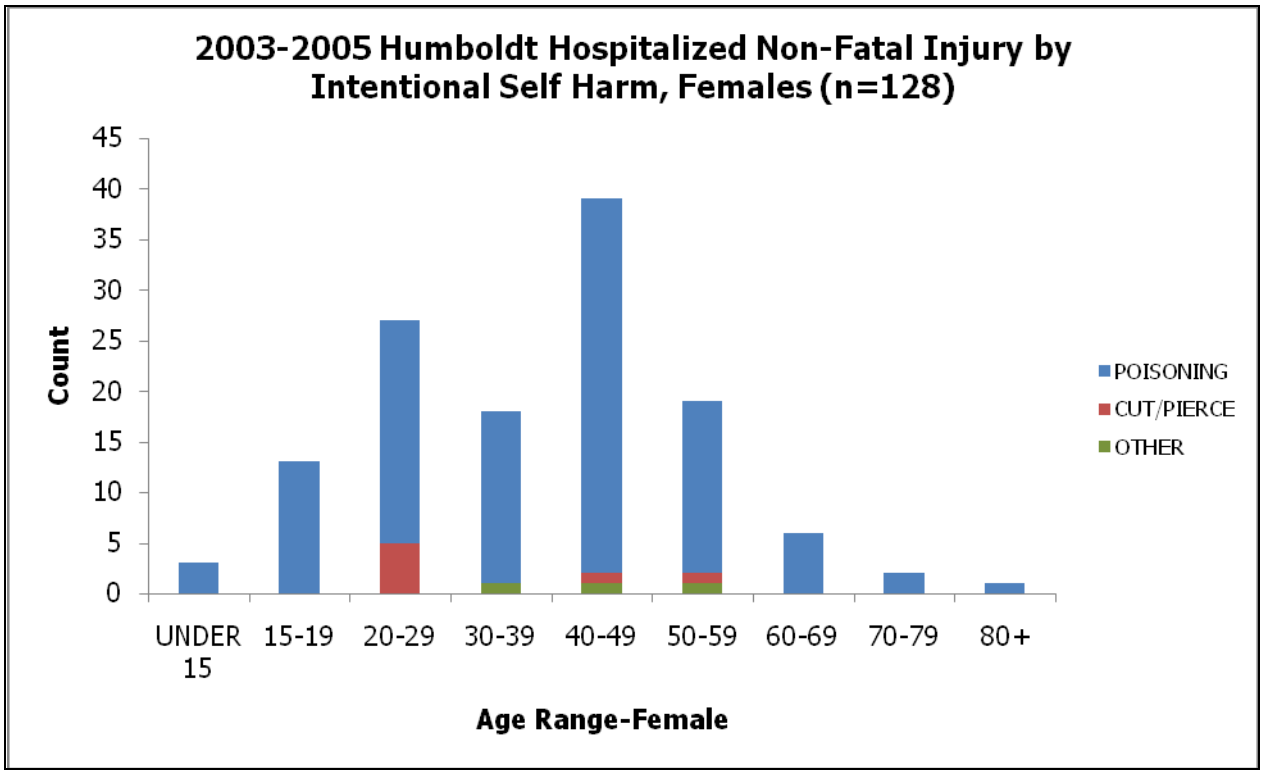


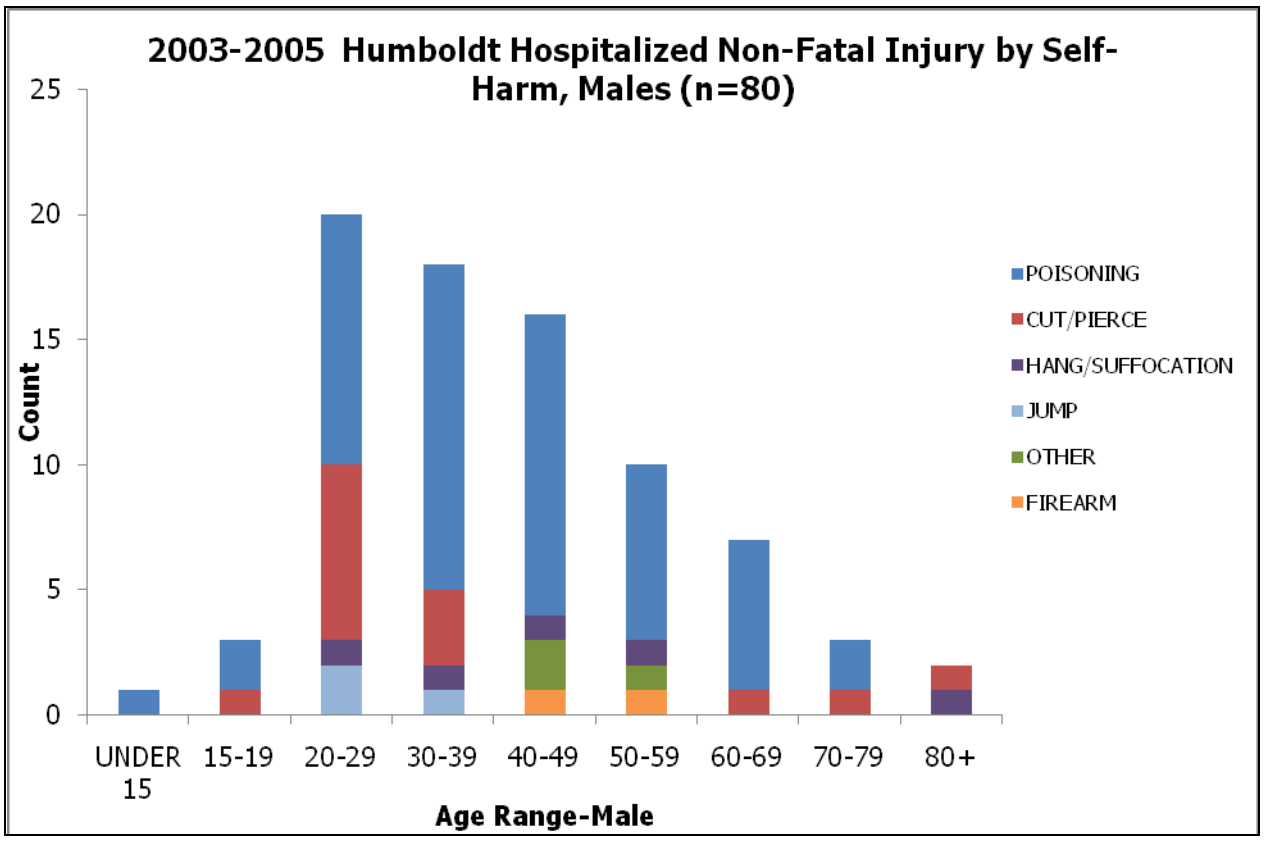
Hospitalized non-fatal suicide injuries, 2003-2005[11]



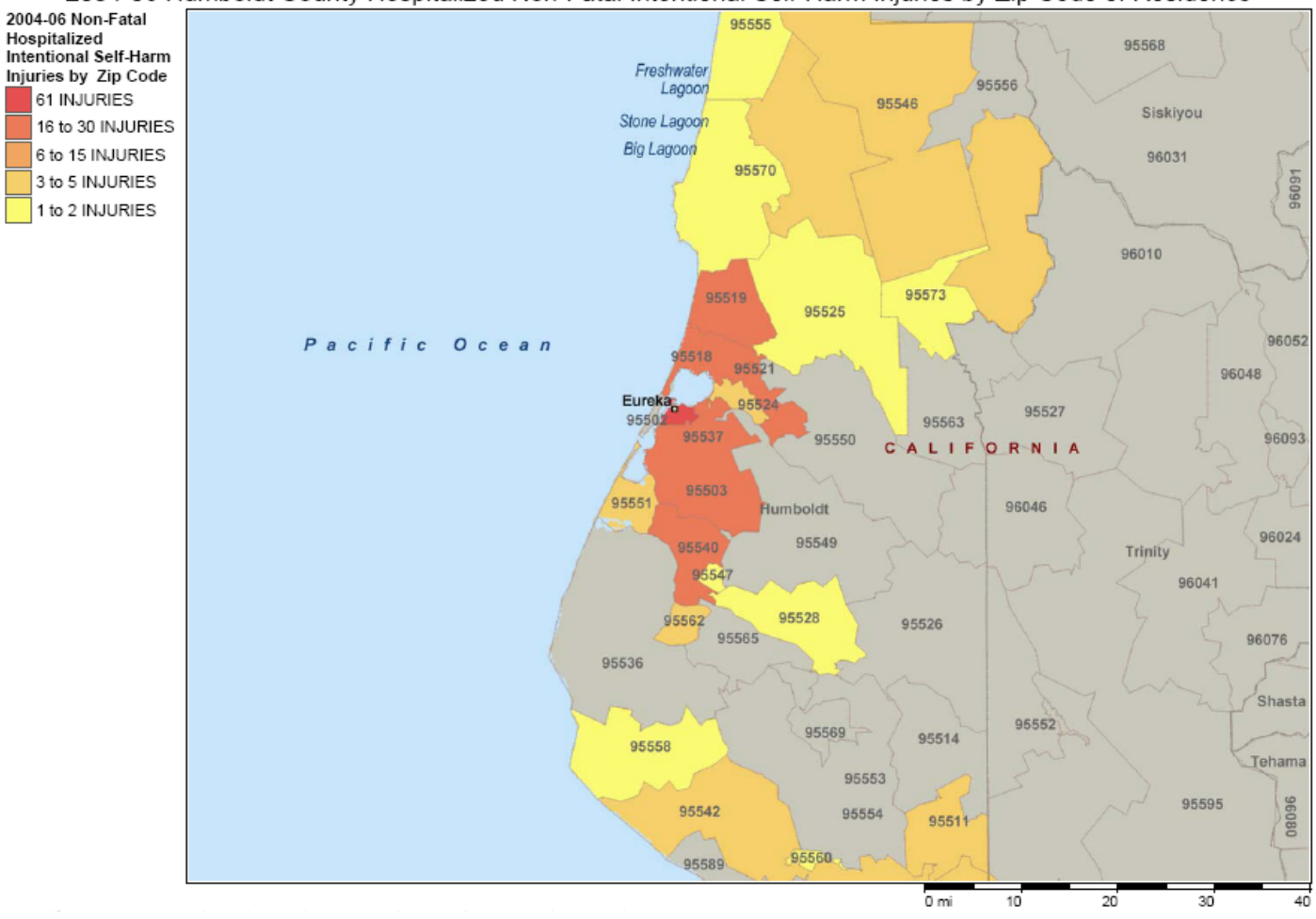
[10] AVSS
[11] EPICenter; Poisoning includes alcohol and other drug overdoses.


2003-2005 Humboldt County Hospitalized Non-Fatal Injury by Intentional Self-Harm by Race/Ethnicity (n=208)
4%
3%
93%
White
American Indian/Alaska Native
Other

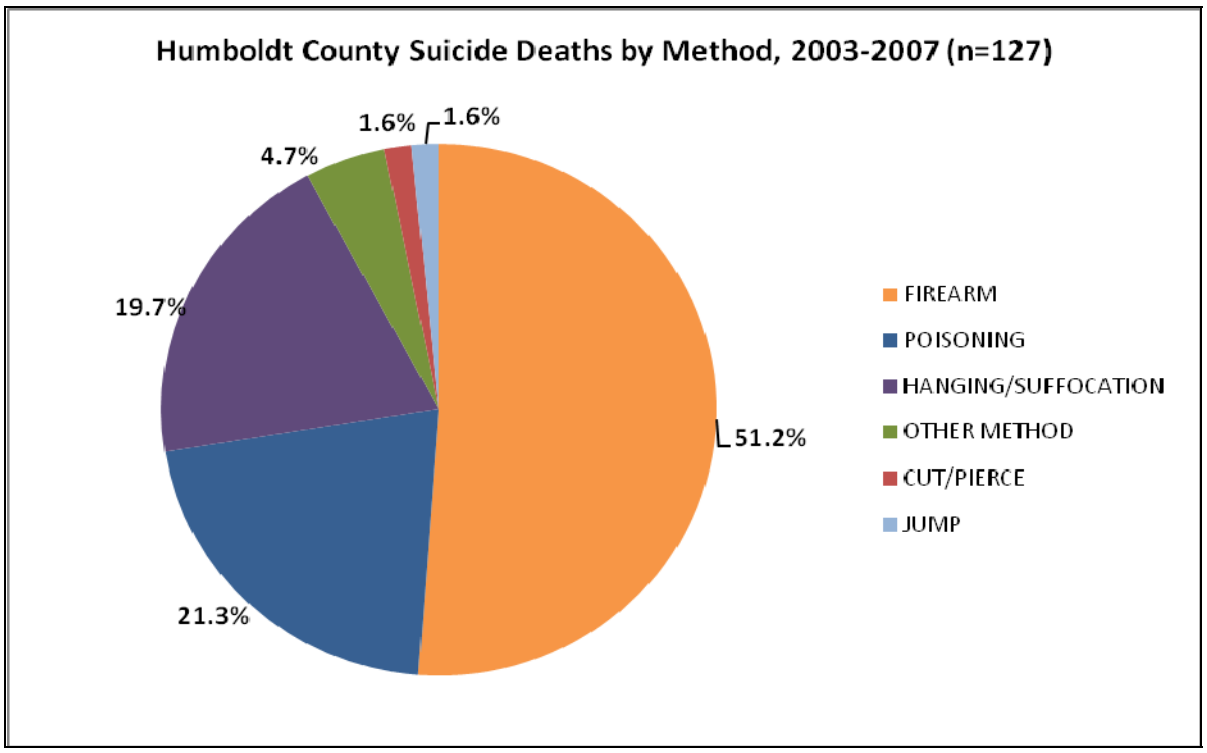

2003-2005 Humboldt Hospitalized Non-Fatal Injury by Intentional Self Harm, Females (n=128)
Count
45
40
35
30
25
20
15
10
5
0
UNDER 15
15-19
20-29
30-39
40-49
50-59
60-69
70-79
80+
Age Range-Female
POISONING
CUT/PIERCE
OTHER

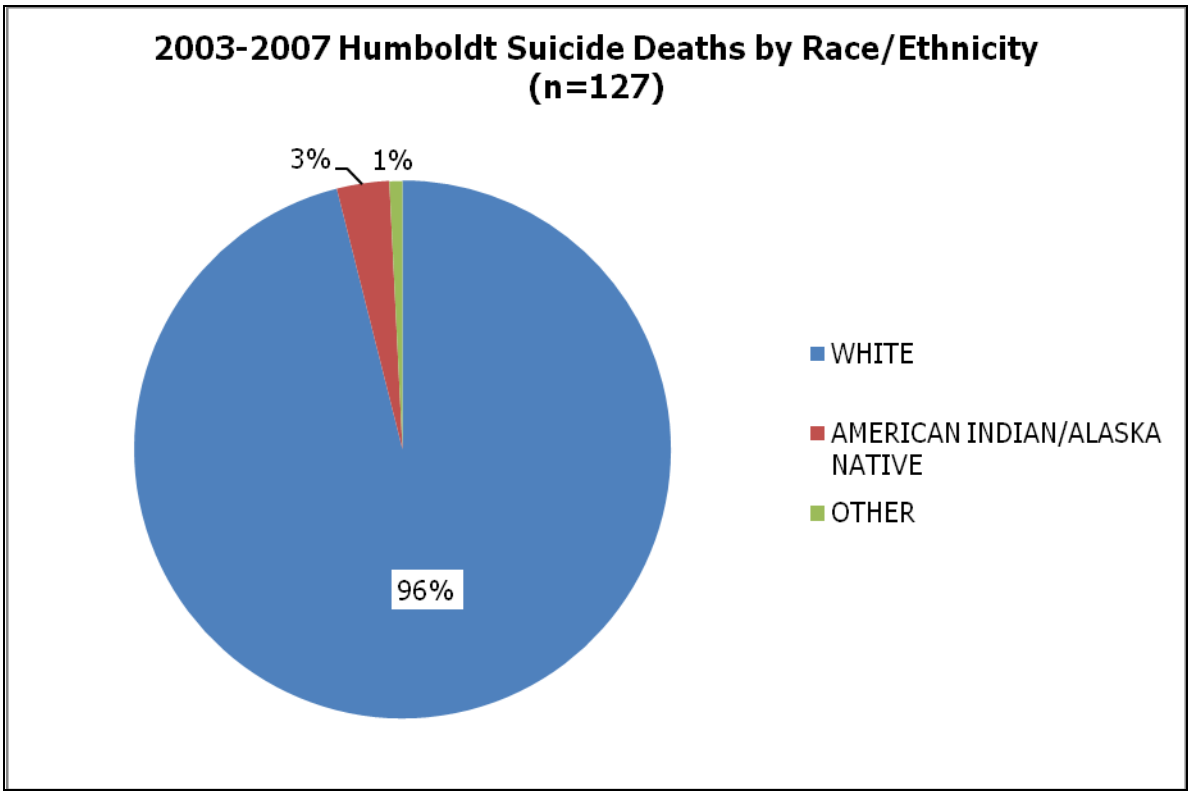


2004-06 Humboldt County Hospitalized Non-Fatal Intentional Self-Harm Injuries by Zip Code of Residence

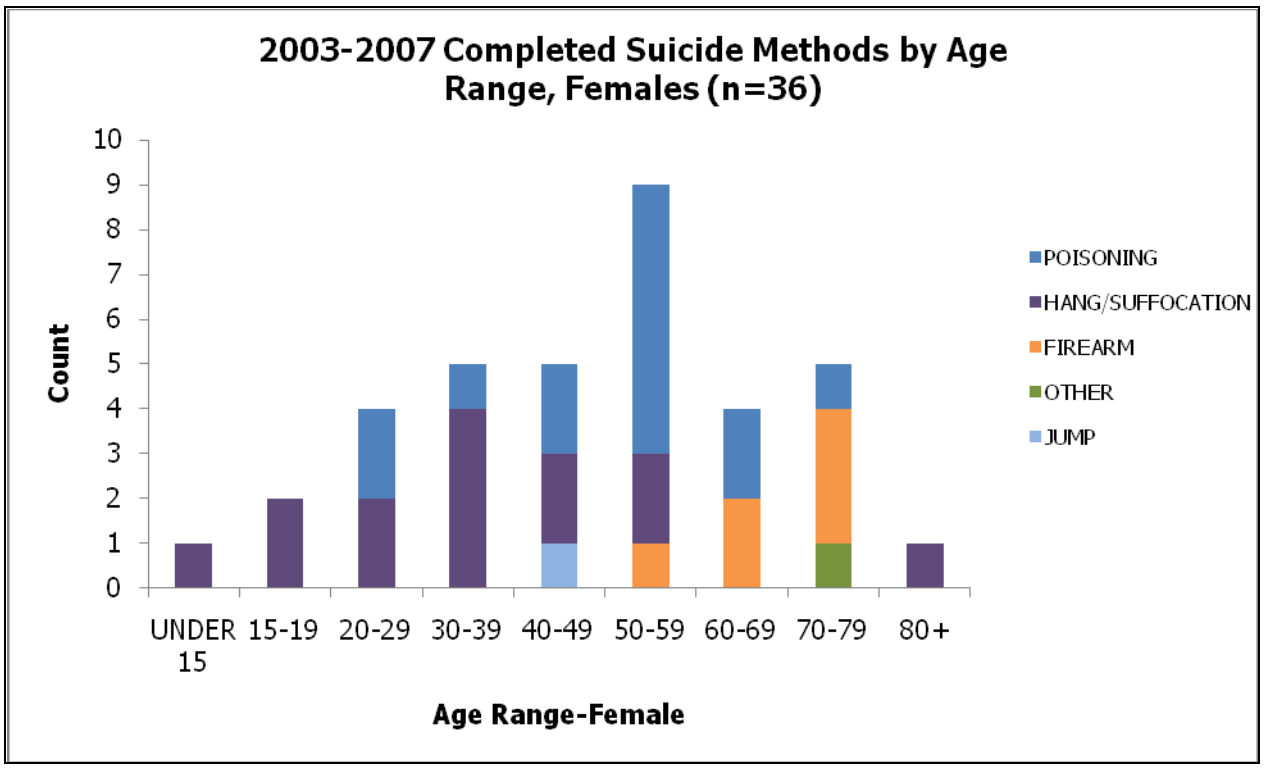


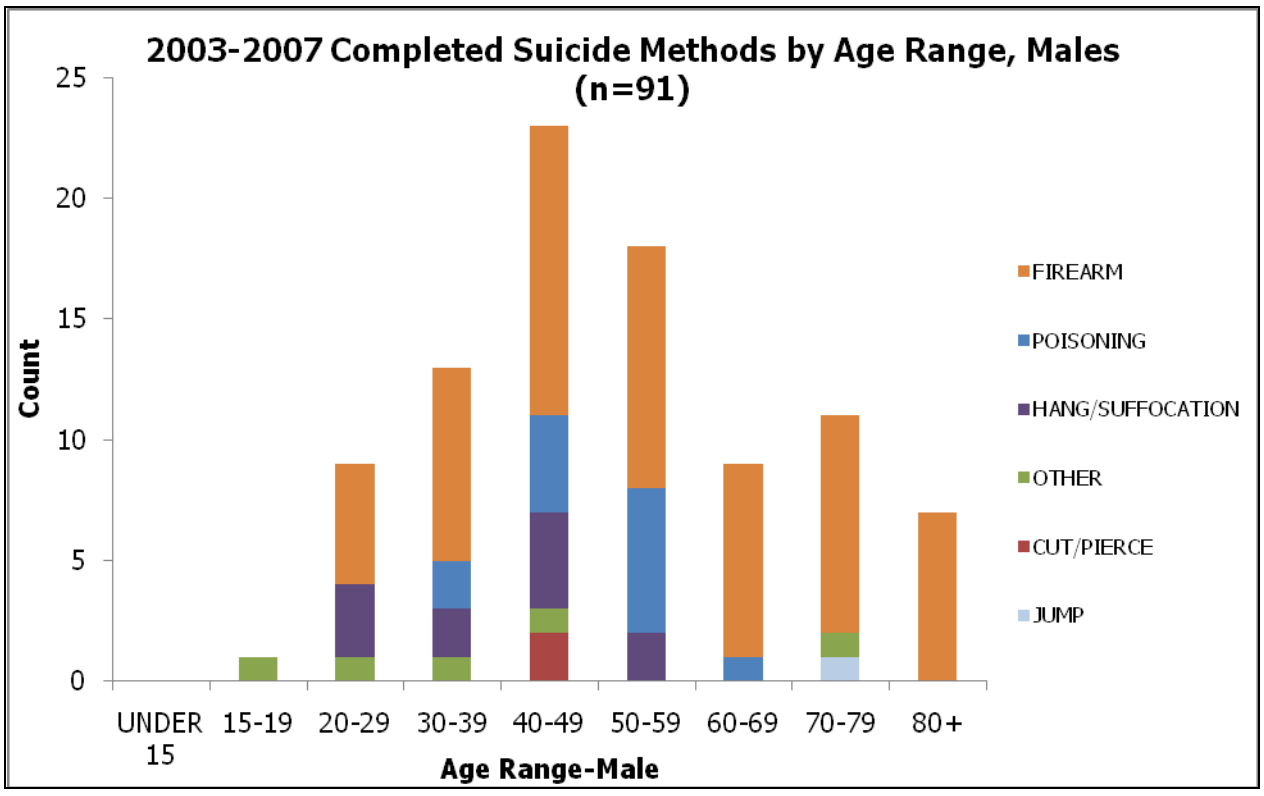
Suicide deaths by method and race[12]:





[12] AVSS


2003-2007 Completed Suicide Methods by Age Range, Females (n=36)
Count
10
9
8
7
6
5
4
3
2
1
0
UNDER 15
15-19
20-29
30-39
40-49
50-59
60-69
70-79
80+
Age Range-Female
POISONING
HANG/SUFFOCATION
FIREARM
OTHER
JUMP


2003-2007 Completed Suicide Methods by Age Range, Males (n=91)
Count
25
20
15
10
5
0
UNDER 15
15-19
20-29
30-39
40-49
50-59
60-69
70-79
80+
Age Range-Male
FIREARM
POISONING
HANG/SUFFOCATION
OTHER
CUT/PIERCE
JUMP

Humboldt County Strategic Prevention Plan

A Project of the Human Services Cabinet's Consolidated Prevention Activities Team

December 2002

Printed on Recycled Paper

Acknowledgements

The efforts of many people went into creating the Humboldt County Strategic Prevention Plan. JoAnne Brown of the Human Services Cabinet provides the team with secretarial assistance. Employees of the Human Services Cabinet Departments contributed to the Strategic Prevention Plan they include: Nancy Bay, Susan Clemens, Lin Glen, Jet Kruse, Joyce Houston, Kathryn Maguire, Jan Ostrom and Lisa Stern. Humboldt County employees also provided input and insight into the report they include: Rick Haeg, Kim Kerr and Alexandra Wineland. The team would also like to thank Sandi Fitzpatrick, The Humboldt County Children and Families Commission, the North Coast Senior Services Collaborative, and The Whole Child Interagency Council for their input.

Introduction

The Consolidated Prevention Activities Project Team (CPA) was organized to plan and evaluate how to improve primary and secondary prevention services the Humboldt County Human Services Cabinet (HSC) provides in the community. The HSC consists of Directors, branch directors, deputy directors, and senior managers of the Department of Health and Human Services and the Probation Department. The Department of Health and Human Services (DHHS) is comprised of three branches, Mental Health, Public Health and Social Services. The HSC Directors are the department directors as well as the DHHS branch directors. Formed in 1995 the HSC's vision is that "Humboldt County is a nurturing, supportive, healthy environment for its children, families, adults and communities."

The CPA is sponsored by the HSC Directors and includes representation from all branches of the Department of Health and Human Services and the Probation Department. The HSC understands the value of prevention. "An ounce of prevention is worth a pound of cure." Unfortunately, at the moment the vast majority of Human Services Cabinet resources provide services trying to "cure" complex problems. The Strategic Prevention Plan is part of a process of beginning to move HSC resources towards preventing the problems and creating healthier communities.

Support for increased prevention activities and focus comes specifically from the Little Hoover Commission's Young Hearts & Minds *Making a Commitment to Children's Mental Health* October 2001 as well as two local plans, The Humboldt County Human Services Cabinet Strategic Plan (2000) and the related DHHS 1259 Plan. The addition of this plan is to focus, update and amplify the recommendations and activities primarily related to Goal 3: Expand multiagency strategies toward prevention and early intervention. and Goal 4: Insure that programs are responsive to cultural, geographic and developmental needs of individuals, families, and communities. This plan is also related to some aspects of Goals 1 and 2. There are numerous citations of the literature throughout this document that also support the importance of prevention activities to improving community health and well-being.

Consolidated Prevention Activities
Project Team Members
past and present include:

Tom Antoon, MFT Alcohol and Other Drug Programs DHHS-Mental Health	***Deni McFarland*** Administrative Analyst II Public Information DHHS-Social Services
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Peggy Falk, MPH Senior Health Program Manager Health Education DHHS-Public Health	***Rebecca Stauffer, MD*** Deputy Health Officer Maternal Child and Adolescent Health DHHS-Public Health
Susan Hoffman Peer Recovery DHHS-Mental Health	***Sheri Whitt, MFT*** Children, Youth and Family Services DHHS-Mental Health
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Mission Statement

The purpose of the Consolidated Prevention Activities Project is to increase the primary and secondary prevention efforts of the Human Services Cabinet programs in order to maximize community and individual health and safety and minimize costs and needs for complex treatment efforts.

Principles

The Consolidated Prevention Activities Project Team recommends that the Human Services Cabinet, adopt the following principles:

1. Recognize that health is a state of physical, mental, emotional, and social well being and not merely the absence of disease or infirmity, and that individual health is closely linked to the health of the community and the environment in which individuals live, work, raise families and play.
2. Acknowledge that families, individuals and communities are best served when we work together.
3. Advocate that new initiatives build on prior successes.
4. Recognize that all people need social and other supports in order to live a full and healthy life.
5. Communicate clearly with involved partners in service delivery.
6. Recognize that services are most effective when they address identified needs as early as possible, and are provided in comfortable, accessible settings.
7. Commit to continuous evaluation and accountability based on agreed upon outcomes.
8. Recognize that cultural diversity is a valued asset and that programs and efforts will strive to be inclusive and non-judgmental.
9. Engage respectfully with community members and organizations in an effort to improve access to prevention based information, education, programs, services, opportunities and interventions on a planned basis and within the available resources.

Executive Summary

The Human Services Cabinet (HSC) Strategic Plan (2000) and the related DHHS 1259 Plan cite the need to promote, develop and maintain a continuum of services that encourage prevention and early intervention activities. The Strategic Prevention Plan, which focuses on primary and secondary (early intervention) prevention, is the next step in the process of expanding and improving prevention services through the HSC member departments.

Why are primary and secondary prevention services needed? A quick look at health indicators shows significant health problems in our community. Humboldt County's death rates from unintentional injuries, motor vehicle crashes, suicides, drug-related and cancer are all significantly above the State average. Alcohol, methamphetamines, heroin, tobacco and other drug use; poverty; violence; poor nutrition; and lack of physical activity are just some of the many factors that put the members of our community at risk for death and disability. Although many factors put our community at risk, the community also has many factors that protect our members from harm. Protective factors include; health programs that promote immunizations, good nutrition and physical exercise, social support provided through many churches, social clubs and groups, and individual skills such as problem solving.

The HSC currently funds several primary/secondary prevention programs. However, there is a great need and interest to increase funding for primary/secondary prevention programs and thus decrease the need for high end services such as direct medical care, hospitalization, drug treatment and out of county placement of children.

The Strategic Prevention Plan (SPP) has seven overarching goals. They are:

1. Reduce poverty, unemployment and under employment.
2. Prevent and reduce family violence and dysfunction.
3. Prevent and reduce alcohol, methamphetamine, heroin, tobacco and other drug addictions.
4. Improve community health status.
5. Improve community mental health status.
6. Prevent and reduce criminal activity.
7. Improve environmental quality.

The Strategic Prevention Plan makes several recommendations on beginning the process of expanding and improving the primary/secondary prevention services provided by the HSC. Recommendations include and are not limited to:

I. Changing Organizational Practices

1. Model prevention principles and goals within Human Services Cabinet departments and branches.
2. Support staff through organizational changes.
3. Develop a "Learning Environment".
4. Provide cross branch training regarding prevention strategies
5. Look for change opportunities.

6. Enhance a climate of respect.
7. Base program and fiscal changes on data, assessment and tracking.
8. Continue support of Employee Productivity/Wellness.

II. Promote a Process to Sustain Effective Programs

1. Provide a process for sustainability.
2. Strengthen connections to community activities.
3. Improve assessment and evaluation.
4. Develop case review strategy for poor outcomes.

III. Promote primary and secondary prevention activities through program expansion.

1. Enhance the prevention gradient by moving from tertiary toward primary and secondary prevention.
2. Promote the Mental Health Recovery, Wellness, Discovery Movement.
3. Develop a mechanism to surface new issues.

IV. New Program Development

1. All new Human Services Cabinet Programs will include primary and/or secondary prevention services, when possible.
2. Available funds, to the extent they meet the means test will be used to develop primary and secondary prevention programs.
3. The Human Services Cabinet will explore strategies for the use of funds to develop additional primary and secondary prevention programs.

The recommendations include short-term action steps that can be implemented without significant additional financial resources. They include and are not limited to:

- Identify community benchmarks to monitor the effectiveness of overall community interventions.
- Develop a quality assurance process.
- Work with the County Risk Manager and the County Personnel Department to expand an employee productivity/wellness program.
- Develop a suicide death review team.
- Develop primary and secondary prevention training.
- Develop a case review process for poor outcomes.

The Strategic Prevention Plan outlines significant health and social problems facing the County as well as some beginning steps the HSC can take to improve the health and well being in our community. Promoting, developing and maintaining all the needed primary and secondary prevention services will not be an easy process. However, many steps can be taken to enhance implementation of the vision of the Human Services Cabinet Strategic Plan (2000) and the Human Services Cabinet's AB1259 Plan.

Table of Contents

Humboldt County Community Health Indicators
Demographics

	Humboldt County		California	
Characteristic	**Number**	**Percent**	**Number**	**Percent**
Total Population 2000+	126,518	100.0	33,871,648	100.00
Population under age 18 2000+	29,413	23.2	9,249,829	27.3
Population 75 and older^	7,756	6%	1,707,835	5%
Median Income 2000+	$ 32,637	NA	$ 42,472	NA
Unemployment rate (2/00)*		6.8		5.0
Poverty Rate 2000		19		16
Children Living in Poverty+		26.0		19.5
CalWorks enrollees as a percent of population (11/99)*		5.9		4.9
SSI/SSP recipients as a percent of population (11/99)*		4.3		3.1
Age-Adjusted Deaths per 100,000 Population (1996-1998 average)*	515.5		425.7	

\+ California County Data Book 2001. Factors for School Success. Children Now.

* Health Data Summaries for California Counties 2000. Department of Health Services. State of California.

^ Area Agency on Aging

Health and Safety

	Humboldt	California
Prenatal Care (1999)+	82.5%	83.6%
Low Birthweight +	3.9%	6.1%
Teen Births 1999+ (rate per 1,000)	38.6	50.2
Child Abuse Reports 2000+ (per 1,000)	167.9	68.0
Age-Adjusted Deaths Due to Unintentional Injuries (per 100,000 1999-2000 average)^	51.2	27.4
Age-Adjusted Deaths Due to Motor Vehicle Crashes (per 100,000 1999-2000 average)^	9.8	13.7
Age-Adjusted Deaths to Suicide (per 100,000 1999-2000 average)^	17.1	9.5
Age-Adjusted Drug Related Deaths (per 100,000 1999-2000 average)^	21.5	8.5
Age-Adjusted Deaths due to all Cancers (per 100,000 1999-2000 average)^	221.5	179.8
Age–Adjusted Deaths due to Coronary Heart Disease (per 100,000 1999-2000 average) ^	155.5	201.5
Crude case rate of Hepatitis C^	229 .52	93.62

\+ California County Data Book 2001. Factors for School Success. Children Now.
* Health Data Summaries for California Counties 2000. Department of Health Services. State of California.
^ County Health Status Profiles 2002-Department of Health Services and California Conference of Local Health Officers.

Definitions

In developing the Strategic Prevention Plan the Consolidated Prevention Activities (CPA) Team adopted the following definitions of prevention.

Primary prevention is defined as what happens for everyone in the community before there is any sign of trouble or a problem. The idea is to promote healthy people and healthy communities. The target population is the community and everyone living in the community. Strategies may include building skills, providing support, promoting health, changing environments, and promoting awareness. Examples of Human Services Cabinet (HSC) primary prevention programs include: the Humboldt Prevention Newsletter, the restaurant inspection program, Project LEAN and information and referral programs.

Secondary prevention is early intervention. Secondary prevention happens at the earliest sign of a problem or when a person or group of people can be identified as "at risk" of developing a problem. The concept is to intervene to change troubling behavior, stop disease or reduce crisis. The target populations include: "at risk people", people in crisis, and "high risk groups". Strategies may include: providing skills to change responses to situations, changing environments, assessing the level of the problem and recommending solutions, improving access and providing targeted education. Examples of HSC secondary prevention programs include: the Food Stamps Program, Targeted Truancy, the Workforce Investment Act (WIA) Youth Employment, Job Market Employment related services, Women Infants and Children (WIC), the Child Health and Disability Prevention Program, and the Voluntary Intervention Program.

Tertiary prevention is treatment. It is the effort to provide direct services to clients, troubled people or people with existing disease. The purpose of tertiary prevention is to provide treatment, detoxification, therapy, and/or rehabilitation. The target populations include: people with illness and clients. Strategies may include: residential treatment, detoxification, harm reduction, incarceration, and the treatment of injuries or illness. Examples of HSC tertiary prevention programs include: Alcohol and Other Drug Treatment Programs, the Dual Diagnosis Program, Sempervirens, the New Horizons-Regional Facility Program, Healthy Moms, sexually transmitted disease screening and treatment, Child Welfare Services, Adult Protective Services, Juvenile Hall, and Drug Court.

The Strategic Prevention Plan addresses primary prevention. The plan also addresses secondary prevention. The plan does not address tertiary prevention. The plan is an effort to bring attention to the need for primary prevention throughout HSC programs and services.

Primary prevention programs tend to be the least expensive. Tertiary programs are the most expensive because problems have become severely entrenched. By moving towards primary prevention activities, serious conditions are avoided and funds are saved as well.

Prevention Gradient Chart

	Prevention	Intervention	Treatment
	Primary Prevention	**Secondary Prevention**	**Tertiary Prevention**
Purpose	To promote: • Healthy individuals • Resistance to disease • Law-abiding and non-troubled behavior	To intervene at early signs of problems To stop disease To reduce crises To change troubling behaviors	To rehabilitate To reconstruct To treat
Target	Everyone Non-troubled individuals Community conditions	"at-risk" individuals people in crisis "high-risk" groups	Troubled people Diseased people Clients
Strategy	Change environments Promote health Build skills Promote awareness Provide supports	Change environments Assess level of problem and recommend solutions Respond to and defuse crises; short-term Build skills to change responses to situations Improve access Provide information and education Change situations responded to	Treat symptoms: • Detoxification • Therapy • Residential Treat injuries and illnesses Provide skills to rehabilitate

Adapted from: Prevention The Critical Need by Jack Pransky

Prevention Gradient Chart – Agency Examples

	Prevention	Intervention	Treatment
	Primary Prevention	Secondary Prevention	Tertiary
Alcohol and Other Drug Prevention Programs	▪ Friday Night Live ▪ Red Ribbon Week ▪ Humboldt Prevention Newsletter	▪ Reconnecting Youth ▪ Alcohol and Other Drug Death Review	
Alcohol and Other Drug Treatment			▪ SA Treatment Programs
Children Youth & Families Services	▪ Information & Referral	▪ Voluntary Intervention Program	▪ New Horizons-Regional Facility Program
Adult Mental Health		▪ Crisis Unit	▪ Sempervirens ▪ Other treatment programs ▪ Older Adults Mental Health Program
Public Health Branch	▪ Restaurant inspection ▪ Shellfish monitoring ▪ WIC nutrition access ▪ Promoting healthy behavior ▪ Project Lean ▪ Assure adequate medical provider pool ▪ Community health assessment	▪ Alternative Response Team ▪ Field Nursing ▪ Communicable disease monitoring & control ▪ WIC nutrition counseling ▪ CHDP	▪ STD screening treatment ▪ CCS ▪ HIV Client Services ▪ Healthy Moms ▪ ADAP
Social Services Branch	▪ MediCal outreach ▪ Employer outreach ▪ Information & Referral ▪ Cal Works ▪ Community Kiosks ▪ Job Market	▪ ART ▪ IHSS ▪ CalLearn ▪ Food Stamps ▪ Cal Works ▪ Displaced Worker Program	▪ Child Welfare Services ▪ APS ▪ CalWorks ▪ On-the-Job-Training Programs
Probation	▪ Community Congress	▪ Challenge 1 ▪ Targeted Truancy	▪ PACE ▪ New Horizons ▪ Juvenile Hall ▪ Drug Court

Needs Assessment

Introduction

Is there a need for increased primary and secondary prevention in Humboldt County? Is there data indicating that Humboldt County residents experience threats to their health and well being that could be reduced or eliminated if adequate attention was paid to preventing problems in the first place? Are there opportunities to make a difference? The answer to these questions is a resounding "Yes."

After a brief look at some overall factors that affect health and well-being—alcohol, methamphetamines, heroin, tobacco and other drugs, cultural disparities, poverty and violence—this chapter follows the format of an individual life span. The data presents a snapshot beginning with pregnancy and continuing through early childhood, childhood, adolescence, adulthood, and the senior years. Not all available data is presented here—such a catalog is beyond the scope of this report. Instead, Project Team members gathered and reviewed data from their work experience and selected data they believed would best support the need for prevention work in Humboldt County. This data, along with many thoughtful discussions among Project Team members, indicates that there are many potential threats to the health and well being of Humboldt County residents that could be prevented by adequate attention and resources, and that opportunities may exist to do so.

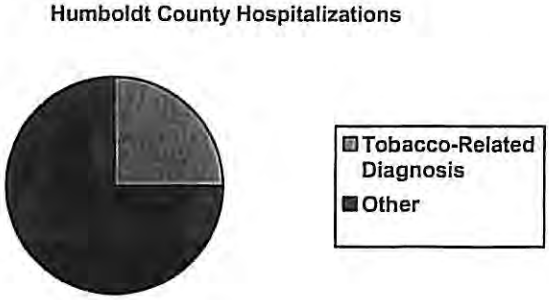
This chapter focuses, to the extent possible, on Humboldt County data. For topics where there is little or no local data, State or national data is used as a reference. Appendix 1 contains further data about the topical areas, and readers are referred there for additional information.

Overall Factors

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drugs:

It is estimated that alcohol abuse cost the United States (U.S.) $184.6 billion in 1998. That is $638 for every man, woman and child living in the U.S. More than 70% of these costs were due to lost work hours from alcohol–related illness or from premature death. Most of the rest of the costs were related to health care services to treat alcohol addiction and the medical consequences of drinking alcohol.[1] As this chapter will show, Humboldt County has a significant alcohol and other drug abuse problem.

In 1998, Humboldt County spent $3.6 million of County Medical Services Program (CMSP) funds for the medically indigent on tobacco related hospitalizations. Twenty–five percent of all hospitalizations in Humboldt County include a tobacco-related diagnosis.[2]



Cultural Disparities:

The divisions of race, ethnicity and culture in the U.S. are very apparent in the health of its people. Despite recent progress in overall health, there are continuing differences in the rates of illness and death among American Indians, Hispanics, African Americans and other populations as compared to white, non-Hispanic populations. These differences are believed to be the result of the complex relationships among hereditary and cultural differences, environmental factors and specific health behaviors.[3] Cultural disparities in Humboldt County are particularly notable in data regarding early entry into prenatal care.

Poverty:

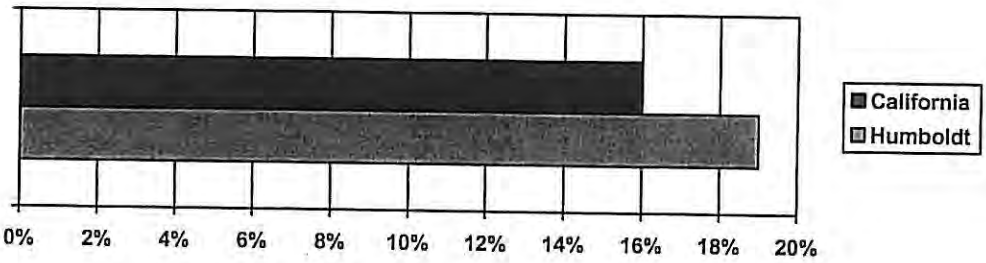
Poverty affects people's quality of life in many ways, including their ability to:

- obtain adequate nutrition
- live in safe environments (their homes and neighborhoods)
- avoid exposure to toxins such as lead and pesticides
- obtain health care and other services
- afford transportation
- participate in recreation activities
- be part of a group that helps support their health and well being

More than 5 million American families with children are living in poverty. Working poor families—those families that have jobs, but are still poor--make up a greater share of that total than in the past. In addition, even more families have employment income that puts them above the federal poverty level but still leaves them far short of being able to afford basic family needs including adequate housing.[4] Single parent families are affected the most. Even during the economic boom of the late 1990's, the poverty rate among families headed by single mothers did not improve, and in fact those families who were poor got poorer.[5]

In the year 2000 census, 19% of Humboldt County residents lived below the poverty level as compared to 16% in California as a whole. Twenty-six percent of children in Humboldt County lived in poverty compared to 19% in California. The median household income in the County was $36,637 compared to California at $42,472.[6] In Humboldt County many seniors whose income puts them above the federal poverty levels have to decide whether to pay for food, PG&E or prescription medications.[7]

Living Below Poverty Level (2000 Census)



Violence:

Violence costs the United States about $425 billion in direct and indirect costs each year. Of these costs, about $90 billion is spent on the criminal justice system, $65 billion is spent on security, $5 billion on treatment of victims and $170 billion on lost productivity and quality of life.[13] The most logical way to reduce these costs is to prevent violence altogether. However, the money spent on violence prevention and alcohol and other drug prevention is modest compared to the spending on crime and drug control efforts such as policing and prison construction. Research has shown that in the long term, prevention is more cost effective than incarceration in addressing violent behavior. [14]

Pregnancy / Infancy

Introduction:

Pregnancy presents one of the most significant opportunities in a parent's life to make positive changes for themselves and their expectant newborn. Pregnancy can also be the beginning of trouble for the unborn child if existing parental problems such as poverty, addictions, poor nutrition, and family violence are not addressed.

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Alcohol, methamphetamine, heroin, tobacco and other drug use by mothers during pregnancy results in a variety of physical and behavioral problems for the infant. Defects caused by using alcohol, methamphetamine, heroin, tobacco and other drugs are completely preventable, unlike many other birth defects. In 1998-2000 there were 45 fetal and infant deaths in the County. A contributing factor in these deaths was alcohol and other drug use in the primary caregivers. [15] Methamphetamines were the primary drug used by 58 of 114 pregnant women (61%) admitted to Humboldt County drug treatment programs from 1994-2000.[16] Babies born to methamphetamine-using women can be born addicted to the drug and suffer birth defects, low birth weight, tremors, excessive crying, and behavior disorders.

In 1998-2000 there were 45 fetal and infant deaths in the County. A contributing factor in these deaths was alcohol and other drug use in the primary caregivers.

Smoking during pregnancy increases the risk of miscarriages, still born babies, low-birth weight babies and sudden infant death syndrome (SIDS). One out of every five pregnant women in Humboldt County smokes. Almost one-third of pregnant, school-aged mothers smokes. A recent Humboldt County study conducted with new mothers found a very strong correlation between tobacco use and being a victim of domestic violence, alcohol abuse, having a child living outside the home, and having a psychiatric history.[17]

Family Violence:

Intimate partner violence experienced by a pregnant woman could potentially result in injuries or death to her or the unborn child, in illness, or compromised health for either. Estimated rates of women who experience intimate partner violence during pregnancy range up to 20%. The rate of pregnant women who have experienced intimate partner violence at any time in the past range up to 30%.[18]

Oral Health:

The Humboldt County Children's Oral Health Report associates poor oral health with poor pregnancy outcomes, low birth weight and pre-term labor, or premature rupture of membranes. These problems may be caused by toxins produced by the mother's oral bacteria, which cross the placenta and harm the unborn child. In addition the response of the mother's immune system to oral infection may stimulate a response that interferes with normal fetal growth.[19] A mother's oral health is a major determinant in the infant's oral health.

Prenatal Care:

Early and adequate prenatal care is very important to the delivery of a healthy baby to a healthy mother. Women are encouraged to obtain prenatal care as soon as they learn they are pregnant and no later than the first trimester of pregnancy. Good prenatal care addresses more than just medical issues of pregnancy and can identify and respond to problems such as depression, substance abuse, and domestic violence. In Humboldt County, early entry into prenatal care remains a significant problem, with only 77% of pregnant women starting prenatal care in the first trimester.

Birth weight is a good indicator of newborn health. Humboldt County typically meets the National goals and for 1999 had a rate of 4% as compared to 6% statewide.

Conclusion:

Birth outcomes in Humboldt County are generally good, as measured by birth weight. This is a tribute to the medical care during pregnancy. However, less favorable outcomes occur later in the child's first year of life. Beyond providing adequate medical care, we must assure that pregnant women have other issues such as family violence, depression, alcohol, methamphetamine, heroin, tobacco and other drug use and addictions adequately addressed. Addressing these other issues depends upon someone recognizing that the issues exist, knowing of an appropriate referral source, and ensuring that the woman or family members follow though with the referral.

Early Childhood—Ages 0-5

Introduction:

It has been recently recognized that the early years of life are critical in human brain development. During the early years, basic brain processes that determine a child's ability to regulate his or her mood, attention, physical and emotional responses and interaction with the environment will be set. This time of life presents important opportunities and risks for the child. Good nurturing by caretakers and stimulating environments will go a long way in preparing the child for the next major task of entering school ready to formally learn. Harmful home and social environmental factors during these early years can cause the child to develop problems in regulating his or her responses and interactions with others. These problem responses may not adequately prepare the child for the physical, social, emotional, and intellectual challenges ahead. Brain structure and function is affected by these earlier experiences both positively and negatively.

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Two out of three infants and young children served by the Humboldt County Women, Infants and Children Nutrition Program (WIC) are exposed to tobacco smoke in their homes.

Alcohol, methamphetamine, heroin, tobacco and other drug use by parents or caregivers can have a particularly severe impact during a child's early, formative years. SIDS deaths have been associated with exposure to secondhand smoke, as have recurring respiratory and ear infections. Fires and burn injuries, caused by burning cigarettes and matches, can also result in injuries and death to children.[29] Two out of three infants and young children served by the Humboldt County Women, Infants and Children Nutrition Program (WIC) are exposed to tobacco smoke in their homes. [30]

Children living in homes where substance abuse occurs are at risk for child abuse and neglect, mental illness and depression, low self esteem, low functioning in school, behavior problems, and multiple chronic health problems in later years.

Fifty-two percent of children in foster care in Humboldt County have alcohol or other drug use by caregivers as one of several contributing factors to the child's removal from the home.[31] The Healthy Moms Program found that about 75% of program participants between 1997-2001 reported using methamphetamines when they entered the program, and 50% reported the drug to be their primary drug of choice. Half of these women had a child not living at home because the home was unstable or unsafe.[32]

Child Abuse and Neglect:

The United States' performance on preventing child abuse has worsened over the last 20 years, with the greatest proportion of victims being the very young. In Humboldt County in the year

2000 the rate of child abuse reports per 1,000 people was 168, compared to the state rate of 68 (Children Now 2001). In January 2001, the Humboldt County Child Welfare Services (CWS) caseload had open cases on 382 children. Of these children, 4% (14) were less than one year old and 26% (99) were ages 1-5.[33] The fact that these are CWS cases indicates that an allegation of child abuse was confirmed to meet the legal definition of abuse and neglect.

What happens to CWS referrals that don't meet the legal definition? CWS has approximately 1,407 reports of general neglect yearly. Some of these reports are referred to the Alternative Response Team (ART). ART provides intensive Public Health Nurse case management to families referred by CWS, who are at risk of child abuse or neglect and have a child age 0-5. In 2000 ART received 346 referrals, 213 received services. The common reasons for referral are: lack of parenting supervision, poor parenting, alcohol or other drug abuse, domestic violence, medical/health issues, emotional abuse and mental health issues.[34] Unfortunately, most cases referred to CWS are not eligible for either CWS or ART services and depend upon community based organizations to provide assistance, if the families are fortunate enough to receive this assistance. Many abuse and neglect situations are referred to CWS several times before they worsen to the point of meeting the legal definition of abuse and neglect that requires CWS to take action.

Early Childhood Education:

Quality child care/early childhood education can make a big difference in insuring that a child is "ready to learn," with the gains being the greatest for the most disadvantaged children. Quality care can be understood as both prevention and intervention. As a prevention method, research has shown that for every dollar invested in quality child care, $7-$10 dollars are saved in intervention services. A high standard of care influences children's social, emotional and cognitive development. In some cases a child care provider may be the one stable adult in a child's life, and the one person who the child can form a healthy attachment, necessary for the formation of future relationships. Research has repeatedly shown that higher quality care is associated with enhanced social skills, reduced behavioral problems, increased cooperation and improved language in children. Children in quality childcare/early education settings are less likely to be retained in school, be in special education, or drop out of school later on in life. Paying for quality care can be a significant problem for families. Woefully inadequate subsidized care rates exacerbate the situation. Additionally, only 39% of eligible children receive HeadStart services. An investment of public monies is essential to address the true cost of quality child care as it can not be borne by families or the child care field.

Injuries in Childhood:

In Humboldt County, from 1991-2000, the number of deaths of children 1-17 years of age that were attributable to injuries is three times the number of natural deaths. Most of the injury deaths are due to motor vehicle crashes.[35]

Nutrition and Physical Activity:

Anemia appears to be a significant problem among young children in Humboldt County. Current data shows that anemia rates continue to increase in Humboldt County's 2 to 3 year old children. In the County, 22% of 2-3 year olds are anemic compared to 18% nationwide.

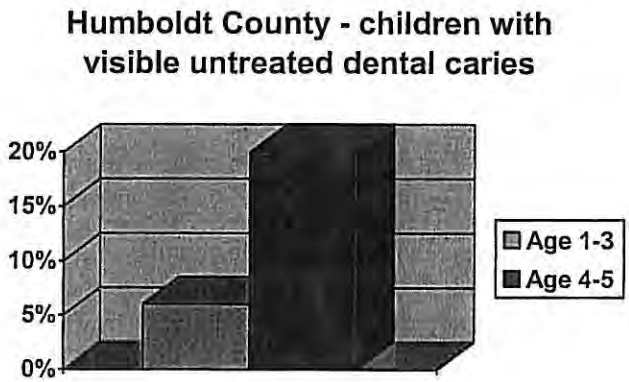
Iron deficiency anemia results from not having nutritious foods, inappropriate food choices and inadequate feeding practices. Poverty may be considered a root cause. Anemia in children can lead to poor motor development, impaired learning, decreased educational achievement, abnormal behavior, decreased resistance to infections, and increased susceptibility to lead poisoning. Children under age 3 are particularly at risk. Iron deficiency at this critical period may cause irreversible damage. Primary prevention of iron deficiency in infants and preschool children can best be achieved through diet.[36]

Childhood obesity is a result of a complex combination of factors that include family relationships, physical activity and food choices. Obesity is a risk factor for diabetes, low physical activity and general poor health. The Centers for Disease Control Pediatric Nutrition Surveillance data indicates that between 1996 and 1998 obesity almost doubled among 2-3 year olds and 5-9 year olds in Humboldt County.

Oral Health:

Data collected in Humboldt County provide evidence that we are experiencing, along with the rest of the nation, a crisis in oral health and dental diseases, especially in vulnerable populations. Low-income families are at greater risk of harboring the bacteria responsible for tooth decay. Family members pass it to infants who then become carriers. Over-use of bottles and juice results in early tooth decay.

In Humboldt County, 6% of children ages 1-3 and 20% of children aged 4-5 years had visible untreated dental caries as reported in an anonymous survey given by three local pediatric services. Children with Medi-Cal or Child Health and Disability Program insurance were five times more likely to have an untreated cavity than children with private medical insurance. Baby Bottle Tooth Decay can occur in very young children with newly erupting teeth, and is consistently higher in children from low socio-economic groups.[37]



Post-neonatal Deaths:

In spite of the potential negative consequences that a woman could experience during pregnancy, most Humboldt County children are born with an adequate birth weight and with few health problems. However, post-neonatal deaths (28 days to 1 year of age) have been occurring at a

higher rate than that of the State for a decade. At their worst, they were three times higher than the State.[38]

Factors that may cause these deaths include:

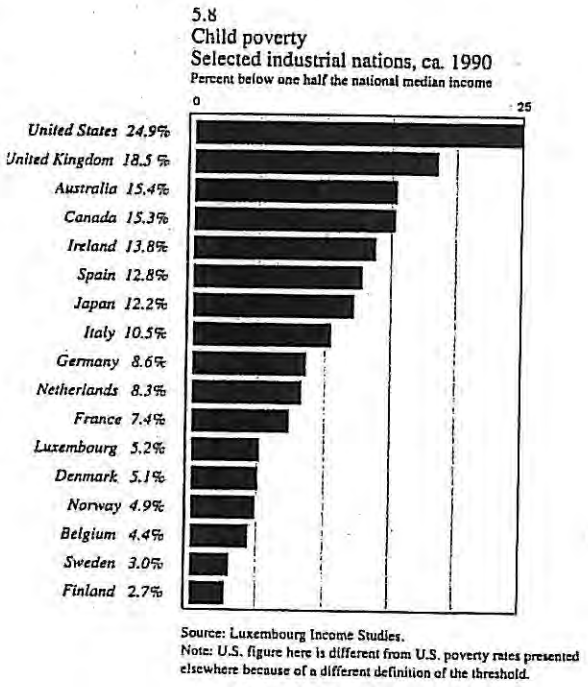
- Abuse and neglect of the child by parents and caregivers, including inadequate parenting skills
- Alcohol, tobacco and other drug abuse by parents and caregivers
- Poverty and lack of other resources and supports, including/transportation
- Lack of intervention in child abuse and neglect cases
- Unwanted or unplanned pregnancy, and high stress
- Sudden Infant Death Syndrome (SIDS)[39]

Poverty:

Children who experience poverty are more likely to score lower on standardized tests, be retained a grade, and eventually drop out of school. The worse the degree of poverty, the worse the school achievement overall.

Locally, WIC provides services to 79% of the eligible population as compared to a state average of 77%.

All other industrialized nations do more to lift their children out of poverty than the U.S., according to a recent survey by the Luxembourg Income Study (UNICEF – The Progress of Nations 1996).



Conclusion:

Insuring that not only the basic needs of food, clothing, and shelter are met, but also that a child is in a safe, consistent, nurturing environment is a tall order for even the healthiest caregivers and their supports. For single parents or those facing the challenges of underemployment, addiction, mental illness, physical health problems or other stresses, the task of successfully raising a child can be extremely stressful and difficult.

Families who feel included in and a part of a supportive, vital community or neighborhood are more readily able to support their own children and have more resources available to them to do so. It is normal for parents to feel burdened. We can make it normal for support to be available.

Childhood—Ages 6-12

Introduction:

Children now enter a school system that is burdened with increasing responsibility for curriculum standards and testing. Children face these standards very early in their school experience. They have to move into the formal education environment and into the larger community. Parents may have issues as they remember their own school experiences and have concerns about their child's success.

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Children begin to learn about alcohol, methamphetamine, heroin, tobacco and other drugs and their effects long before they are confronted with actual use of the substances. The patterns of alcohol, methamphetamine, heroin, tobacco and other drug involvement are established over time and progress (or not) according to a complex process that involves family values about alcohol, methamphetamine, heroin, tobacco and other drug use, the family's pattern of alcohol, methamphetamine, heroin, tobacco and other drug use, and the larger society.

A recent local Smoking Cessation Pilot Project found that in 250 Public Health Nurse cases, at least one person was a smoker in 56% (140) of the homes. Eighty-one percent (81%) of the smoking households have children under the age of 12. 215 out of 326 children (2/3 of the sample) lived in a smoking household. [45] Exposure to secondhand smoke has negative health consequences for children including increased asthma, bronchitis, colds and ear infections.

Child Abuse and Neglect:

Humboldt County's rate of child abuse and neglect referrals and confirmed cases is in the top 75% of the State. More than 50% of the confirmed cases were for general neglect followed by physical abuse (22%) and sexual abuse (17%). Statewide, one-third of children reported for maltreatment are less than six years of age. Twenty–four percent (24%) of the CWS caseload in 2000 was age 6-10.[46]

Family Violence:

In Humboldt County, for the period January-July 2001, 23 of 27 families living at the shelters Safehaven and Bridgehouse were victims/survivors of family violence. Of the 23 families there were 23 women and 52 children. The WISH shelter in Southern Humboldt and Humboldt Women for Shelter in Eureka shelter about 250 women and children per year.

The majority of children exposed to domestic violence will in turn be a victim or abuser themselves. There is also a change in the brain

There is also a change in the brain structure of children exposed to abuse that affects behavioral and social development.

structure of children exposed to abuse that affects behavioral and social development.[47]

Injuries in Childhood:

Injuries occur at a higher rate in homes where adult supervision is lacking or less than adequate. Such circumstances include caregivers who abuse alcohol and other drugs, experience family violence, are underemployed, and/or suffer from depression. In Humboldt County the leading cause of death for ages 6-12 is unintentional injuries.[48] In 1998, the county ranked 38 out of 58 counties for deaths due to motor vehicle accidents and 52 out of 58 for the number of hospitalizations due to motor vehicle accidents.[49]

Media Violence:

Violence in media, for the most part, shows that perpetrators go unpunished and ignores the consequences of violence (including the pain of victims, victims' families, and families of perpetrators), or depicts consequences unreasonably. Viewers begin to identify with the aggressors and the aggressors' solutions to problems. People with greater exposure see the world as a dark and sinister place. The critical period for lasting harm to media violence exposure is pre-adolescent childhood.[50] By age 18 the average young person will have viewed an estimated 200,000 acts of violence on television alone. Over 1000 studies attest to a connection between media violence and aggressive behavior in some children.[51]

Mental Health in Childhood:

Children exposed to family violence, child abuse and neglect or parental AOD use are at high risk of developing mental health disturbances. The number of children served by County Mental Health from October 1996-July 1999 increased from 150 to over 350. This increase reflects the increased capacity gained by hiring additional staff. The total days children have been hospitalized for mental health reasons has also been increasing since December 1999.[52]

Nutrition and Physical Activity:

Although most overweight children do not experience medical complications during childhood as a result of obesity, psychological and social hazards are prominent. Young people who are overweight are at risk for societal discrimination and development of a poor self-image. The child who grows up with a poor self-image is less likely to achieve his/her potential role in society as a healthy, productive individual. Treatment of the obesity is difficult and frequently unsuccessful. Prevention is preferable.[55]

Conclusion:

An assertive, well-organized family is more likely to get their needs met at school while others will need assistance. Children who start school when they are not socially, emotionally, physically, or intellectually ready will likely remain behind without specific strategies to help them either at school or at home.

Other transition times occur during changes of schools such as entering middle school or because of a move. These are times of disruption in a child's social network that can be challenging, especially for children who have not learned to adapt well, usually because disruptions have been negative.

As children become older and more independent and aware of their surroundings outside of home and school they become exposed to new risks and opportunities. They remain influenced by the activities that occur at home, some of which may come in conflict with what they learn at school and in other environments.

Adolescence—Ages 13-21

"Adolescence can be many things...it is a time of rapid change physical, sexual and cognitive changes within a young person, and of changes in the adolescent's world and the demands placed on the young person by society." [Conger (1986)] Adolescent minds and bodies are undergoing extreme rapid change. Adolescence is a time to break away from childhood and transition to the adult world; a time of experimentation, sexual confusion, and a search for identity. Adolescents are prone to risk-taking and experimentation as they learn to take on new capabilities and obtain greater freedom. These behaviors are normal, and they can lead to serious health consequences.

In Humboldt County, every year approximately:

- 5 people aged 12-24 are killed in motor vehicle crashes,
- 410 teens become parents, and
- 75 million dollars are spent treating adults for tobacco-related illnesses caused by a habit that began in adolescence.

The Department of Finance has indicated that the number of people ages 10-17 in the county increased 17% between 1990 and the 2000. The county's overall growth rate for the same period was 14%. It is estimated that between 1985 and 2020 the percent of minority youth will double in the county. [56] Since today's teens are tomorrow's parents, workforce, and leaders; it is crucial that teens experience optimal health and well-being.

Adolescent Sexuality:

Adolescents are at greatest risk of Sexually Transmitted Diseases (STDs) because they more frequently have unprotected sexual intercourse, are biologically more susceptible to infection, and may have social behaviors that increase their risk. In 1998, 79% of reported STDs were among 13-29 year olds. The major reportable diseases include chlamydia, gonorrhea, pelvic inflammatory disease, syphilis, and non-gonococcal urethritis.

The impact of being a teen parent is significant on the well being of both the child and the not yet fully developed teen parent. Teen parents are less likely to finish high school, thus jeopardizing their ability to earn a sufficient income to support themselves and their child. The teen birthrate for 15 – 17 year old mothers continues to decline in Humboldt County. From 1989-2000, 835

pregnancies occurred in this age group, an average of 70 each year. However, during this same time period, the birthrate for 18-19 year olds increased and averaged 132 births per year. This is problematic because there are fewer support programs for women of this age, and yet the young women are not usually fully functioning adults able to support a family.[58]

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Experimentation with alcohol, tobacco, and other drugs can, for the majority of teens, be a brief period of testing limits. For some teens however, this experimentation can lead to many negative consequences including direct physical harm, impaired judgment that can lead to risk taking and violence, disengagement from school, and the support of illegal drug trafficking. Adolescent substance use, particularly of tobacco, can lead the way to adult addictions. Ninety percent of current adult smokers started smoking during adolescence. Long term use of tobacco, alcohol and other drugs can lead to serious illness and death, increased medical care use, and higher health care costs.[59]

Close to 90% of teens in Humboldt County say it is "easy" or "very easy" to get cigarettes even though it is illegal to sell or give tobacco products to anyone under 18 years of age.

Most people who smoke in Humboldt County started when they were 16 years old.[60] One in five Humboldt County 11th graders are regular smokers. [61] Close to 90% of teens in Humboldt County say it is "easy" or "very easy" to get cigarettes even though it is illegal to sell or give tobacco products to anyone under 18 years of age. Sixty–one percent of Humboldt County teens surveyed that bought cigarettes were not asked for identification. [62]

The California Department of Education collected "Healthy Kids" data in Humboldt County 7th, 9th, and 11th grades in Fall 1999, Spring 2000 and Fall 2000. 1,902 students participated, representing 13 schools in 9 school districts. Using these numbers as a guide for extension to all 7,000 9th-12th grade students, it is estimated that over 600 high school students have tried methamphetamines. The Humboldt County **Methamphetamine Fact Book** is an excellent resource for additional information about methamphetamine use among both adolescents and adults.

In 1999 in Humboldt County there were 234 juvenile arrests for alcohol and other drug related offenses. The County's rate of school-reported alcohol and other drug related crimes is three times the state average and is also considerably higher than other small and metropolitan rural county rates. The County's rate of juvenile arrests for drug or alcohol offenses is far higher than the state as a whole.[63] Average yearly arrests for drug offense have increased among youth by nearly 92% since 1985. [64]

Child Abuse and Neglect:

As of January 1, 2001, the local CWS caseload had 114 children ages 11-15 (30% of total) and 62 children aged 16+ (16% of total).

Criminal Activity:

Although Humboldt County has worked hard to address juvenile justice issues, our community has experienced much of the same difficulties as the rest of California. Increased population, as well as increased gang activity combined with drug use, has increased the number of adolescents in the juvenile justice system.

Between 1995-1999, countywide arrest data showed that an average of 1,036 juveniles are arrested each year. Of those arrests about 233 involved felony offenses and 823 involved misdemeanor offenses. Overall average yearly felony arrests have increased 31% while misdemeanor arrests increased 27%. About 290 female juveniles are arrested each year. Female arrests have increased at nearly three times the rate of male arrests since 1985. While the majority of females are arrested for misdemeanor charges, an increasing number are being arrested for felonies. Nearly one out of every five felony and misdemeanor arrests processed through the Probation Department involve youth who have been arrested for serious crimes of violence and weapons charges. Between 1985-1999, juvenile arrests involving violent crime and weapons have increased by 87% while all other juvenile arrests have increased 19%. [65]

Education:

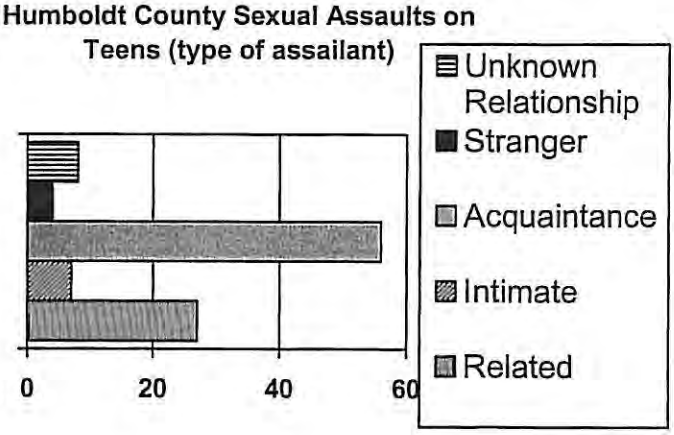
In the school year 1999-2000, there were 1,622 students enrolled in 12th grade in local public high schools. Of those, 1,369 graduated--85%. In the same school year the 9-12 grade drop-out rate was 3.2% as compared to a State rate of 2.8%.[66]

Family and Dating Violence:

Family violence can occur in families with adolescents and have a lasting impact on the witnesses and victims. Men who have a family history of observing or experiencing abuse are more likely to inflict abuse, violence, and sexual aggression. The issue of dating violence begins to emerge as adolescents begin dating.

There is little data documenting the incidence of dating violence among adolescents. One teen at the 1998 Humboldt County Teen Dating Violence Prevention training made the following remark. "When two boys are fighting, the school administration expels the boys. You know, zero tolerance. When a boyfriend hits his girlfriend, nothing is done because they think they will only get back together."[67]

Humboldt County's Rape Crisis Team reports that from October 1, 2000 to July 31, 2001 there were 102 reported sexual assaults on teens ages 12-17. In these cases the assailant was either related by blood or marriage (27), an intimate partner (7), an acquaintance (56), a stranger (4), or relationship not reported (8). Many of the "acquainted" were in dating relationships but not specifically "boyfriends."



For the group ages 18-25 there were a total of 109 sexual assaults, with the assailant relationship defined as related (23), intimates (9), acquainted (59), stranger (6), and not reported (12). [68]

Mental Health Issues:

Research has shown that unrecognized or untreated mental and emotional health disorders increase young people's risk of school failure, dropout, alcohol and other drug use, HIV transmission and other difficulties.

Seven youths committed suicide in Humboldt County for the years 1991-2000.[69] From 1989-1999 fourteen 13-19 years olds in Humboldt County committed suicide. A history of depression, alcohol or other drug use, and aggressive or disruptive behaviors are the strongest risk factors for attempted suicide. Other risk factors include: adverse life events, family violence, firearm in the home, and incarceration. Over 64% of youth suicides nationwide involve firearms. Completed suicides are more common among males because they are more likely to use lethal methods. Suicide attempts are more common among females.[70]

Nutrition and Physical Activity:

Within Humboldt County poor diet and physical inactivity are second only to tobacco as preventable causes of death among adults. Childhood and adolescence are critical times for development of healthy lifestyle habits. Obese adolescents face increased risks for many serious health problems, such as high blood cholesterol levels, abnormal glucose tolerance, and high blood pressure. These health risks are compounded by discrimination, psychological stress, poor body image, and low self-esteem.

The incidence of obesity has increased, affecting approximately one out of five adolescents, a two-fold increase over the past two decades.[71] More than 80% of obese adolescents remain obese as adults, with even more severe consequences including heart disease, cancer and Type 2 diabetes.[72]

Conclusion:

Every adolescent should have the confidence, character, competence, and connections they need to live a healthy and fulfilling life and contribute positively to society. The time of adolescence may be the last significant opportunity for us, as a society and community, to provide the necessary resources and eliminate the barriers that can turn our young people either onto a path of health and well being or to one of destructive and self-limiting behaviors. The more we provide developmental assets to adolescents, such as ongoing relationships with caring adults, safe places and structured activities, health care, and marketable skills through effective education, the less likely they are to engage in negative behaviors and the more likely they are to experience positive outcomes.

Adulthood—Ages 22-60

Adulthood is the most productive time in a human's life span. Adults are the major economic backbone of our community. However, it is also a time when health habits established earlier in life can develop into life-threatening illnesses or behaviors. There is a strong connection between income and health status that becomes apparent at this stage of life. Behavior during these years also lays the foundation of the quality of life for our senior years.

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

"The Impact of Alcohol and Illicit Drug Use in Humboldt County," published in December 1999, provides an in-depth look at the problem in our community. According to this report death, serious illness and injury affect at least a thousand people per year. Hospital discharges involving alcohol and other drugs alone affect 900. Many of the people killed or injured are the innocent victims of drunk drivers.

The rates in Humboldt County are higher than the statewide rate and the rate for either small or metropolitan rural counties in eight significant areas. These indicators are:

- Total deaths attributable to alcohol or other drug use
- Total injuries attributable to alcohol-involved accidents
- Alcohol and other drug misdemeanor arrests combined
- Alcohol and other drug related crimes committed at schools
- Juvenile arrests for drug or alcohol offenses
- Number of retail liquor outlets (on and off site sales). In the years 1990-1996, per 100,000 total population, Humboldt County had an average of 359 retail liquor outlets as compared to the State average at 216.[73]
- Admission to treatment for alcohol use
- Admission to treatment for methamphetamine use[74]

Methamphetamine use is of special concern in Humboldt County. Use of methamphetamine causes a variety of serious health issues, including raising blood pressure, dangerous heart rhythms, malnourishment, teeth loss, and skin problems. Those who inject the drug are at risk for hepatitis B and C and/or HIV/AIDS. Use is associated with psychological problems and can make mental health problems worse. Methamphetamine users are at higher risk of abusing their partners and abusing or neglecting their children.

According to the recently published **Methamphetamine Fact Book**, applying the California rate of methamphetamine use to Humboldt County, 1,200 people here use methamphetamine in any given month. Ninety-five percent of "dangerous drug" arrests are for methamphetamine. Excluding marijuana, methamphetamines constituted between 75% to 96% of the value of all drugs seized by the Drug Task Force in the last four years.

Sixty percent of residents in the women's shelter in Garberville in the year 2000 reported methamphetamine involvement in the family. In a random sample of 37 women served in the

past five years at Humboldt Women for Shelter in Eureka, 32% of cases involved methamphetamines use in the victim, abuser or both.[75]

In the County misdemeanor alcohol and other drug offenses affect more than 3,000 people over the age of 18 every year. There are over 1,000 admissions to alcohol and other drug treatment programs each year and there are long waiting lists.

Tobacco use is a significant cause of death and illness in the County. In 1998, 21% of all deaths in the County were related to tobacco use. In most cases, a death due to tobacco-related disease means suffering a chronic illness and a substantial shortening of the life span than would otherwise be expected.[76] Smoking is the leading known cause of preventable death and disease in men and women. [77] Humboldt County is in a region (Northern and Central Mountain) with the highest prevalence of cigarette smoking for white females in California.[78]

Communicable Diseases:

The California Department of Health Services states that 2.0% of all Californians are infected with Hepatitis C (HCV). The Humboldt County Department of Health and Human Services-Public Health Branch estimates that approximately 4% of Humboldt's population is currently infected with HCV. This is significantly higher than the estimate of the overall rate of infection in the state. In 1999, Humboldt County had the state's 8th highest crude case rate for hepatitis C. Humboldt's rate of 218.55 was much higher than the state rate of 104.04. [79] In 2000, there were 336 reported cases of chronic HCV in Humboldt County.

Criminal Activity:

The Office of the Attorney General State of California Department of Justice reports that Humboldt County had a higher crime rate than the statewide average. The FBI Crime Index shows that in 2000, Humboldt had a reported crime rate of 4,362 crimes per 100,000 population as compared to a statewide average of 3,712. The rate of violent crime in Humboldt County has decreased over the last four years from a rate of 577 (per 100,000 population) in 1997 to 334 in 2000. In 2000, Humboldt County's violent crime rate was significantly lower than the statewide average. The rate of forcible rape, however is consistently higher than the State's average. In 2000, the rate of forcible rape was 51/100,000 while the State's average was 28/100,000. Humboldt County also has much higher rate of burglary and larceny theft than the State.

Employee Productivity and Wellness:

Private businesses alone spend more than a quarter of a trillion dollars on health services each year. Employee productivity and wellness is of growing interest to the business community. Healthy employees incur fewer health-related costs, take fewer sick days, have better morale and are more productive. Unfortunately, our health as a people is on a decline. We're eating more, exercising less, experiencing more stress, sleeping less and gaining more weight. This affects every employer. Employers can make major contributions to improving health by offering work-site health promotion programs, which can increase comprehensive employee health.

The County of Humboldt has an aging work force. The average age of county employees is close to 50. A survey of the most prescribed prescription medications used by county employees showed the top three to be psychotropic drugs. County employees as a population also reflect the growing national trend toward becoming more overweight.[80]

Family Violence:

Women who are victims of intimate partner violence (IPV) have greater annual health care costs than women who are not victims. As the consumption of alcohol by either the victim or batterer increases the rate of serious injuries associated with domestic violence also increases. Common consequences can include: chronic depression, suicidal thoughts and attempts, lowered self-esteem, alcohol and other drug abuse, and post-traumatic stress disorder and for some death.

Injuries:

A leading cause of death among adults in Humboldt County is injuries, especially injuries related to motor vehicle crashes. Humboldt County ranks 54th out 58 counties for deaths due to unintentional injuries. In past years drowning, burns, and falls have also accounted for a significant number of deaths and injuries in our community.

Humboldt County ranks 54th out 58 counties for deaths due to unintentional injuries.

Mental Health:

Major depression is the leading cause of disability in the U.S. Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder. Mental disorders also are tragic contributors to death with suicide representing one of the leading causes of death in the US.[81] Humboldt had a death rate due to suicide from 1996-98 of 17.7 per 100,000 people. This is significantly higher than the state average for the same time period of 10.2 per 100,000 people.

Nearly one in five Americans are affected every year by mental and behavioral disorders, yet too often these illnesses are not talked about and not treated.

Domestic violence is a serious and startlingly common public health problem with mental health consequences for victims, who are overwhelmingly female, and for children who witness the violence. Victims of domestic violence are at increased risk for mental health problems and disorders as well as physical injury and death. The mental health consequences of domestic violence include depression, anxiety disorders (e.g., post-traumatic stress disorder), suicide, eating disorders, and substance abuse.

Nutrition and Physical Activity:

Obesity among adults continues to rise each year in the United States. Obesity is related to chronic health conditions such as diabetes, heart disease, cancer and cardiovascular disease.

The percentage of obese individuals in California rose from 10% in 1991 to 19% in 2000. Diabetes increased by 33% among adults during the 1990s, reflecting the surge in the obesity epidemic. The largest increase in obesity was found among whites, who had a 7% increase in obesity between 1998 and 1999. Researchers also found a 10% increase in obesity among individuals with some college education, compared to a 6% increase among those with a high school education.[92]

The publication "Cardiovascular Disease Risk Factors among California Adults, 1984-1996" divides the State into ten regions. The Northern and Central Mountain Region includes Humboldt County. For the years 1994-96 the following results for several cardiovascular disease risk factors were identified for the Northern and Central Mountain Region.

- The highest prevalence of overweight for white females
- The third highest prevalence of overweight for white males
- The fourth highest prevalence of high blood pressure for white males
- The fifth highest prevalence of high blood pressure for white females
- The highest prevalence of physical inactivity for white females and white males[93]

Poverty:

The poverty rate in Humboldt was 19% in the 2000 Census, higher than a decade ago, and higher than the California rate of 16%, which is higher than the national rate. Humboldt County's unemployment rate was 6.8%, as compared to the State's 5%.

Sexuality:

Sexually transmitted diseases (STD) are a hidden epidemic that result in tremendous health and economics cost to the community. The prevalence and consequences of STDs are both under-recognized and growing. Health care providers and clients are often reluctant to discuss sexual health because of the biological and social factors associated with STDs. Social stigma and lack of pubic awareness contribute to the fact that many infections go diagnosed and untreated. Routine screening for STDs is not widespread.[94]

Despite major advances in the treatment of HIV disease, HIV remains one of the top 10 leading causes of death for people aged 25-54 in California as well as in the nation.[95] Humboldt County also has a significant problem with STDs. In 2000, there were 352 reported cases of chlamydia in the county, one of the highest reported rates of chlamydia in the State.

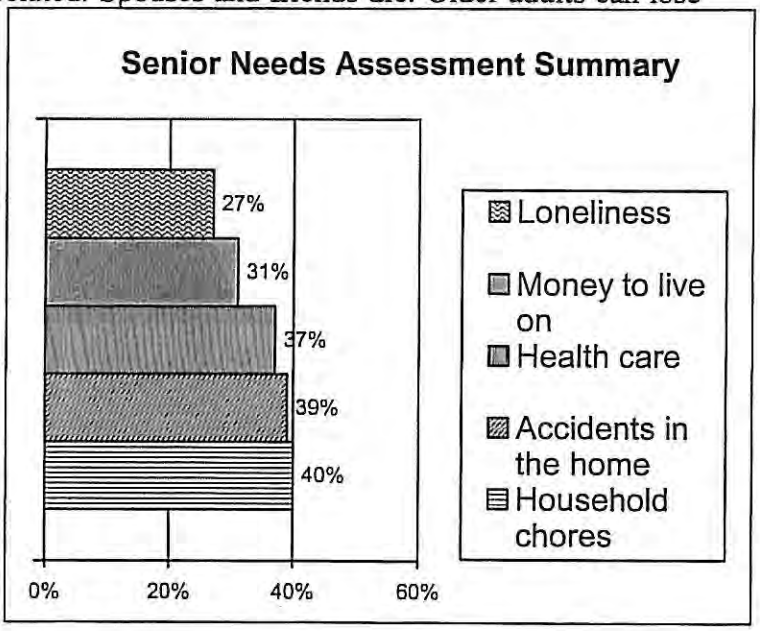
Conclusion:

People spend most of their lives as adults. If they are healthy mentally and physically, living and working in environments free from violence and alcohol and other drugs, with sufficient income to meet their needs, they can be the workers, volunteers, leaders and parents that all communities need to thrive and grow. Poverty, substance abuse, physical or mental illness and violence can turn this potential into a huge community burden.

Seniors—Age 60+

Persons age 65 and older constitute the fastest growing segment of the American population. Older adults are at a time in their life where they can enjoy the benefits of years of hard work and experience. They are a valuable part of our community, being the holders of the community experience, wisdom, values and knowledge. Older adults add generational richness to family and community life. Sixteen percent of Humboldt's population is 60 years old or older. The largest growing population of seniors are 75 years and older. The biggest issues for seniors are quality of life and quality of care. This is also a time in life where past decisions about behavior may result in serious health consequences. Leading causes of death in this age group are heart disease and cancer. Some of the major concerns that face older adults are isolation, loneliness, and depression. These issues can be very interrelated. Spouses and friends die. Older adults can lose their mobility. These factors can increase isolation and in turn can increase loneliness and depression.

Senior Needs Assessment Survey Summary Report 2001 by Area 1 Agency on Aging, found five needs/concerns reported by Seniors: help with household chores (40%), accidents in the home (39%), health care (37%), money to live on (31%), and loneliness (27%). Most concerns about accidents in the home were related to falling in the home due to health problems, lack of balance and agility, trouble walking, recent falls, and poor vision.



Alcohol, Methamphetamine, Heroin, Tobacco, and Other Drug Use:

Surveys suggest that the elderly consume less alcohol and have fewer alcohol-related problems than younger people. However, hospital staffs have been shown to be significantly less likely to recognize alcoholism in an older patient than in a younger patient.[97] Alcohol-related consequences of heavy drinking can be mistaken for medical or psychiatric conditions common among the elderly, including depression, insomnia, poor nutrition and frequent falls. Therefore,

alcohol problems among the elderly may go undiagnosed and untreated or may be treated inappropriately.

It is believed that older people are less likely to abuse substances, except perhaps prescription psychoactive medications. Abuse of street drugs is very rare among the elderly; thus the "drug of choice" for seniors is alcohol. One study found that alcohol abusers in their 50s and 60s had a mortality rate nearly three times higher than expected. Alcoholism in late life tends to be associated with solitary drinking and may represent attempts to cope with loneliness, anxiety, or pain. Elders can and do use prescription psychoactive medications for problems such as pain or insomnia. Although seniors are less than 15% of the population, they receive 60% of the psychoactive prescriptions. Nearly 25% of community-dwelling elderly persons are using some sort of psychoactive drug. There are no good statistics on the rate of substance abuse by seniors.[98]

Heart disease, cancer and stroke are the major causes of death for people over the age of 65.[99] Smoking cessation at this age can have a very positive effect on a person's health. Many of smoking's negative health effects including reduced lung function, increase risk of heart attacks and strokes and reduced circulation can be substantially decreased within a few months after stopping.

Caregiving:

Approximately 12.8 million Americans need help with everyday activities, of these 57% are seniors and about 40% are adults with disabilities. Advances in technology and medicine have not only resulted generally in people living longer, but in making it possible for people with disabilities to live independently in the community with assistance. Assistance is the key to making independent living possible for many people, young or aged, who have a strong desire for independence and control over their own life.

It has been repeatedly demonstrated that the costs associated with providing supportive assistance to allow a person to live in their own home are substantially lower than housing and caring for someone in an institution. Communities must take the lead in encouraging and supporting the development of such supportive services, including supporting family caregivers and training people to be professional caregivers.

Wives, mothers and daughters have traditionally assumed the role of caregiving for family members. One in four American households are now looking after family members over the age of fifty who have a disability or are frail. Each month, these families spend a total of $1.5 billion of their own money on the care of relatives and friends. With an aging population, it is not uncommon for people to be raising their children and caring for an aging parent or relative at the same time. The value of such unpaid care has been put at $196 billion annually, making caregivers the largest unpaid labor force in our country.

According to a survey by Family Circle and the Kaiser Family Foundation, more than half (55%) of adult children who have a parent 65 years of age or older say their parent has a physical or mental health problem, or both. Forty-two percent say they visit at least once a week and 17%

shop or run other errands on a routine basis. Thirty-seven percent report that they are worried about how to juggle caregiving with their other responsibilities and are worried about maintaining their own health. Thirty-four percent of women and 24% of men say they have missed work as a result of caring for an aging parent.

Elder Abuse:

Unfortunately, abuse of elders occurs just as child abuse does. During the months May-July 2001 Humboldt County's Adult Protective Services received a total of 115 reports of alleged abuse. Some of these reports were for self-neglect (such as neglecting personal hygiene, clothing, shelter, inadequate nutrition, or failure to protect oneself from harm) and some for abuse perpetrated by others. Of abuse perpetrated by others that was confirmed by investigation, most was related to financial abuse.[100]

Mental Health:

Depression is strikingly prevalent among older people. Up to 20% of older adults in the community and up to 37% in primary care settings experience symptoms of depression. Depression is a foremost risk factor for suicide in older adults. Despite the prevalence of depression and the risk it confers for suicide, depression is neither well recognized nor treated in primary care settings. Depression also contributes to excess disability by hastening functional impairment in patients with Alzheimer's disease. The fast pace of modern life, with its emphasis on independence, also contributes to excess disability by making it more difficult for older adults with impairments to function autonomously.[101]

Prevention in mental health has been seen until recently as an area limited to childhood and adolescence. Now there is mounting awareness of the value of prevention in the older population.

Nutrition and Physical Activity:

Economics plays a key role in assuring that older adults eat a healthy diet. Many older adults have to choose between paying for prescription drugs, energy costs and food. Like other people, many older adults do not eat enough fruits and vegetables and do not have enough variety in their diet. Like all Americans, older adults are also becoming more obese. Poor diet and lack of physical activity results in older adults gaining more weight than is healthy for them.

Poverty:

The Humboldt County Department of Health and Human Services-Social Services Branch states that many seniors who are eligible are not accessing the Food Stamp Program for a variety of reasons including the perceived stigma of using stamps to buy food. Statewide only 5% of the households using food stamps are elderly.[102]

Statewide only 5% of the households using food stamps are elderly.

Senior Health Problems:

The top five chronic conditions reported by Humboldt County seniors in 1999-2000 were cardiovascular disease (49%), arthritis (41%), respiratory (29%), cataracts (27%), and hypertension (25%). Twenty-four percent (24%) of clients age 74 or less reported six or more chronic conditions, compared to 27% in the State. Thirty-one percent (31%) of clients age 75 or more reported six or more chronic conditions, compared to 40% in the State. High-risk clients were those who were low income (52%), over 75 years old (50%), living alone (47%) or had more than six chronic conditions (28%).[108]

Conclusion:

With the numbers of older adults increasing faster than any other group, it is critical that their needs be addressed. Crucial to this task is ensuring that older adults have sufficient income to meet their needs; that those who interact with them are trained to recognize potential health and mental health issues; that there are adequate resources in the community to address any identified needs; and that there are adequate opportunities for older adult inclusion and participation in community life.

Summary

Looking across the life span, we see that there are many potential threats to the health and well being of Humboldt County residents. Alcohol, tobacco and other drug use; child abuse; living in poverty; family violence; injuries; lack of good nutrition and physical activity—all of these factors can negatively affect people's lives. The effects of some of these factors last a lifetime, causing suffering not only for the individuals experiencing them, but also for the communities in which they live.

Risk Factors

Three broad, major risk factors that contribute to potential negative consequences for some children and adults stand out from the needs assessment. These risk factors are:

- Alcohol, methamphetamine, heroin, tobacco and other drug use
- Family violence and dysfunction
- Poverty, homelessness, joblessness, and underemployment

These risk factors and their potential consequences are often intertwined so closely that it is difficult, if not impossible, to state with any certainty what "caused" what or which came first. Was it family violence that led to alcohol and other drug use, or did alcohol and other drug use lead to family violence? Or was it poverty that started the cycle, or the loss of a job? Whether a child or adult experiences one or more of these risk factors can make a significant difference in the quality of her or his life. The following provides a guideline for analyzing the identified problem areas.

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

The abuse of alcohol, methamphetamine, heroin, tobacco and other drugs places an enormous burden on society. Alcohol, tobacco and other drug abuse harm family life, the economy, and public safety. It gives many of our children and youth a poor start in life. Although no population group is immune to substance abuse and its effects, families in the lower socio-economic strata suffer disproportionately. The root causes of substance abuse are complex.

Substance abuse can have an impact from earliest infancy through old age. Some infants are born already compromised through exposure to substances consumed by their mothers during pregnancy. Prenatal exposure to alcohol, tobacco or other drugs during pregnancy is linked to psychological, learning and physical problems in children. For example, more than 2,000 infants are born every year in the United States with fetal alcohol syndrome, a leading preventable cause of birth defects and developmental disabilities caused by drinking alcohol during pregnancy and other factors.[109]

Substance abuse has also been documented in numerous studies showing the relationship of alcohol/drug use to crime and violence. According to the July 2001 report "Community Indicators of Alcohol and Drug Abuse Risk" for Humboldt County, in 1999 there were 762 adults arrested for drug violations and 1,484 adults arrested for alcohol violations. During this same year there were 234 juveniles arrested for alcohol and drug offenses.

The literature on prevention has identified four major areas of risk for substance abuse and related problems:

- Community factors, such as:
  --the availability of substances

--policies that encourage or fail to discourage substance use—for example, tolerance of sales of tobacco and alcohol to minors
--poverty/lack of empowerment
--social disorganization - strongly related to poverty and lack of empowerment
--high rates of transition and mobility

- Family factors, such as:
  -- family history of substance abuse
  --marital discord
  --economic deprivation
  --poor family management (discipline, and problem-solving skills)

- School factors, such as:
  --academic failure
  --low school involvement
  --disorderly school behavior

- Individual/peer factors, such as:
  --early onset of alcohol/tobacco/other drugs experimentation
  --friends who use alcohol/tobacco/other drugs
  --peer rejection
  --youth related behavioral problems (e.g. teen pregnancy, violence, aggression, increased levels of impulsivity/hostility)
  --alienation
  --favorable attitudes toward alcohol/tobacco/other drug use

These risk factors can vary according to an individual's age, psychosocial development, ethnic/cultural identity, and environment.

The scientific evidence is clear: alcohol, methamphetamine, heroin, tobacco and other drugs are addictive substances. People who are at risk have difficulty in avoiding and escaping dependency. Harmful substances are often used as a coping mechanism for people overwhelmed with daily stresses, or as a form of self-medication for people with emotional issues. The abuse of alcohol, methamphetamine, heroin, tobacco and other drugs is a preventable health problem. Much of the risk associated with such abuse could be reduced (or eliminated) by changing individual and community norms. Prevention education, intervention, and treatment must be readily available to everyone, not just those who suffer from substance abuse addictions.

Often addiction is seen as a root problem needing to be corrected rather than seeing it as self-medicating or coping mechanisms for underlying conditions and problems as described above. Dealing with daily stresses and challenges is a normal part of life. However, there is a continuum of coping skills that exist, from highly useful skills to destructive ones. Choice of coping mechanisms is often determined by one's sense of achievement and ability to affect change. Some coping mechanisms may seem to be initially helpful (methamphetamine use by overburdened mothers) before the serious negative consequences of addiction are present.

Family Violence and Dysfunction Exposure:

The Adverse Childhood Experiences (ACE) Study, conducted with a group of middle-aged, middle class Americans, found a strong relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. Some of these causes of death are some types of heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. In addition, those exposed to such abuse or dysfunction experienced increased health risks for alcoholism and other drug abuse, depression, suicide attempts, smoking, poor self-rated health, sexually transmitted disease, physical inactivity and severe obesity.[110] The ACE Study reveals a powerful relationship between our emotional experiences as children and our adult physical and emotional health and mortality. The study also makes it clear that time does not heal some of the negative experiences. "One doesn't 'just get over' some things."[111]

The study found that adverse childhood experiences are more common than acknowledged and that they had a powerful correlation to adult health fifty years later. The ACE Study compared the current adult health status to seven categories of negative childhood experience. Three categories were focused on personal abuse:

- recurrent physical abuse,
- recurrent emotional abuse,
- sexual abuse

Four were categories of household dysfunction, where the person grew up in a household:

- with an alcoholic or a drug user;
- where someone was imprisoned;
- where someone was chronically depressed, mentally ill, or suicidal;
- where the mother was treated violently

One in four adults in the study were exposed to two categories of the abuse experience. One in sixteen adults were exposed to four categories of the abuse experience. Given an exposure to one category of abuse, there is an 80% chance of exposure to another category of abuse. The risks do not occur in isolation—a child does not grow up with an alcoholic or in a home with domestic violence in an otherwise ideal household.[112]

The Centers for Disease Control, National Center for Injury Prevention and Control, provides excellent statistics and information regarding the childhood effects of family violence. Some of the highlights of this data are:

- Each additional act of violence toward a spouse increases the probability of the violent spouse also being abusive to the child.
- Men who have a family history of observing or experiencing abuse are more likely to inflict abuse, violence, and sexual aggression.
- Each year more than ten million American children witness violence within their families.

- Witnessing violence is stressful and it is a risk factor for long-term physical and mental health problems such as alcohol and substance abuse, child abuse, and intimate partner violence. [113]

Exposure to traumatic acts of aggression and violence as a child almost guarantees that children will develop unhealthy patterns of learning, social and imitative skills. Between 60%-80% of the witnesses/victims of serious violence will develop post-traumatic reactions or even full-blown Post-Traumatic Stress Disorder (PTSD). Categories of acute or chronic human violence include assault, homicide witness, rape, and physical or sexual abuse. Early trauma affects brain development, interfering with concrete thinking ability, comfort in social situations, language development, comfort with praise by others, and trust of others. Chronic trauma can result in distorted thinking, aggression, language delays, and predatory behaviors.[114]

Poverty, Homelessness, Joblessness and Underemployment:

A March 2001 publication, "The Future of Work and Health" identifies key relevant themes relating to poverty.

1. Getting left behind by a changing economy. The past five years have brought progress in reducing unemployment and poverty rates and in raising real wages for some residents. However, these wage gains come after two decades of wage stagnation and leave many families at or just above the poverty level.

2. A widening of income inequality. A relatively new body of research demonstrates that wide gaps between rich and poor, even in relatively affluent societies, are associated with poor health. The evidence of the mid 1990s was that income inequality in California was large and growing.

3. Changing work arrangements. Over the past three decades there have been many changes in work arrangements from rapid growth in the share of women who work, to changes in access to benefit and training programs, to a wider array of work schedules and new employer-employee contractual arrangements. These changes have placed new pressures on families to combine work and family responsibilities and created new insecurities about "social contract" issues like benefits, childcare and opportunities for career advancement.

Social stratification and inequality influence the experiences of daily life through the intermediary structures of poverty, segregation, and prejudice. These structures determine how much access individuals have to resources, power, autonomy, and status, and influence the types of stressors that individuals experience, their interpretations of those stressors, and the resources they have to cope with them.[115]

Numerous studies in many countries show that people with the highest poverty rates suffer the worse health problems. In other words, people who are poor have higher rates in all disease categories, including heart disease, stroke, cancer (smoking and non-smoking related), injury-related deaths and suicide. Some of the reasons may be related to fetal and early childhood

nutrition, access to adequate housing and other basic services, but some of it is also related to education, early experiences with success, and personal opportunities.

Conclusion:

We know that some people are able to thrive in adulthood in spite of severe adverse experiences in childhood, and have either learned or otherwise acquired protective strengths that allow them to overcome these obstacles and lead healthy, successful lives. The next section looks at factors that can be acquired or learned, or provided in the environment that may prevent an individual from entering the negative cycles previously described.

Protective Factors

Introduction

Just as there are risk factors for individuals, families and communities, there are also protective factors. Protective factors are forces that tend to move people in the direction of health, safety and dignity as well as protect them from the negative events and stressors in their lives. Access to adequate food, clothing and shelter are the most basic of the protective factors. In providing services and supports we need always to be mindful of Maslow's Hierarchy of Need--until the "basic needs" of adequate food, clothing and shelter are met, people cannot address the "higher needs" of meeting their full potential.

In addition, just as the presence of the three broad, major risk factors discussed in the prior chapter can contribute to negative consequences, so can the absence of these risks serve as protective factors. Thus:

- Living in a healthy, environment free of violence is protective
- Living in a smoke-free, addiction-free home is protective
- Being employed and having an adequate income is protective

Following is a brief listing of some of the other protective factors that can help people have satisfactory lives in spite of adverse conditions.

Income

The importance of having an adequate income cannot be overemphasized. Having adequate income means having jobs, for most people, and these jobs need to pay a living wage--enough so people can address at least their basic needs of food, clothing and shelter. The more income people have the greater their ability to meet their "higher needs" and to purchase the services that may not be available through social support. Access to some of the other protective factors are, in fact, determined by income.

Support for Low Income Families. According to the report "The Future of Work and Health," there are three key strategies for helping low income, rural families.

1. Economic Growth – Without sustained productivity growth and low unemployment, substantial gains in real wages and income are not possible. Though federal macroeconomic policies seem far away and out of our control, they are, nevertheless, crucial to making continued progress for all workers and especially for low wage workers.

2. Income Support Policies –Everyone will not be able to get high wage jobs even with bold new education and training programs. Income support policies like the minimum

wage, health insurance, Earned Income Tax Credits and subsidies for health care and childcare will continue to be needed to reduce the impact of poverty.

3. Workforce Investment – In the decade ahead the focus of workforce investment policy must shift from a primary emphasis on basic employment to career advancement. People need meaningful work that pays a living wage with adequate benefits.

Health

Good Nutrition and Physical Activity. Nutrition during fetal development and early childhood has a lifelong impact on physical and intellectual development and capacity. People today are generally taller and have higher IQs than a century ago primarily because of good nutrition. Nutrition and physical activity throughout the lifespan are important factors for determining rates of obesity, and can either contribute to or protect from heart disease, cancer and many other chronic illnesses. Worksite health promotion programs can improve worker well-being and productivity. Adults and seniors s+uffer the consequences of lifelong poor nutrition and lack of physical exercise such as heart disease, cancer, diabetes, poor mobility and many others, including depression.

Good nutrition depends, in large part, upon having sufficient income to purchase healthy foods.

Safe Housing and Living Environments. Improvements in the safety features of homes (lead-free paint, fire alarms), schools (earthquake standards, playground surfaces and equipment standards), and vehicles (restraints, traffic laws) protect people from injury and death. There are many prevention levels on which both passive and active protective features can improve the safety of a community in terms of clean air and water, smoke free policies and crime limited neighborhoods. Again, access to safe housing and living environments depends, in large part, upon having sufficient income to live in a safe home, in a good neighborhood with good schools, far from toxic or hazardous sites.

Access to Immunizations and other Disease Prevention Measures. Basic, inexpensive measures exist to protect us from both common and more rare, but serious diseases. Some of these measures actually prevent a disease, and some screen for early detection of the disease, giving the opportunity to treat it with early, less costly interventions. The cost benefit ratio for these activities is high. In order for people to benefit from these basic services they must be assured of adequate health insurance and access to competent medical providers. Again, this access is often determined by income.

Social Support

People who live in environments where they feel supported by family, church members, neighbors or other people lead healthier, more fulfilling lives. The quality of life for senior citizens is highly influenced by the degree of connection that they have to intimate partners, friends, groups and associations. Some people are able to "buy" many of these "services" if they

do not naturally exist. For example, if extended family does not live nearby, they can hire a qualified "nanny" or take their child to quality childcare.

Communities can also improve social support through friendly, welcoming community centers and programs that encourage community members to get together and become friends. Ensuring that treatment for depression, other mental illnesses and alcohol and other drug treatment is available also promotes social interaction. To the degree that people support one another, there is less need for high cost professional services. Varying types of support can occur in the form of home-based services, access to social and community groups, welcoming neighborhood centers, faith groups and service activities.

Communities that are Inclusive and Culturally Diverse. Communities that are healthy invite participation by and membership for all residents, and value the unique contributions of each sub-group. Community members are valued and encouraged to take responsibility in projects and activities when community leaders demonstrate a "cultural sensitivity" that allows them to acknowledge and accept different ways of doing things without having a first hand knowledge of other cultures. They are able to value and work with diversity.

Individual Skills

Competence, Social Skills and Assertiveness. People need strong, healthy internal perceptions and the skills to be socially competent. Critical conditions include (Hawkins and Weis):

- Cognitive, affective and behavioral skills to succeed
- Multiple opportunities for meaningful, positive involvement
- Reinforcement for competent behavioral performances

Critical Thinking Skills or Problem-solving Skills. Research suggests that teaching critical thinking skills is more important for people than learning the specific content of a subject (Bernard).

Internal Locus of Control. People who have more control over their lives are healthier both physically and mentally. People who have control over their work, money, children, families, and communities see the positive impacts of their own behavior and are healthier for it. Children also need to experience the impact of their behavior on the world around them.

Resiliency and Self-Efficacy. Despite life's stresses, people find confidence that their internal and external environment is predictable, that life has meaning, and that things will work out as reasonably well as can be expected (Werner, Hawkins, Bernard). This outlook on life can be achieved by:

- Having the opportunity for active involvement in family, community, school, and other social arenas
- Teaching and learning skills for success and positive participation

- Providing reinforcement for attitudes and behaviors, with the focus on positive instead of negative reinforcement

Conclusion

Protective factors are critical elements that contribute to the health and well being of individuals, families and communities. Providing supports, activities, and services that increase protective factors for these groups can reduce the negative impacts of family violence and dysfunction, alcohol, tobacco and other drug use, and poverty, homelessness, joblessness, and underemployment.

GOALS

1. Reduce poverty, unemployment and under employment.
   Priority areas are:
   A. Food stamps promotion, education and outreach.
   B. Promote career education and training.
   C. Promote access to health care.
   D. Promote life long learning.

2. Prevent and reduce family violence and dysfunction.
   Priority areas are:
   A. Prevent and reduce child/elder neglect and abuse.
   B. Prevent and reduce domestic violence.
   C. Prevent and reduce dating violence and rape.
   D. Encourage healthy media images.

3. Prevent and reduce alcohol, methamphetamine, heroin, tobacco and other drug addictions.
   Priority areas are:
   A. Prevent and reduce youth access to and interest in alcohol, methamphetamine, heroin, tobacco and other drugs.
   B. Improve public policy addressing alcohol, methamphetamine, heroin, tobacco and other drug use.
   C. Increase student awareness and perception of media involvement in targeting youth as future consumers;
   D. Educate families about their responsibility to decrease children's involvement in alcohol, methamphetamine, heroin, tobacco, and other drugs.
   E. Perinatal substance abuse prevention.
   F. Support the recommendations in the Impact of Tobacco Report.

4. Improve community health status.
   Priority areas are:
   A. Oral health.
   B. Increase the community's level of physical activity.
   C. Improve the nutritional habits of the community.
   D. Prevent and reduce injuries.
   E. Prevent and reduce communicable diseases, including sexually transmitted diseases.
   F. Increase adequate prenatal care.
   H. Employee productivity and wellness.

5. Improve community mental health status
   Priority areas are:
   A. Prevent and reduce suicide deaths.
   B. Reduce the number of people living with untreated depression.
   C. Reduce the number of people living with untreated dual diagnosis.
   D. Reduce the stigma of mental illness.

6. Prevent and reduce criminal activity.
   Priority areas are:
   A. Early identification of the factors that increase the risk of delinquency and criminal activity.
   B. Strengthen protective/resiliency factors as a way of reducing risks.

7. Improve environmental quality.
   Priority areas are:
   A. Promote food safety.
   B. Improve water quality.
   C. Assure safe housing.
   D. Reduce solid waste and hazardous waste generation.
   E. Improve indoor air quality.
   F. Maintain the safety of recreational areas.

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
DEPARTMENT									
HEALTH & HUMAN									
SERVICES									
MENTAL HEALTH	Early Years Mental			$ 50,000.00			State		
BRANCH	Health Program			$ 62,000.00			Prop 10		2
				$ 10,000.00			Northcoast		2
							Children Service		
	Community Based			$ 29,634.00			Federal		3
	Counseling								
PUBLIC HEALTH									
BRANCH									
Health Education									
402 E&P AIDS	HIV Prevention	High risk Individuals		$ 97,200	X		Fed/State		2&3
412 Tobacco	Tobacco Use Prevent	Community	$ 135,000	$ 15,000		X	State		2
414 Gen. Health Ed	General Health	Community	$ 468,112			X	Real/314D	MAA50-75% 01-02	2
434 Master Settlement	Tobacco Use Prevent	Community	$ 20,000			X	County		2
436 Pro. LEAN	Physical Act. & Nutrition	Youth and low income	$ 83,404			X	Fed/State		2&3
							USDA Match		
441 HIV Prevention	County to HR people	High risk Individuals		$ 32,500	X		Fed/State		3
442 HIV Street Outreach	HIV testing street	High risk Individuals		$ 67,158	X		Fed/State	MAA 50% 01-02	2
443 HIV Youth	HIV Pr Youth RAVEN	Street Youth		$ 200,000	X		Fed/State		3
445 HIV Women	HIV Pr. Women	High risk women & part		$ 65,000	X		Fed/State	MAA 50% 01-02	2
446 HIV AM. Indian	HIV Prev. Am Ind UIHS	Am. Indians	$ 150,000		X		Fed/State		3
488 Domestic Vio. Prv	Domestic Viol. Prev.	Community	$ 182,000		X		Fed/State/Prop 10		2&3
AOD Services									
SAPT Substance Abuse	Pri. Prevention 6 Str:	Community	$ 219,373			X			3
Prevent & Treat	1. Inform Dissemin.								
Funds	2. Education								
	3 Alternatives								
	4 Prob ID and Refer								
	5. Comm. Based Process								
	6 Environmental								
Friday Night Live	Pri. Prevention	14-18 years old	$ 3,000		X				3
(FNL)	Same as SAPT but focus								
	on education, alternatives								
	& Community based pro.								

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
	(teen leadership institutes,								
	peer clubs & cross age								
	tutoring								
Club Live (CL)	Same as FNL	12 to 13 years old	$ 3,000		X				3
Safe & Drug Free	Same as SAPT	12 to 18 years old	$ 20,816		X				3
Schools & Comm.	focus on Ed (in school)								
Seymour Funds	Pri. & Sec treatment	Community	~$6,145	~$12,475		X			2
(Trust Funds from fines)									
Fees	Must be used on same	Community	$ 9,238			X			2
	activity for which is was								
	collected eg sub series								
406-EH Unit									
Food Facility	Food Facility Regulation	All consumers	$ 258,846				Fees/		2&3
Compliance							Realignment		
Land Use	Septic Permits,	Consumers and Users	$ 301,987				Fees/		2&3
	Construction and	of water and recreational					Realignment		
	Subdivision Project	areas							
	Reviews								
NSSDS Monitoring	Monitoring of	Consumers and Users	$ 32,730				Fees/		2&3
	Nonstandard Sewage	of water and recreational					Realignment		
	Disposal Systems	areas							
Water Systems	Inspection of Water	Consumers of	$ 45,000				Realignment		2&3
	Systems	drinking water							
Vector Control	Education and assistance	Residents	$ 60,000				Realignment		2
	in reduction of vectors								
	such as rodents								
Pool Regulation	Inspection and regulation	All Consumers	$ 20,000				Fees/		2&3
	of pools and spas						Realignment		
Rabies	Education and control	All Consumers	$ 20,000				Realignment		2
	of rabies								

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
411-CUPA	Regulation and inspection	Residents within zone of	$ 526,869				Fees		3
	of hazardous materials	influence of facilities							
	facilities including	and consumers of							
	underground storage	recreational waters							
	tanks and acutely	and drinking water.							
	hazardous materials								
	storage facilities								
430-Integrated									
Waste									
HHW	Education and collection	All Residents		$ 222,799			Fees/Grants		3
	of household hazardous								
	waste								
Oil Grant	Education and	All consumers, do-it	$ 89,500				State Grant		3
	establishment of waste	yourself oil changes							
	oil and waste antifreeze								
	collection facilities								
LEA	Regulation of solid waste	All Residents	$ 173,705				Fees/Grants		3
	disposal facilities,								
	investigation of illegal								
	handling and disposal of								
	garbage								
Source Reduction	Education and	All Residents	$ 326,745				Fees/Grants		3
	identification of								
	alternatives to								
	generation and disposal								
	of solid waste								
Mercury Reduction	Education and	All Residents		$ 10,000			Grant		3
	collection of mercury								
	containing household								
	and medical products								
WIC									
415 WIC	Nutrition	Children pregnant women	$ 400,000	$ 100,000	X		Federal		3
	Breast feeding support	preg. Woman & new moms		$ 23,600			Prop.10		2
	Oral health promotion	infants & children		$ 8,000			Wellness foun.		2

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
MCAH									
CHDP	well child exam admin	0-18 years, income eligible	$ 200,000		X		Fed/State	Title XIX	2&3
Injury Prevention	MVA & other	0-adults	$ 85,000			X	Fed/State	Title XIX	2&3
Dental Care PH	Dental Activities	0-18 yrs esp. 0-5	$ 82,000	$ 50,000		X	Foundation	SPMP	2
								50-75%	
MCAH			$ 412,400					All	2&3
FIMR	Infant death review	0-1 year			X		Fed/State	MCAH	
CDR	Child death review	1-18 years			X		Fed/State	Programs	
Prenatal care	access to care for				X		Fed/State		
Guidance	high risk , income								
	eligible pregnant women								
HHF	Home visitation collab.	0-5 years				X	Fed/State		
	for stakeholder agencies								
Child Care Health	liaison with child care to	0-5 years	$ 65,000			X	Prop 10		2
	improve child health 0-5								
Public Health Nursing									
404 Adolescent Family	case management for	teen parents 18 &		$ 158,029	X		State	FFP	2
Life/TAPPN	pregnant and parenting	younger, services to the	$ 40,280				State	T-19 02-03	2
	teens & siblings, subs	age of 20							
	HCCC								
405 MVIP	case management to	sev. Med at risk infant		$ 88,679	X		State	Title XIX	2
	medically fragile infants	from neonatal inten.care						TCM	
		unit & who meet		$ 36,321			Realign		2
408 Alternative	early intervention/case	medical criteria						Title XIX	2
Response Team (ART)	management for 0-5							TCM	
	at risk for abuse/neglect	at risk child. 0-5 referred		$ 594,766					
		from CWS gen neglect							
409 HIV testing	countywide HIV testing	12+ years old		$ 119,319	X		State		3
	and counseling								
416 Public Health	all communicable	Community		$ 1,484,196	X	X	realign	TCM	2
Nursing Field	disease control, High							Title XIX	
Services	Risk Maternal Child							2002-03	
	Health, home visitation,								
	medical case mgmt..								
417 Preventive	health screening clinics	55+ and non-frail	$ 11,600	$ 46,400	X		required 50%	TCM	2

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
Health for the Aging	countywide ages 55 above	comm. dwelling and able					county match	Title XIX	
		to make own decisions					realignment	2002-03	
		re medical care							
422 Clinic Services	clinic services countywide	Community	$ 93,624	$ 187,249		X	Bill for		2
	STD, immunization(adult,						services		
	abd children, foreign						F Pact		
	travel, TB testing, women's						Medi-Cal		
	health Willow Creek						realgin		
428 Immunization	coordination of children's	children to college age		$ 102,000	X	X	realign		2
Program	immunizations countywide						fees		
	activities are primary,								
	secondary and tertiary								
435 PH Laboratory	Lab services: water testing	community and high risk	$ 283,908	$ 662,451		X	Medi-Cal		2&3
	food safety, milk testing,	people					Ins. , FPACT		
	disease testing						state		
431 Healthy Moms	Early intervention services	at risk children 0-5		$ 91,305		X	state		3
	for at risk children 0-5								
PH Other							fees		
440 PH Planning	Epi, disaster planning	Community	$ 320,787			X		USDA Match	2&3
and Support	nutrition								
407 Childhood Lead	Health ed, PH case man.	Providers, child at risk	$ 37,200	$ 18,600	X		State		3
Poisoning Prevention									
Alcohol and Other	Reviews deaths from	Community	$ 10,000				CMSP		2
Death Review	alcohol and other drug						Cal Endowment		
	use								
Community Health	Case management for	Adults with AOD		$ 80,000			CMSP		2
Outreach Worker	AOD clients on release	issues being released					Cal Endowment		
Case Manangement	from jail	from jail							
Program									

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
SOCIAL SERVICES									
BRANCH									
Cal work incentives		at risk children	~$100,000	~$300,000					
		25% to 200% of poverty							
Healthy Families	0-19	250% poverty	$ -	$ -	X				
Insurance									
Cal-Learn	Schooling for	Pregnant/Parenting		$ 129,000		X	Fed/State		
	Teen Parents	Youth under 19 w/o GED							
Child Care	Provides $ for Child Care	WtW Recipients		$ 1,032,299		X	Fed/State		
WtW	Provides training/job	WtW Recipients		$ 4,517,826		X	Fed/State		
	search/counseling								
Car Loan Program		WtW Recipients		$ 100,000		X	Incentive		
Diversion Funds	One Time Cash	Cal/Works Recipients		$ 2,810				2.50%	
Incentive Funds	Deposits for Rent/Utilities			$ 15,000		X	Fed/State		
	Funds for Purchase of								
	Work Clothes								
Special Circumstance	Provides Funds for Home	SSI/SSP/IHSS/Aged		$ 38,212		X	State		
Program	Repairs/Applicances								
Independent Living	Educational/Vocational	Youth Transitioning		$ 229,925		X	Fed/State		
Skills	Counseling Basic Living	From Foster Care							
	Skilss								
Alternative Response	Voluntary In-home	Children at Risk of		$ 500,000		X	Fed/State	15%	
Team	Services	Abuse or Neglect							
Food Stamps	Providing a Food Source	NAFS		$ 1,675,000		X	Fed/State	15%	
							County		
Homeless Assistance	Providing Shelter	Homeless		$ 1,000,000		X	County		
Medi-Cal	Providing Medical	People with medical		$ 3,561,000		X	Fed/State		
	Insurance	needs							

CONSOLIDATED PREVENTION ACTIVITIES FUNDING MAP

Title	Description	Target Population	Annual Funding Primary	Annual Funding Secondary	Not Flex	Flex w/in Prog. Guides.	Source	Matching	Level
Employment and	Youth Program	Disadvantage youth		$ 300,000		X	WIA		3
Training		14-21 years old							
	Career ed. & training	Adults and		$ 925,000		X	WIA		3
		dislocated workers							
PROBATION									
DEPARTMENT									
202 CPA 2000	Delinquency Prevention	At risk youth & families		$ 528,466		X	State	Title IV-E	2
								Title XIX	
Totals			**$ 5,191,124**	**$ 19,115,110**					
KEY									
MAA Medi-Cal Administrative Activities									
TCM Targeted Case Management									
WIA Workforce Investment Act									
01-02 Effective Fiscal Year 2001-02									
02-03 Effective Fiscal Year 2002-03									
Level indicates at what level can these funds be matched. Funds at level 1 or 2 can be matched to increase revenue. Funds at level 3 are not matchable.									

Recommendations

The Spectrum of Prevention

The **Spectrum of Prevention** identifies a range of actions that can be implemented to effectively achieve prevention goals.

The Spectrum provides a framework for planning prevention activities. In an arena where categorical funding is the rule, addressing individual projects is the norm. The Spectrum provides a common language and a consistent methodology for describing and choosing actions. It fosters conducting prevention in a multi-faceted, even integrated, and hopefully collaborative manner. The Spectrum provides an understanding and helps demonstrate that even short-term, seemingly freestanding activities are inter-connected and are part of a broader context.

Project Team members are strong advocates of using the Spectrum to effectively implement prevention activities in Humboldt County. Following is a brief overview of the seven "bands" of the Spectrum and some examples of potential local strategies that fall within it.

Strengthening Individual Knowledge and Skill

This band represents a more "classic" approach to prevention. Professional experts reach out directly to specific individuals at risk of injury or disease, encouraging them to change their behavior. Many health providers and community agencies currently use this strategy of education and counseling.

- Home visiting.
- Parenting support groups.
- Provide hepatitis C education.
- Provide STD education.

Promoting Community Education

The goal of community education is to reach the greatest number of people possible, as well as to build a critical mass of people who support strategies for healthy behavior. Like individual education, community education aims to change behavior. However, it also aims to influence and shape community norms. A well-coordinated community education campaign, including media advocacy, can raise awareness about a particular issue and pave the way for action. Like policy initiatives, this strategy reaches a large number of people.

- Tobacco, nutrition, family violence media campaigns.
- Partnering with businesses to get the message out.
- Social marketing campaigns.
- Promote community awareness of mental health issues.
- Promote food stamp program to seniors and working poor.

Educating Providers

This strategy reaches an influential group of individuals who have daily contact with large numbers of people at high risk for injury and disease. Educating professionals, para-professionals, peer mentors and community activists working in health and other community services can result in them becoming front-line advocates for prevention.

- New oral health paradigm.
- Training providers about family violence prevention.
- Case review efforts and associated recommendations.
- Car seat training.
- Primary prevention training.
- Develop and promote HSC Prevention Learning Circles.
- Educating about changes in the laws and regulations.

Fostering Coalitions and Networks

Working together, community organizations, policy makers, businesses, health providers and residents can form coalitions and networks in the community and lend powerful support to policy and other actions represented by the various bands of the Spectrum. Coalitions and networks also provide an opportunity for joint planning, system-wide problem solving and collaborative policy development. By developing efforts jointly, through coalitions and networks, programs share ownership, build skills and avoid duplication.

- Support coalitions and collaboratives to build capacity in outlying communities.
- Connect interventions for synergy.
- Form a suicide death review team.
- Support the Alcohol and Other Drug Death Review Team.

Changing Organizational Practices

By changing its own policies, an organization can affect the health and safety of its members and influence the community as a whole. It can also provide a role model for other agencies or policy makers.

- Focus on primary prevention efforts.
- Encourage communication between programs.
- Use a case review process to learn about system issues.
- Nurture the nurturers – support staff in their work.
- Move towards consultation versus intervention.
- Fluoride in water systems.

Mobilizing Communities

In the context of health services delivery or even public health, community mobilization is a relatively young concept. Traditionally, prevention activities have been performed in a medical-model manner, with the provider-expert as the center, providing services to individuals.

- Community networks.
- Family resource centers.

Influencing Policy and Legislation

Legislation and policy initiatives have proven to be the most effective strategy for achieving broad societal changes. Both formal and informal policies have the ability to affect large numbers of people by improving the environments in which they live and work and by encouraging them to change their behavior.

- Encourage the Board of Supervisors to continue their support of families and people.
- Support subsidies for poor families such as childcare, Earned Income Credit and others.
- Work toward developing living wage jobs and associated training programs.
- Promote harm reduction as well as abstinence.
- Work with state wide professional organizations to support prevention activities.

Recommendations

After a thoughtful review of the data, literature, and resources available for prevention, the members of the Consolidated Prevention Activities Team developed the following recommendations to begin the process of expanding and improving prevention services in Humboldt County. The first three broad recommendations are short term, "above the line" recommendations, followed by action steps. The fourth broad recommendation is a long term, "below the line" recommendation with guidelines focusing on new and expanded program development.

I. Changing Organizational Practices

1. Model prevention principles and goals within Human Services Cabinet departments and branches.
   - Apply principles of primary and secondary prevention in order to support staff.
   - Make organizational policies consistent with prevention goals (e.g. waste reduction, violence free policies, tobacco free policies).

2. Support staff through organizational changes.
   - Encourage staff involvement with the change process.
   - Assure effective communication.
   - Base changes on analysis and planning.
   - Support people through the change process.

3. Develop a "Learning Environment".
   - Encourage learning strategies regarding primary and secondary prevention activities.
   - Provide staff time for primary and secondary prevention education.
   - Encourage membership from all Human Services Cabinet branches and departments in learning about prevention.
   - Encourage questions and discussion about primary and secondary prevention practices within departments, branches and programs.
   - Encourage understanding "best practices" and research-based programming.

4. Provide cross branch training regarding prevention strategies.
   - Use media and social marketing.
   - Encourage leadership development.
   - Use the Spectrum of Prevention.

5. Look for change opportunities.
   - Include staff in defining strategies.
   - Develop strategic partnerships.
   - Exchange what assets we have for assets we need.

6. Enhance a climate of respect.
   - Encourage client/community assessment and evaluation of services.
   - Encourage staff assessment and evaluation of services.
   - Encourage a service environment that is friendly, warm and inviting.
   - Encourage a climate of cultural sensitivity.
   - Treat partners as equals.
   - Support and encourage leadership growth of staff and community partners.

7. Base program and fiscal changes on data, assessment and tracking.
   - When possible, all programs should develop outcome measures, linked to indicators.
   - When possible, develop a set of indicators across all ages.
   - Publish data and indicators at regular intervals (biannually); distribute to county staff and community. Work with similar projects e.g., Prop 10.

8. Continue to Support Employee Productivity/Wellness.
   - Advocate for health insurance plans that cover prevention services.
   - Work to assure safety standards for all employees.
   - Encourage policies that promote physical activity and good nutrition.
   - Continue the development of policies that limit employee exposure to tobacco smoke.
   - Work with the County Risk Manager and County Personnel Department to expand an Employee Productivity/Wellness Project.
   - Continue support of Employee Assistance Program assuring that it addresses alcohol and other drug issues.

II. Promote a Process to Sustain Effective Programs

1. Provide a process for sustainability.
   - Maintain current effective programs.
   - Following initial start-up grant funding, programs must be evaluated.
   - Cost-effective and valued programs should be sustained.

2. Strengthen connections to community activities.
   - Promote quality collaboration.
   - Build on what exists, use the "eyes and ears" in the community.
   - Encourage partnerships.
   - Empower community development.
   - Respond to early identification of risk situations.

3. Improve Assessment and Evaluation.
   - All new programs will be consistent with the Humans Service Cabinet Strategic Plan and the AB 1259 Plan.

- All new primary and secondary programs will be consistent with the Strategic Prevention Plan's goals.
- Evaluation is designed into program from the outset.
- Programs will be adjusted based on evaluation of effectiveness.
- Use community and client input as well as quantitative data.
- Select community bench marks and monitor effectiveness of overall community interventions.

4. Develop Case Review Strategy for Poor Outcomes.

- Departments and branches identify poor outcomes such as death/severe injury, or at risk for out of county placement.
- Conduct case review conference with involved parties on such cases for the purposes of:
  - Identifying system issues and responding with recommended changes.
  - Staff support and empowerment.
  - Encouraging a culture of problem solving.
  - Improved collaboration.
  - Understanding the impact of primary prevention and early intervention.
  - Assist in the development of primary and secondary prevention programs.
  - Assuring that poor outcomes are seen as opportunities to learn.

III. Promote primary and secondary prevention activities through program expansion.

1. Move down the prevention gradient from tertiary toward primary and secondary prevention.
   - Encourage programs to move funding from tertiary prevention towards primary and secondary prevention activities, when possible.
   - Use program resources to apply secondary prevention strategies such as serving siblings of clients.

2. Promote the Mental Health Recovery, Wellness, Discovery Movement.

3. Program expansion should address the same steps as new program development.

4. Develop a mechanism to surface new issues.
   - Based on local assessment of needs – quantitative and qualitative data.
   - Engage key stakeholders early.
   - Define the problem in understandable (non jargon) language.

Short Term Action Steps

From the recommendations above are short term action steps that can be implemented without significant additional resources.

- Identify community benchmarks to monitor the effectiveness of overall community interventions.

- Develop primary and secondary prevention learning strategies including HSC departments and branch staff, community members and consumers.

- Develop a quality assurance process that is based on:

  - Outcomes and not just process.

  - That includes HSC department and branch wide client and staff needs assessment and evaluation of services and service delivery.

- Work with the County Risk Manager and County Personnel Department to expand an employee productivity/wellness program.

- Develop a suicide death review team.

- Support Alcohol and Other Drug Death Review Team.

- Develop primary prevention training.

- Develop a case review process for poor outcomes.

- Include HSC Department and branch wide (as appropriate) primary prevention staff representation on primary and secondary prevention funding committees (e.g. Cal-Works Incentives Funding Committee).

IV. New Program Development

1. All new programs will include primary and/or secondary prevention services, when possible.

2. Funds to the extent they are available and meet the means test will be used to develop primary and secondary prevention programs.

3. The Human Services Cabinet will explore strategies for the use of funds to develop primary and secondary prevention programs.

Guidelines for New and Expanded Primary and Secondary Prevention Program Development:

1. The program shall developed through the Project Management Essentials team approach, when appropriate.
2. The program shall be related to at least one Strategic Prevention Plan goal.
3. The program shall be research based, based on best practices or be based on a strong theoretical foundation.
4. The program shall show a favorable cost benefit ratio.
5. The program shall put an emphasis on primary or secondary prevention.
6. The program shall have a clearly identified evaluation process with measurable outcomes.
7. The program shall be culturally competent.
8. The program shall address geographic diversity, if applicable.
9. The program shall identify stakeholders and a strategy to develop the collaborative process.

Appendix 1

Following is additional data relating to the Needs Assessment chapter. This additional data is organized in the same way as that of the Needs Assessment.

Overall Factors

Cultural disparities

Hispanics living in the United States are almost twice as likely to die from diabetes as are non- Hispanic whites. Hispanics also have a higher rate of high blood pressure and obesity than non-Hispanic whites. However, the rate of low birth weight infants is lower for the total Hispanic population compared with that of whites. [i]

American Indians have an infant death rate that is almost double that for whites. The rate of diabetes for this population group is more than twice that for whites. American Indians also have a disproportionately high death rate from unintentional injuries and suicides. [ii]

Poverty:

Local data shows that from December 2000-May 2001 there were an average of 59 requests for temporary housing assistance and 14 requests for permanent housing assistance from families with children. The average total approved was 25 for temporary and 8 for permanent housing assistance. Clients can receive assistance only once in a lifetime.[iii] These statistics show people are not keeping stable situations--they are repeatedly coming back and requesting temporary assistance. The impact on children of not having stable homes is tremendous.[iv]

According to Humboldt County's RAVEN project, it provides services to 700-1000 "street youth" per year. Some of these youth are local homeless youth, some just don't go home, even if they have a home, and others are just traveling through the area.[v]

In California, in 2000-01, 57% of pregnant women were Medi-Cal eligible.

Women are more likely than men to be in poverty as they grow older. Nationwide the percentage of elderly women in poverty is nearly twice as high as the percentage of elderly men. Divorced and never-married elderly women are at the greatest risk of poverty. [vi]

Pregnancy / Infancy

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Exposure to alcohol can result in Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Exposure to other drugs can result in the infant experiencing withdrawal, low birth weight, and problems such as hyperactivity. FAS and FAE may result in cognitive, speech and perceptual abnormalities later in life.[vii]

Recent information has shown that of new mothers who used tobacco in Humboldt County:[viii]

- 49 percent who had a history of being a domestic violence victim used tobacco versus 13 percent who did not use tobacco
- 70 percent who had a history of alcohol abuse used tobacco versus 12 percent who did not use tobacco
- 83 percent who had another child living outside the home used tobacco versus 15 percent who did not use tobacco
- 41 percent who had a psychiatric history documented in their medical chart used tobacco versus 15 percent who did not use tobacco

Prenatal Care:

Rates for entry into prenatal care for Asian, American Indian, and Hispanic women are worse than those of white women. These rates lag behind California as a whole and the national Year 2010 goal.[ix] Tobacco and other drug abuse, American Indian ethnicity or Spanish as primary language, and lack of resources have been identified as risk factors for late entry to prenatal care.[x]

Professionals working with pregnant women have found that intimate partner violence can result in a woman entering prenatal care late in the pregnancy, receiving sporadic care, or not seeking prenatal care at all.[xi] Other factors include lack of adequate transportation and support services in outlying areas, lack of affordable quality childcare, lack of knowledge about need for prenatal care, lack of support from male partners, and systemic problems that work against early identification of pregnancy.[xii]

Early Childhood—Ages 0-5

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Alcohol and other drug use is closely tied to child abuse and neglect, mental illness and depression, a history of being abused, (family/cultural history,) and social isolation.[xiii] Of the 279 clients currently in foster care in Humboldt County, approximately 37% have drug or alcohol use by caregivers as one of several contributing factors. Of these families, 33% also had mental illness as a contributing factor. 46 children in foster care were ages 0-5.[xiv]

Family Violence:

Abuse to pregnant women can affect the mother's health and the infant's weight at birth. One study, performed with women abused by their male intimate partner, found that infants gained weight more rapidly in situations where the abuse ended than in situations where it continued. Abuse ending by the infant's age of 6 months was a significant predictor of the rate of weight change from 6 to 12 months.[xv]

Childhood—Ages 6-12

Child Abuse and Neglect:

In the year 2000, 3,275 allegations of neglect and abuse were made in Humboldt County. Of these 12% were confirmed, 21% were inconclusive, 9% were considered unfounded, and 57% were "assessed only." [xvi]
In the years 1995-2000 an average of 239 children per year were in foster care. This number has slowly declined over the period. For the period July 1993 to November 1999 the number of children placed out-of–home (includes group home placements from Probation, Social Services, foster homes, and others) went from a high of 390 in early 1995 to a low of 240 in early 2000. [xvii]

A study of 95 children in grades K-2 showed that greater violence exposure was associated with emotional distress symptoms as reported by youth and their teachers.[xviii] Another study of children ages 1-15 whose parents were experiencing a high conflict divorce found that those who witnessed domestic violence and experienced child maltreatment experienced a powerful impact over time, which resulted in a steep increase in emotional distress symptoms.[xix]

Media Violence:

The more "real life" the violence portrayed the greater the likelihood that it will be "learned." Children learn that violence is an acceptable solution to resolving even complex problems, particularly if the aggressor is the hero. Media violence may make aggressive and antisocial behavior easier, numb viewers to future violence, and increase viewers' perceptions that they are living in a mean and dangerous world.[xx]

Besides increased violent behavior, excessive media exposure has been linked to obesity in children, decreased physical activity and fitness, increased cholesterol levels and sodium intake, repetitive strain injury (video computer games), insomnia, photic seizures, impaired school performance, increased sexual activity and use of tobacco and alcohol, decreased attention span, decreased family communication, desensitization, and excess consumer focus. Excess exposure to the Internet is feared by some to lead to "cyberspace seduction" of children by pedophiles.[xxi]

Mental Health in Childhood:

In addition, the monthly caseload of the Family Intervention Team (FIT) has been steadily rising. FIT is a formal collaboration between CWS, Mental Health, Probation and schools that coordinates/authorizes group home placements for children and monitors resources coordination for children who are either placed or being considered for out-of-county placement.[xxii]

Adolescence—Ages 13-21

Family and Dating Violence:

A recent study examined the association between having a history of dating violence and the sexual health of adolescent females. The prevalence of dating violence among adolescents ranges up to 39%. The affected girls were more likely to exhibit a spectrum of unhealthy sexual behaviors, attitudes, beliefs and norms that could lead to unintended pregnancy, STDs and HIV infection.[xxiii] The U.S. Justice Department states that women age 16 to 24 were the most vulnerable to non-fatal intimate violence at a rate of 15.6 victimizations per 1,000.[xxiv]

Mental Health Issues:

A 1992 California Mental Health Survey indicates serious mental health disorders in up to 7% of youth ages 0-17. 28,000 hospitalizations occur in California for mental health disorders among youth ages 10-19.

Nutrition and Physical Activity:

The California High School Fast Food Survey found that 71% of schools surveyed sold fast food items. These items accounted for up to 70% of all food sales at the school. At least 72% of the districts allow fast food and beverage advertising such as posters and other signs on campus.[xxv]

Adulthood—Ages 22-60

Alcohol, Methamphetamine, Heroin, Tobacco and Other Drug Use:

Pre-employment drug-screening data for the year 2000 shows that 45% of 1,043 people screened were negative for AOD; 30% were positive for marijuana, and approximately 25% were positive for methamphetamines only or in combination with other drugs. Post-accident (after an accident had occurred at work) drug screening data showed that about 80% were positive for methamphetamines only or in combination with other drugs, 10% were positive for marijuana and 10% were negative for AOD.[xxvi]

Participants at the Prosperity 2000: Leadership for the North Coast Economy conference identified drug use among employees as one of the major challenges to workforce development in the County. [xxvii]

Family Violence:

In 1992 and 1993 28% of female victims of homicide and 3% of male victims of homicide were killed by an intimate partner. Battered women who killed their batterers committed some of these homicides. The US Justice

Department states that women age 35 to 49 were the most vulnerable to murder by an intimate partner. Women separated from their husbands were victimized by an intimate partner at rates higher than married, divorced, widowed or never married women.[xxviii] In 1996 30% of all female murders were perpetrated by husbands, ex-husbands, or boyfriends. 3% of all male murder victims were killed by wives, ex-wives, or girlfriends. As a consequence of severe IPV female victims are more likely than male victims to need medical attention, take time off from work, spend more days in bed, and suffer more from chronic stress and depression. Non-lethal intimate violence results in financial losses to women victims that are conservatively estimated to be $150 million per year. Medical expenses accounted for at least 40% of these costs, property losses for another 44%, and lost pay for the remainder. [xxix]

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MENTAL HEALTH SERVICES ACT

HUMBOLDT COUNTY

Recommendations Submitted by Advisory Groups to MHSA Steering Committee

July 25, 2005

Table of Contents

Children and Youth Advisory Group

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	ONE (TIE)

Provocative Proposition (Describes Preferred Future)	Awareness, Outreach, and Access All children, youth, and families know *what* health and human services—including mental health services—are available, know *where* services are available, know *how* to access services and are able to receive them within their communities in a culturally respectful, safe, affordable, timely and user-friendly manner.

Recommendations: Awareness, Outreach, and Access	1. Outreach to children, youth, and families where they naturally congregate. 2. Provide services outside of the 9—5 workday. 3. Use technology to increase county-wide services. 4. Develop low-cost and free transportation options. 5. Focus on culturally-inclusive outreach.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Awareness, Outreach, and Access	1. Outreach to children, youth, and families where they naturally congregate. Systematically refit and upgrade family and parent outreach efforts and accessibility of children and youth mental health services to align with locations that children and youth gather and locations where families and parents are accustomed to seeing and accessing information. *"Go where the kids are."* Services and/or access to them need to be located where children and youth gather naturally. Natural contact points for this age group include schools, churches, family resource centers, after-school programs, daycare centers, non-profit youth organizations (for example, Boys and Girls Club). Utilization of these natural contact points would include all of the following: access to written literature, access to an informed peer, adult, para-professional, or professional. *"Go where the families and parents are."* Distribute written materials detailing what mental health services are available to children, youth, and families and how to access these services through "non-traditional" but high-traffic areas where people already are accustomed to seeing and accessing other forms of information related to children, youth and families. For example, post fliers or pamphlets at bookstores, coffee shops, restaurants, barbershops, doctor offices, laundromats, bars/nightclubs, the Bayshore Mall, break rooms at private employers, etc. Private businesses regularly are willing to post information or provide space for a stack of fliers related to "public benefit" causes, events, and awareness.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Awareness, Outreach, and Access (continued)	2. Provide services outside of the 9—5 workday. Increase mental health services available to children and youth during non-school hours. Increase evening and weekend services so children and youth do not have to miss classes to receive mental health services and increase parent involvement and participation in treatment due to not having to miss work. Increase options and incentives for line staff to flex their time toward non-9am – 5pm hours. Actively seek out and incorporate input from parents/caregivers related to available service times of mental health treatment and the impact on: 1) the child/youth school attendance, participation in social development and personal enrichment activities (for example, sports, church events, participation in after-school activities) and sharing in family activities; 2) the parent's/caregiver's ability to keep their job and manage appointments within the restrictions of personal leave as dictated by their employers. 3. Use technology to increase county-wide services. Make mental health services accessible in all geographic locations of Humboldt County. Specifically, services for children and youth must be available county-wide, beyond the Fortuna to Arcata, Highway 101 corridor. Increase services to remote areas of Humboldt County through the use of technology (for example, "tele-psychiatrists"). Technology would be used to extend services rather than replace in-person services. Use of technology in providing services would be part of a provider-guided service and treatment plan.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Awareness, Outreach, and Access (continued)	4. Develop low-cost and free transportation options. Provide children, youth, and their families and/or caregivers consistent access to low or no-cost transportation to and from mental health services. • Develop and adopt a county-wide transportation plan that addresses specific needs of children and youth. This plan would include an upfront "transportation needs" questionnaire to be completed by the children, youth and their parent and/or caregiver along with the appropriate caseworker or provider. • DHHS would consistently be "at the table" in regards to county-wide public transportation planning. • Specific no-cost or low-cost transportation resulting from this proposal would be based on individual client needs. Examples include free taxis, discounted bus fares, and public school bus lines. 5. Focus on culturally-inclusive outreach. Every culture has different ways it takes care of its health and human service needs of families and of children and youth specifically. The County Mental Health Department should seek to understand these natural, already-developed networks of care within the local Latino community, Native American community and Hmong community. Partnership within these networks must be established and maintained over time. Consistently, outreach efforts to the general populace must include specific outreach to the Latino, Native American and Hmong communities. Create and distribute informational literature in all locally-relevant, non-English languages (for example,Spanish and Hmong) Have each translation done by a local speaker of the language (as opposed to computer translation) in order to have culturally-relevant terminology and dialect. For all written materials—English and other languages, use terminology that is at the literacy level of the community. Review current materials for exceptions to this and make adjustments as necessary.

How Awareness, Outreach, and Access Relate to AB 1881 Strategic Plan	One of the goals of integrated services is to provide services "where clients and families are located." This proposition and the related recommendations provide direction as to how this goal can be accomplished.

Children and Youth Advisory Group (continued)

How Awareness, Outreach, and Access Relate to MHSA	One of the goals of MHSA is to "increase access to services." This proposition and the related recommendations provide specific suggestions about how to increase access to services. One of the goals of MHSA is to "enhance cultural sensitivity and competence." This proposal and related recommendations will assist in accomplishing this goal.

How Awareness, Outreach, and Access Relate to Community Input	"Availability and Access of Services" was the top prioritized theme in community meetings and the second prioritized theme for stakeholder meetings. Specific comments within these two sets of meetings include "mental health workers should go to youth—youth should not have to go to them," "make mental health services known outside the Eureka area," "provide services where the people are," "obvious access points… conveniently located," and "fast, easy, timely access to services and providers. Related comments found in the Survey themes included "improved accessibility of services… easier access process," "community-based services in outlying areas," and "assistance with unmet needs (childcare, transportation, etc)."

Children and Youth Advisory Group (continued)

Requirements for Successful Implementation of Awareness, Outreach, and Access	Important to successful implementation of *ALL* above recommendations (1-5): 1. Individual providers and/or case managers must continually remember that parents and families are "doing the best that they can do" in regards to attending sessions, implementing behavioral changes and communicating their needs and obstacles. Communications with parents and families regarding such issues as missed appointments and transportation challenges would go better if the provider and/or case worker comes from a place of "how can I work with you and how can I be of assistance in helping you overcome barriers." 2. A child or youth (and family) accessing services is highly dependent upon *already knowing* whom to contact (a safe and trusted person) before a need is present. 3. All efforts related to accessibility and outreach would include the differing perspectives of subsets of our local community: the Latino, Native American and Hmong communities, communities located in the remote areas of the county, and the gay, lesbian, bi-sexual, transgender community.

Existing Programs and Information to Leverage for Awareness, Outreach, and Access	• Family resource centers are natural partners in the implementation of recommendations 1—5. • Engage private businesses and non-profits in outreach and accessibility efforts (for example, Bayshore Mall, local restaurants).

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	ONE (TIE)

Provocative Proposition (Describes Preferred Future	Include Youth Voice A child or youth voice is always heard, encouraged and included in decisions regarding individual consumer services and the mental health system. Inclusion of children and youth creates an empowered individual and increases personal "stake" in any agreed-upon health and human services, including mental health services. Youth are treated as equal partners with provider(s) from the start of the relationship.

Recommendation: Include Youth Voice	Launch a system-wide initiative to include youth voice. Launch a short-term (1-2 year) initiative regarding upgrading and increasing the inclusion of the youth and TAY voice and involvement in DHHS—including the Mental Health Branch. Create sustainable practices for involving the youth and TAY voice in all DHHS committees and input processes that involve the public. Providers and administrators understand, appreciate and include youth and TAY as an integral, desirable component of mental health service program development and oversight. Key components of this recommendation include training for adults (for example, providers, parents, and caregivers) on how to incorporate youth voice in an age and developmentally-appropriate manner, and review and upgrade of the current norms in involving children and youth wishes in the development of treatment plans.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Include Youth Voice	1. Launch a system-wide initiative to include youth voice. Create an oversight committee that includes TAY to oversee this initiative. Full implementation of this recommendation would include all of the following: • Measurable objectives and goals for youth and TAY involvement on DHHS committees. • Creation of a pool of youth and TAY who are engaged, willing youth who are interested in mental health services. (Similar to Teen Court.) • Training for providers and parents or parental figures on best practices for increasing children and youth involvement in choosing (and therefore increasing their stake in following) treatment plans. • Development of recommendations of how to involve children and youth in an age-appropriate and developmentally-appropriate manner. • Development of recommendations for a child or youth role at team meetings. Meetings involving multiple adults focused on a child's or youth's mental health services would engage the child/youth as an active participant. Every effort would be made to take the fear out of these meetings s so the child or youth sees them as a positive component of their treatment. The child or youth would know what the meeting is for, what will be discussed, who will be at the meeting, what gets decided at and after the meeting and the process in which they will have input. • Development of a mentorship program that pairs young adults and TAY with children and youth.

How "Include Youth Voice" Relates to AB 1881 Strategic Plan	One of the goals of integrated services is to "see client, family, community, at center of the integrated system of care with holistic view of needs." This proposition and recommendation directly speaks to involving the child or youth client "at the center of the integrated system of care." One of the goals of integrated services is to "focus on positive outcomes." This proposition and recommendation, would create empowered youth clients—a definite positive outcome.

Children and Youth Advisory Group (continued)

How "Include Youth Voice" Relates to MHSA	Goals of MHSA are to "increase involvement of clients and families in community mental health system," "develop and/or enhance housing availability and reduce homelessness," and to "reduce involuntary care." Through implementing this proposition, youth will be more involved. Indirectly, through implementing this proposition, youth and TAY homelessness reduction will likely result, as will a reduction of youth and TAY involuntary care. (Due to the fact that involved youth = empowered youth who are more invested in positive results.

How "Include Youth Voice" Relates to Community Input	Top priorities among community and stakeholder meetings included "Collaboration and Coordination" and "Positive Provider/Consumer Relationship." Inclusion of the youth voice (the focus of this proposition) relates to both of these priorities. The comments "see client as a whole person… and treat them with respect and dignity," and "integrate resources and people through a team approach" are at the core of this proposition and recommendation.

Requirements for Successful Implementation of this Recommendation	1. It is essential that providers treat children and youth with respect and honor their involvement in the mental health systems development. 2. All involvement of children, youth, and TAY would be age and developmentally-appropriate. 3. Coordination with TAY is a requirement of this proposition. (See below.)

Children and Youth Advisory Group (continued)

Existing Programs and Information to Leverage "Involve Youth Voice"	This recommendation talks about a "youth voice, "yet the advisory group realizes that it is individuals who are young adults (or TAY) that likely would become more involved in committees of DHHS. Coordination between TAY-focused initiatives and children and youth-focused initiatives in this regard would make sense. Existing programs and people who have had success in incorporating the youth voice: • Teen court • Kelly Remington, College of the Redwoods • YES (Youth Education Services) at Humboldt State University (HSU) • HSU Service Learning Program

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	TWO (TIE)

Provocative Proposition (Describes Preferred Future)	Full Spectrum of Services A full range of options and choices are offered and in place in Humboldt County to meet the mental health needs of all the area's children, youth, and families. Full spectrum services include: 1) comprehensive, accurate assessment and diagnosis; 2) services for all ages and developmental stages of children, youth and their families; 3) a full range of prevention, early intervention, intervention and treatment, high-end services and follow-up services *within our community.*

Recommendations: Full Spectrum of Services	1. Develop local, high-end treatment options for children and youth. 2. Focus on Families. 3. Assure Accurate Diagnoses.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Full-Spectrum of Services	1. Develop local, high-end treatment options for children and youth. The current reality of sending children and youth out-of-county as a result of local gaps in high-end services would change. Develop housing and acute-care facilities (for example, short-term hospitalization) options that are supported by both public agencies private organizations for high-end children and youth. Develop local options for children and youth in need of: 1) substance abuse treatment; 2) treatment for severely and/or chronically ill children and youth; 3) treatment for children and youth with co-occurring issues; and 4) specialized housing and treatment for minor sex offenders. Development of local options for high-end needs children and youth is a large and multi-faceted task. The Children and Youth Advisory Group suggests the following recommendations be considered when developing local, high-end care: • Develop age-appropriate Alcoholics Anonymous and Narcotics Anonymous programs. • Travel to out-of-area facilities to learn and incorporate best-practices in new, local treatment facilities and services. • Work closely with the probation department and local adult facilities to best leverage funding and talents.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Full-Spectrum of Services (continued)	2. Focus on families. A significant component of developing true full-spectrum mental health services would be to incorporate and respond to the interwoven needs of families. A mapping and review of how county-wide mental health services currently respond to the needs of whole-family care would occur, with an additional, five-year implementation plan for increasing family-centered services. Opportunities and gaps identified in the mapping of family-focused services would be sorted into two categories—1) items for medium and long-term implementation and 2) "quick wins." Small changes that are not highly resource-dependant would be made to greatly increase the family-focus of existing services. Development of new and/or the leveraging of existing family-focused services would address the changing needs of families as children grow up. In other words, the needs of a family evolves as a child grows through the stages of 1) pre-natal, 2) infant, 3) pre-school age, 4) elementary-school age, 5) secondary school age, and 6) TAY. Development of a plan for better serving families is a large and multi-faceted task. The Children and Youth Advisory Group suggests the following recommendations be considered when strengthening services to families. • Families of children and youth receiving mental health services would also receive case management services as needed. • Mental health consultation would be available for staff (for example, childcare, home visitors) who could be part of the solution for prevention and early intervention for 0-5 age children. • Coordination and collaboration would occur between OBGYNs, pediatricians, family practice doctors for the prevention of and early treatment of post-partum depression. • Coordination and collaboration between schools, families, and family practice medical providers would occur for the prevention and early intervention of children and youth mental health and/or behavioral issues. • Coordination between youth-focused and TAY-focused programs would be effortless for the client and family as an individual moves from one age group to the next .

Children and Youth Advisory Group (continued)

Detailed Recommendations: Full-Spectrum of Services (continued)	2. Focus on families (continued) • Incorporate alternative treatment options for children, youth and their families. Personal enrichment and pro-social activities (for example, sports, music lessons, church activities, clubs, family outings) all assist in holistic wellness of the individual child/youth receiving services *and* strengthens the family. • Individuals working with a child or youth consumer would have some format for inquiring into the family's needs for ancillary services and a method for referral and follow-up. 3. Assure accurate diagnoses Accurate diagnoses of mental health issues and illness in children and youth are a complex issue. Additional resources (for example., time, money, training and staff) would be focused toward meticulous diagnoses for children and youth clients. Best practices for accurate diagnosis in children and youth would be studied and implemented. Routine inclusion of medical evaluations would be considered. An increase in second opinions and multi-disciplinary assessments and diagnoses would occur.

Children and Youth Advisory Group (continued)

How "Full Spectrum of Services" Relate to AB 1881 Strategic Plan	One of the goals of integrated services is to "commit to implementation and development of strength-based, recovery-oriented, client and stakeholder inclusive treatment, support and prevention system of care, responsive to emerging community needs, inclusive of evidence-based practice consistent with Humboldt County's diverse cultural, ethnic background and values." This proposition and its recommendations are well-aligned with this goal.

How "Full Spectrum of Services" Relate to MHSA	Implementation of this proposition and its recommendations support all seven of the stated goals of MHSA. We feel that this proposition is foundational in addressing all seven MHSA priorities.

How "Full Spectrum of Services" Relate to Community Input	Throughout the top-ranked priorities of community meetings, stakeholder meetings and the written survey results, the theme of Full- Spectrum Services was prominent. Specific comments about services delivered locally, accurate diagnosis and family-focused services were found throughout these three bodies of input.

Requirements for Successful Implementation of "Full Spectrum Services"	1. Inclusion of the child or youth voice in prescribing and modifying treatment plans is essential 2. A complete and updated listing and mapping of the "full spectrum" of treatment options and choices for children and youth. Identification of what already exists 3. An understanding of family needs when designing local, high-end services will be critical. Parents and TAY should be included in this process

Existing Programs and Information to Leverage for "Full Spectrum Services"	• There are steps that can be taken in broadening the range of treatment options that do not require funding. Making all line staff aware of existing treatments and new treatment options as they become available is a way to leverage what already exists. • Children and youth non-Mental Health Branch activities and programs (for example, Rotary, Humboldt Sponsors, Church camps/activities) can all be looked at for "alternative" treatment options.

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	TWO (TIE)

Provocative Proposition (Describes Preferred Future)	Parent Support Parents and caregivers of children feel supported and guided by someone they feel comfortable with and can relate to in order to become more able to make informed choices about: 1) mental health services for their children and youth; 2) how to access and interface with other services and agencies; and 3) parent support, services and parenting skills information and education. Families are equal partners with the provider(s) from the start of relationships.

Recommendation: Parent Support	Launch a parent-focused support program. Create a parent and caregiver-focused support program. When implemented, this program would include the following key components: • *NAVIGATOR FOCUSED ON FAMILIES. De*velop a navigator program specifically to work with parents of children/youth who will be or are receiving mental health services. • *PARENT-TO-PARENT SUPPORT*. Develop sustainable parent-to-parent support that includes a Parent Partner Program, Parent Support Groups, and a 24/7 warm-line for parents.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Parent Support	Launch a parent-focused support program. The parent and/or caregiver support program would include all of the following specifics: • An advisory group of parents and caregivers that helps the DHHS develop and implement the navigator program and parent support programs. • Frequent opportunities for individual parents and caregivers to give input and feedback on services for their child or youth. • A "menu" or "multiple paths" approach to services that would allow parents to choose (with the provider) an appropriate course of treatment and services for their child or youth. • Coordination with other health and human services such that the navigator can easily make referrals and assist families in a holistic way. • A defined process (including outreach and recruitment) for training and enabling parents and caregivers to become peer-supports, para-professional supporters to other parents and families. • A 24/7 warm-line for parents and families that provides assistance for low and high-end need situations.

How "Parent Support" Relates to AB 1881 Strategic Plan	One of the goals of integrated services is to "see client, family, community, at center of integrated system of care with holistic view of needs." This proposition and recommendation are aligned with this goal.

How "Parent Support" Relates to MHSA	One of the goals of MHSA is to increase access to services. This proposition and recommendation would increase access to services for both parents and their families. One of the goals of MHSA is to "increase involvement of clients and families in community mental health system. This proposition and recommendation would greatly increase parental involvement in the mental health system.

Children and Youth Advisory Group (continued)

How "Parent Support" Relates to Community Input	Both the community and stakeholder meeting priorities included increased assistance focused on parents and families. Parental/family needs showed up under multiple headings: "Availability and Access to Services, "Outreach," "Full-Spectrum Services," and "Collaboration and Coordination." Emphasis on parental and family involvement cross-theme was pervasive, and shown in comments such as "establish a liaison or navigator to help families through the system from the beginning," a need for "parent services (e.g. support groups)," and "services for family members."

Requirements for Successful Implementation of "Parent Support"	1. Individual providers and/or case managers would continually remember that parents and families are doing the best that they can do in regards to attending sessions, implementing behavioral changes and communicating their needs and obstacles. Communications with parents and families regarding such issues as missed appointments, transportation challenges, would go well if the provider/case worker came from a place of "how can I work with you and how can I be of assistance in helping you overcome barriers." 2. A child or youth (and family) accessing services is highly dependent upon *already knowing* whom to contact (safe and trusted person) before a need is present. 3. All efforts related to accessibility and outreach includes the differing perspectives of subsets of our local community: the Latino, Native American and Hmong communities, communities located in the remote areas of the county, and the gay, lesbian, bi-sexual, transgender communities.

Existing Programs and Information to Leverage	Parental support systems and programs that already exist should be looked at for examples and best practices. In particular, the following program may be of interest: • NAMI Family-to-Family program(s) • Redwood Coast Resource Center, Family Resource Center for Families of Children with Special Needs • Assorted programs of family resource centers.

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	TWO (TIE)

Provocative Proposition (Describes Preferred Future)	Public Awareness and Professional Alignment A child or youth (and their family) will be able to say to their friend, co-worker, boss, neighbor or other, that they are getting mental health treatment, and it would be as much of a non-issue as saying that they were taking piano lessons. The terms "mental health" and "mental illness" no longer make people nervous when mentioned in conversation. The mystery surrounding mental health services, in particular those offered by the Mental Health Branch, has all but vanished, resulting in organizations formerly serving as "watch dogs" of DHHS efforts now being able to refocus energy on collaborative efforts within DHHS and the Mental Health Branch. Acceptance of services aimed at prevention and intervention of mental illness is similar to society' acceptance of weight loss programs and treatments for medical diseases.

Recommendation: Public Awareness and Professional Alignment	Develop public awareness and professional alignment. Develop a two-part education and awareness program that aims to de-stigmatize mental health issues. • An intra-system communications effort would bring DHHS providers, organizational providers, and private providers together around the shared concern of public mental health perceptions. • A public awareness campaign would involve the Mental Health Branch, organizational providers and private providers. The public awareness campaign would include "boilerplate" information that was created by the DHHS and used by all providers throughout the region's extended mental health system. Two goals of this recommendation are 1) to increase the level of interest in and discussion about mental health issues within the public; and 2) to engage all mental health providers (DHHS and others) in a common effort that will positively impact all involved.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Public Awareness and Professional Alignment	Develop public awareness and professional alignment. 1. Create a cross-agency, cross-provider task force that identifies key pieces of the message and story to be told. 2. Hold focus groups (including ones in the Latino and Native American communities) to find out more about what creates the current stigma surrounding mental illness. 3. Hold an event for local and state decision-makers that kicks off the public awareness effort. 4. Hire a public relations firm to develop the key message and story into a communications "package" that includes: • 1-page facts sheet—that can be used as talking points for all involved in mental health issues and policy makers. • Public service announcements for television and radio. • Boilerplate information and images that can be used in individual providers' collateral and outreach efforts. This information would be available on-line through password access.

Children and Youth Advisory Group (continued)

How "Public Awareness and Professional Alignment" Relate to AB 1881 Strategic Plan	One of the goals of integrated services is to "create public education and outreach efforts." This proposition and recommendation provides direction as to how to accomplish this goal. One of the goals of integrated services is to "develop cultural and client diversity capacity." This proposition and recommendation, if implemented, will assist in meeting this goal.

How "Public Awareness and Professional Alignment" Relate to MHSA	One of the goals of MHSA is to "increase involvement of clients and families in community mental health system." If clients and families have greater awareness of mental health issues, and the stigma has subsided, greater involvement will result.

How "Public Awareness and Professional Alignment" Relate to Community Input	"Training and Education" was ranked third in the summary of prioritized themes in the community meetings and also the stakeholder meetings. A specific comment under this theme was for the community to have "greater understanding of what mental health means." "Community Characteristics" was the top ranked theme in Surveys. Specific comments under this theme included "less stigma attached to mental illness/addictions," and "community showing care and concern for people" (with mental health issues).

Requirements for Successful Implementation of "Public Awareness and Professional Alignment"	1. Involvement of a true cross-section of mental health stakeholders in message/story development. 2. Education of the media to have them "on board" with this issue. 3. Public awareness and educational efforts that represent the cultural diversity of our area.

Existing Programs and Information to Leverage for "Public Awareness and Professional Alignment"	• Leverage existing resources and materials that are available through national and state public awareness campaigns.

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	THREE

Provocative Proposition (Describes Preferred Future)	Quality Data Quality data is an essential component of the change effort in county-wide mental health services. It supports individual choice, program decisions, needs identification, quality assurance and coordination of services.

Recommendations: Quality Data	1. Create a database and delivery system. Create a coordinated, county-wide system including DHHS, nonprofit agencies, and schools to compile meaningful, unduplicated statistics based on a predetermined set of data elements to better analyze services and gaps in services that are delivered to children and youth in Humboldt County. 2. Create an evaluation and feedback system. Create a two-part evaluation and feedback system that would improve the quality of individual client services and the entire mental health system.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Quality Data	1. Create a database and delivery system. Because of the critical importance of up-front buy-in and agreement of objectives from *all involved partners,* a comprehensive Needs Assessment and Participant Charter would be created and implemented at the beginning of such an effort. When implemented, the combination of a needs assessment and charter would align all partners on the structure, language and terminology definitions, funding, processes for updates, processes for the review of data, the decision making process across agencies, and the flow chart for dealing with problems. The database and delivery system would include all of the following specifics: • Adoption of agreed upon definitions of terms and definitions of data elements up front (i.e., everyone would agree upon what a *referral* is, what a *case* is, what a *contact* is). • Up-front agreement on structure, language, funding, processes for updates, processes for review, the charter for participating members, the decision making process, ways to handle problems • Inclusion of and access to data and statistics on fee-for-service (private) providers • A user-friendly, central database would be available on-line and in print. • DHHS and Mental Health Branch Department Managers would have regularly-scheduled meetings to discuss data and processes. Analysts would have regularly-scheduled meetings to discuss data and processes. Information technicians would meet regularly to discuss access to each others' data for collection purposes.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Quality Data (continued)	2. Create an evaluation and feedback system. Create a two-part evaluation and feedback system that would improve the quality of individual client services and the entire mental health system. This would include: • *CLIENT FEEDBACK*. The feedback system would allow all consumers to give feedback to providers in a usable format. • *SYSTEM EVALUATION*. On a regular basis, line staff, administrators, contract providers and key community stakeholders would evaluate the DHHS Mental Health system. The evaluation and feedback system would include all of the following specifics: • All consumers participating in DHHS, private, and nonprofit mental health programs would have the ability to provide feedback about their experiences. • Consumers would have a choice as to whether the feedback is confidential not. • Feedback from consumers would be gathered at periodic intervals over the duration of services, as well as at end of service. • Feedback would be shared with the individual providers of services, as well as with administrators of the evaluated programs. • Processes for reviewing and implementing changes from feedback would be created. • Outcome measurements would be defined so that all providers would measure outcomes in the same manner.

Children and Youth Advisory Group (continued)

How "Quality Data" Relates to AB 1881 Strategic Plan	Goals of integrated services include to "integrate administrative functions of Public Health, Social Services and Mental Health," and to "focus on positive outcomes." This proposition and its recommendations support attainment of these goals.

How "Quality Data" Relates to MHSA	Establishing a database and delivery system and establishing a client and services feedback loop are foundational in achieving *all* of the stated MHSA goals.

How "Quality Data" Relates to Community Input	"Collaboration and Coordination" ranked highly in the prioritized themes of both the community meetings and stakeholder meetings. A database and evaluative process are essential to collaborative efforts. The theme of Provider and Consumer relationships was among the top prioritized themes of the stakeholder meetings. An evaluation and feedback process would support quality provider and consumer relationships.

Requirements for Successful Implementation of "Quality Data"	1. Active solicitation of feedback from clients. 2. Organizational providers, fee-for-service providers, schools, probation and other stakeholder involvement in planning so that they have compatible software. 3. Current, relevant and usable data. 4. Funding for both initial effort and long-term maintenance.

Existing Programs and Information to Leverage for "Quality Data"	• Search out existing software and databases that have been used in other communities for multi-agency data sharing of this nature. • Sustain and build upon existing Humboldt Community Switchboard information and referral database and delivery system.

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	SEVEN

Provocative Proposition (Describes Preferred Future)	Education and Training On-going education, training and support are essential components in changing local mental health service delivery, understanding and responding to consumer needs, and positively impacting community perceptions of mental health illness and mental health issues.

Recommendation: Education and Training	Create a DHHS Education and Training Unit and Strategy. Create a sustainable, comprehensive education and training unit within DHHS that is charged with meeting the on-going and evolving training and educational needs of 1) Mental Health Branch providers; 2) organizational providers; and 3) the other key community stakeholders involved in developing and maintaining a high-functioning mental health system in Humboldt County (for example, school and educational partners, probation, medical providers, and private providers Create a county-wide mental health education and training strategy and five-year plan that details training and education objectives for 1) Mental Health Branch providers; 2) organizational providers; and 3) other key community stakeholders—including, but not limited to school and educational partners, probation, medical providers, childcare providers, and private providers.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Education and Training	Create a DHHS Education and Training Unit and Strategy. Training and educational efforts supported by Mental Health Branch staff and detailed in a strategic plan would focus on the following: • Preventative education for children and youth • Education for mental health care providers (for example, front line staff) • Education for medical health care providers • Education for other individuals who regularly work with children and youth (for example, probation, educators, and childcare providers) • Education for parents and caregivers of children and youth Listed below are areas where there is either a significant lack of education or the need far outweighs what is currently available. The areas are grouped by the target audiences. The lists are not exhaustive. 1. Training, Education and Support for Children and Youth: • Education regarding gender and sexual orientation • Peer-to-peer support and training • Suicide prevention • Mental health education in schools, similar to sex education • Life skills education in schools, similar to the ILS training for foster youth • Regular and casual peer education and support where youth hang out • Anonymous question boxes at locations where youth hang out. 2. Training, education, support for mental health providers: • On-going training for the critical initial contact person(s)and caseworkers at the Mental Health Branch, and at other organizational providers that consumers first encounter. • Peer-support groups for providers • Annual updates on the implementation of MHSA and 1881 initiatives • Repeated trainings due to staff turn-over and the inability of agencies and providers to send all staff members at the same time • To enhance prevention and early intervention, ensure line staff understands the community and cultural contexts.

Children and Youth Advisory Group (continued)

Detailed Recommendation: Education and Training (continued)	3. Training, education, and support for medical providers: • Training for pediatric primary care providers and OBGYN providers in post-partum depression (PPD), screening for PPD and referral resources that can be made available to new moms and families • Offer training for medical professionals in how to use mental health consultation. 4. Training, education, support for parents and caregivers: • Adults in how to determine appropriate involvement of children and youth in determining their treatment plans • Involve TAY in sharing their experiences with parents and caregivers of youth and children • Include training on identifying post-partum depression for new moms and dads 5. Training, education and support for other stakeholders: • Train probation staff, school staff and teachers, recreational staff, law enforcement, and childcare workers on how to appropriately document children and youth behaviors for mental health providers.

How Education and Training Relate to AB 1881 Strategic Plan	Establishing a DHHS department, position, and plan dedicated to the training and educational needs of clients, providers, community partners and stakeholders is a foundational element for achieving *all* 1881 stated commitments and goals.

How Education and Training Relate to MHSA	Establishing a DHHS department, position, and plan dedicated to training and educational needs of clients, providers, community partners and stakeholders is a foundational element for achieving *all* MHSA goals.

How Education and Training Relate to Community Input	Training and Education were among the top-ranked themes in both community meetings and stakeholder meetings. Specific comments in both groups talked about training for mental health staff, teachers, law enforcement, clients, and families.

Children and Youth Advisory Group (continued)

Requirements for Successful Implementation of Education and Training	1. Successful training and education efforts would involve the appropriate staff and community members from the Mental Health Branch and all other stakeholder groups. The DHHS Training and Education Unit would "lead the charge" but involve organizational providers, local non-profits, schools, medical professionals, probation and others in the following: 1) coordination of training/education; 2) development of curriculum; 3) delivery of curriculum; 4) after-training support. 2. On-line, web-based training modules to support the use of education beyond the initial training. 3. Release time and/or stipends for Mental Health Branch, medical, non-profit, and probation staff and others that receive training that is built into their duties, rather than added on top of their responsibilities. 4. On-going funding to sustain a DHHS Training and Education Unit. 5. Carefully considered language and cultural considerations for all training and education efforts. 6. Post-curriculum implementation support and clearly communicated expectations regarding training usage for those receiving education. 7. Regularly updated training and education programs. 8. Well-qualified trainers with local experience who are currently practicing in the discipline they are teaching, 9. Agreement of terminology across disciplines

Children and Youth Advisory Group (continued)

Existing Programs and Information to Leverage for Education and Training	• Suicide prevention training has occurred in some schools for staff and/or youth. • Faith-based initiatives should be explored. • Build on the previous model of the Healthy Families Collaborative (sponsored by Public Health for home visitors). • Use family resource centers to leverage decentralized training. • DHHS Training and Education Unit may tie in to the Office of Cultural Diversity currently being created. • Use or modify existing Best Practices training, education and curriculum that has been developed and tested in other areas outside of Humboldt County. • Re-examine character education from 30 years ago as it relates to Life Skills training in schools.

Children and Youth Advisory Group (continued)

Total Number of Recommendations Made by Children and Youth Advisory Group	EIGHT	**Priority Number of this Recommendation**	EIGHT

Provocative Proposition (Describes Preferred Future)	Collaboration Children, youth, and families are supported holistically with fluid communication, collaboration, and coordination between partners.

Recommendation: Collaboration	Focus on three levels of collaboration. In order to truly meet the mental health needs of our community's children, youth and families, develop three types of collaboration:: 1. LEVEL 1: Between adult-focused providers and system and child/youth–focused providers and system 2. LEVEL 2: Between agencies and providers focused on child/youth consumers 3. LEVEL 3: Between persons delivering services to an individual child or youth and their family (Individual Client Focused). For each of these three intersections of people and processes, the Mental Health Branch would lead a cross-partner, cross-agency effort of mapping and upgrading communication, collaboration and coordination. Implementation of this recommendation would provide an integrated family-unit approach to services.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Collaboration	1. Build collaboration between adult-focused and child/youth-focused providers and systems. Coordination between adult-focused and child and youth-focused providers and systems would be broad-based. There would be many opportunities to leverage resources, cross-train employees and upgrade referral mechanisms between these two systems of services. Collaboration between these two groupings would likely take a long time. Our group provides the following two suggestions as a starting point for this process. • Map the current, separate delivery systems of adult-focused and youth-focused services, with attention paid for natural overlaps and connection points between the two delivery systems. • Create a committee of front-line providers to look for and act upon low-risk, low-cost collaboration opportunities. Other assorted, specific recommendations that fall under the larger proposal related to adult and youth collaboration include the following: • When adults begin receipt of mental health services, they would be asked about the presence of children and youth in the home and if these children and youth are in need of assistance. Children and youth needs would be referred and followed up on by appropriate provider(s) • Increased coordination and collaboration with OBGYNs, pediatricians, and family practice doctors for prevention of and early treatment of post-partum depression. • Child Death Review Team for suicides would be expanded to include youth and TAY up through age 21. • More solutions would be sought in how to best utilize funds in a world of "parent as client" and "child as client" as opposed to "family as client" • In existing meetings that are focused on either children and youth services or adult services, all participating individuals would be treated with respect and seen as true partners in the larger goals. • Create crisis response teams that would have the authority and knowledge to work with whole families' needs.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Collaboration (continued)	2. Build collaboration between programs and providers focused on children and youth services. Collaboration between children and youth-focused providers and systems exists and would be built upon. There would be many opportunities to leverage resources, cross-train employees and upgrade referral mechanisms between the Mental Health Branch, non-profit providers and fee-for-service providers of children and youth mental health services. Collaboration, cooperation and coordination would be an ongoing, long-term objective for all stakeholders focused on mental health services for children and youth. The following three suggestions would be essential "next steps" for collaboration among this group: • Create and maintain a matrix of all providers' (for example, DHHS, non-profit, and private) children and youth services, ages served, and geographic emphasis. This information would be gathered and periodically updated. Information would be categorized and made available to provider organizations and individuals administering services, and the community. • Create an on-going advisory group of DHHS providers, organizational providers, private providers and children and youth clients and/or their parents and families to continue leveraging ideas generated out of the MHSA Children and Youth Advisory Committee. • Establish a Mental Health Liaison who would make a focused effort to outreach and involve representatives from ages 0-5, acknowledging the role that these representatives play in preventing mental illness in children and youth.

Children and Youth Advisory Group (continued)

Detailed Recommendations: Collaboration (continued)	3. Build collaboration between persons delivering services to individual children and youth clients. The current use of teams in delivering mental health services to children and youth would be built upon in a manner that contributes to the efficiency and effectiveness of individual client treatment. Increased collaboration among team members would include the following components: • Teams would have the ability to resolve or respond to any conflicting mandates or advice that a children and youth (and their family) receive. • Children and youth participation (voice) on the team would be systematically included and upgraded. • The team model would evolve to include identification of additional resources that an individual children and youth (and their family) doesn't know about or know how to access. • Develop a mechanism that would allow non-traditional adult participants that the child/youth trusts to be included on the team (for example, a pastor, coach, or parental figure who is not a relative) • Use of teams would be used as appropriate throughout the continuum of treatment-not just in the beginning. • Development of a communication "tree" for each client at the beginning of treatment would help solve family problems/issues as they come up during treatment. All involved parties would receive notification and respond to support the child or youth and his or her family (for example, knowing that a child involved in Child Welfare Services had a family member enter alcohol or drug rehabilitation or jail would help to better assist the overall needs of the family unit).

Requirements for Successful Implementation of this Recommendation	1. Collaborative efforts at the line-staff level would require support from the top of all organizations and agencies involved. 2. Communication, collaboration, and coordination take time and money. Adequate financial support would be necessary for all involved parties. 3. There are many aspects of a "team approach" to treatment that would need further clarification. 4. Facilitation of meetings by a neutral party may help collaboration and coordination efforts move forward more efficiently than if facilitated by someone who is from a participating agency.

Children and Youth Advisory Group (continued)

How Collaboration Relates to AB 1881 Strategic Plan	One of the goals of integrated services is to "integrate administrative functions of Public Health, Social Services and Mental Health." This proposition and its recommendations directly align with this goal.

How Collaboration Relates to MHSA	Implementation of this proposition and its recommendations support all seven of the stated goals of MHSA. This proposition is foundational in addressing all seven MHSA priorities.

How Collaboration Relates to Community Input	Collaboration and Coordination" was the top prioritized theme among stakeholder meetings, and among the top themes from community meetings. Top themes from survey results all have elements of collaboration and coordination incorporated.

Existing Programs and Information to Leverage for Collaboration	• Use existing data in compiling a provider matrix and list (for example, North Coast Association of Mental Health Practitioners directory and member list and the Humboldt Community Switchboard data) • Learn from Healthy Moms Program. • Take notice of Humboldt Network (Net) meetings when planning any inter-organizational meetings focused on sharing information and collaboration. • Consider other models (for example, Family unity model, WRAP model, Family-to-Family model, Family resource centers). • Use existing child death review team process (for example, bylaws, members, and staff coordination) to expand suicide and violent death review of TAY through 21 years of age.

Transition Age Youth Advisory Group

Total Number of Recommendations Made by TAY Advisory Group	FOUR	**Priority Number of This Recommendation**	ONE

Provocative Proposition (Describes Preferred Future)	Transition Age Youth Involvement The participation of TAY (Transition Age Youth = ages 16 to 25) in all aspects of Mental Health services and education give youth the ability contribute to increasing culturally sensitive, preventive mental health care in all areas of Humboldt County. Due to TAY involvement, services are timely and effective, especially in early intervention and prevention, resulting in the inclusion of family, permanent relational connections, friends, and community. Such involvement and impact contributes to the stabilization and recovery of TAY clients.

Recommendation: TAY Involvement	Create a TAY Task Force focused on outreach, prevention, and intervention.

Detailed Recommendation: TAY Involvement	Create a TAY Task Force focused on outreach, prevention, and intervention. • A TAY Task Force would focus on outreach, prevention and intervention, empower youth to make changes in their communities, increase youths' self esteem through opportunities to speak out and share ideas, and provide outreach services to a variety of agencies. • A TAY Training Team would provide education, cross-training, and mental health awareness and de-stigmatization training for the public. • A mentoring program using older TAY who have experienced the DHHS system would provide one-on-one support and navigation for younger TAY. • TAY would be involved as members of mobile outreach teams, in employment supports, and in mental health services locations.

Transition Age Youth Advisory Group (continued)

How TAY Involvement Relates to AB 1881 Strategic Plan	A goal of the AB 1881 Strategic Plan is to increase consumer and community stakeholder involvement, and to increase individual and family recovery and self-sufficiency. This proposition directly involves TAY in collaboration with the Mental Health Branch to provide education, treatment and recovery services to the entire community.

Transition Age Youth Advisory Group (continued)

Total Number of Recommendations Made by TAY Advisory Group	FOUR	**Priority Number of This Recommendation**	TWO

Provocative Proposition (Describes Preferred Future)	Transition Support Transition into adulthood is made easier for TAY (Transition Age Youth = ages 16 to 25) due to the provision of culturally sensitive, independent living skills and services that prevent the need for mental health crisis services, homelessness, drug and alcohol dependence, and unnecessary interaction with the judicial system.

Recommendation: Transition Support	Provide support for TAY to transition into adulthood through building relationships, life skills, and other supports.

Detailed Recommendation: Transition Support	Transition support provided by TAY, support staff from DHHS branches, from naturally-occurring community agencies and systems would assist TAY consumers in identifying important personal relationships, developing life skills, and connecting with culturally appropriate community resources. • Life skills may include: housing search and access, college preparation, job search and preparation, apprenticeships, job shadowing, use of public transportation, social skills, healthy coping skills, banking and money management, and acquiring documentation such as a driver's license, social security card, birth certificate, or school transcripts. • Resources may be agencies, mentors (TAY navigators), case managers, parents, friends, peers, medical services, substance abuse treatment services, traditional and non-traditional practitioners. • Other supports may include subsidized housing, transportation, bus and gas vouchers, clothing and household items. • A co-occurring, voluntary, residential, treatment facility for TAY.

Transition Age Youth Advisory Group (continued)

How Transition Support Relates to AB 1881 Strategic Plan	This proposition and recommendation addresses the need to decentralize services and develop community partnerships in an effort to prevent acute mental illness episodes, homelessness, unemployment, incarceration, and substance abuse among TAY consumers.

Transition Age Youth Advisory Group (continued)

Total Number of Recommendations Made by TAY Advisory Group	FOUR	**Priority Number of This Recommendation**	THREE

Provocative Proposition (Describes Preferred Future)	Education and Training A customer-driven Office of Mental Health Education, Training and Prevention has been created with staff solely devoted to providing culturally-competent education and training for the public, relevant professionals, and TAY (Transition Age Youth = ages 16 to 25) with mental health issues and their families. This office has decreased the stigma of mental illness and increased the public's skills, understanding, awareness and capabilities of dealing with mental health issues and co-occurring disorders as they affect TAY.

Recommendation: Education and Training	1. Develop a training program for professionals. 2. Develop an educational program for public. 3. Develop a program for consumers that includes peer-support groups for TAY. 4. Develop a program for families. 5. Develop a navigation system.

Transition Age Youth Advisory Group (continued)

Detailed Recommendation: Education and Training	1. Develop a training program for professionals. The Mental Health Branch would identify or develop a culturally-competent program that would train law enforcement, educators, medical staff, and other professionals to readily screen, identify and refer TAY with possible mental health issues to appropriate private, non-profit, and public resources. 2. Develop an education program for the public. Identify or develop a culturally competent public information and social marketing program for the community in general and for school campuses. Conduct a campaign to increase understanding and acceptance of people with mental health issues. 3. Develop a program for consumers that includes peer-support groups for TAY. The Mental Health Branch would identify or develop a culturally competent program that would include peer support groups to help TAY with mental health issues understand their own mental health challenges and recovery opportunities. 4. Develop a program for families. The Mental Health Branch would identify or develop a culturally-competent program to help families understand mental disorders, medication options, alternative therapies, treatment options, the mental health system, the judicial system, and how to access all the available services and resources—including private, non-profit and public. 5. Develop a navigation system. The Mental Health Branch would identify or develop a culturally competent, easily accessible resource and referral system for TAY, families, professionals, and the public. The resource and referral system would use webs sites with links to services, handbooks, brochures, videos, and trainings. This navigation and information system would include practical and easily accessible information on all mental health and related services and systems.

Transition Age Youth Advisory Group (continued)

How Education and Training Relate to AB 1881 Strategic Plan	This proposition and recommendation relates to the strategic plan that addresses the need for public education, and provides support and information to TAY consumers, families, support systems, and community providers.

Transition Age Youth Advisory Group (continued)

Total Number of Recommendations Made by TAY Advisory Group	FOUR	**Priority Number of This Recommendation**	FOUR

Provocative Proposition (Describes Preferred Future)	Outreach and Access Increased access for mental health services for TAY (Transition Age Youth = ages 16 to 25) and their families are available throughout the county in a variety of ways, providing culturally-competent, easily-available support that increases stability, recovery and healthy integration into the Humboldt County communities.

Recommendation: Outreach and Access	1. Create a Mobile Service, Consultation, and Resource Team. 2. Establish Mental Health Annexes in Outlying Areas. 3. Create a Mobile Crisis Team.

Transition Age Youth Advisory Group (continued)

Detailed Recommendation: Outreach and Access	1. Create a Mobile Service, Consultation, and Resource Team. This Mental Health Branch mobile team would include a doctor, registered nurse, clinician, case manager and TAY expert advisor to provide services, consultation and additional resources to outlying areas on a weekly basis. The mobile team would utilize existing community facilities such as clinics, schools, churches, and community centers. 2. Establish Mental Health Annexes in Outlying Areas. Mental Health Annexes would be located in outlying areas (e.g. Orick, Orleans, Weitchpec, Garberville, and Fortuna) and would be staffed several days a week by a psychiatrist, registered nurse, case manager, clinician, and a TAY expert advisor. The Mental Health Annexes would partner with existing clinics, Family Service Centers, and Family Resource Centers to share facilities. 3. Create a Mobile Crisis Team. The Mobile Crisis Team would include members from Psychiatric Services, Same Day Services, as well as a doctor, registered nurse and/or clinician, with optional police officer support. The team would be on-call to respond to crises in emergency rooms, schools, clinics, police stations, and in the community at-large.

How Outreach and Access Relate to AB 1881 Strategic Plan	This proposition would provide decentralized services to all outlying areas of the community, strengthening the partnership between county services and community-based organizations.

Adult Advisory Group

Total Number of Recommendations Made by Adult Advisory Group	FOUR	**Priority Number of This Recommendation**	ONE

Provocative Proposition (Describes Preferred Future)	Access Humboldt County Department of Health and Human Services (DHHS) is a flexible system with multiple portals. Clients enter the system through satellite offices in outlying areas, through the attractive and functional primary facility in Eureka, through offices of community providers, or through intervention by mobile crisis teams. There is no wrong door. The client goes one place and tells their story one time. Services are accessible on demand and available in the client's native language. All providers use a uniform assessment tool and all information is available to everyone involved in the care of the client. The client is automatically screened for all services based on this tool. Client information is readily available to all agencies involved in client care, including community-based organizations. Culturally competent services are provided to all clients regardless of race or ethnicity, social class or sexual orientation. DHHS takes the lead in encouraging human rights issues to be addressed. All providers have programs to encourage cultural diversity. DHHS offers training to employees and other service providers in the philosophy and practice of harm reduction. Harm reduction is a principle advocated and implemented as an initial first step throughout the community, including DHHS. Clients can call for help without fear. A crisis response team is available to respond to calls for help initiated by clients, local law enforcement or other providers.

Adult Advisory Group (continued)

Recommendation: Access	The Department of Health and Human Services (DHHS) would work closely with community providers to improve the access and availability of mental health services to residents of Humboldt County by accomplishing the following: 1. Moderate and remove operational barriers 2. Assist clients in identifying and receiving services 3. Provide respectful engagement of the whole person 4. Emphasize recovery and wellness.

Adult Advisory Group (continued)

Detailed Recommendation: Access	The Department of Health and Human Services (DHHS) would work closely with community providers to improve the access and availability of mental health services to residents of Humboldt County by accomplishing the following: 1. Moderate and remove operational barriers to access. • Decentralize access points into the system • Develop a database system to share records and client information between DHHS and community providers • Create and use a uniform assessment tool that encompasses all services needed by clients such as shelter, food, substance abuse counseling, mental health services, health care, etc. • Implement a cooperative agreement allowing single-entry access throughout the county from multiple entry points, including community providers • Create a psychiatric emergency team (PET) for community outreach, including law enforcement, 24/7. 2. Assist clients in identifying and receiving services they need. • Implement pro-active outreach, go to where the people are, reach out to people that won't utilize storefront or institutional access points • Employ a Patient Navigator/Liaison to guide clients in whom to call • Develop a coordinated, county-wide system of transportation • Create mobile assessment teams to go to outlying communities to help them gain access. 3. Provide respectful engagement of the whole person. • Provide universal training in harm reduction, co-occurring disorders and cultural competency – everyone would be trained in how to deal with diverse clients and clients from special populations • Provide bi-lingual/multi-lingual services • Take people as they are without preconceived bias; make no assumptions about clients based on their history or previous encounters. 4. Emphasize recovery and wellness. • Focus on strength-based systems with an emphasis on recovery and wellness • Acknowledge that people can change through respectful, non-judgmental treatment delivery.

Adult Advisory Group (continued)

How Access Relates to AB 1881 Strategic Plan	This proposition and recommendation address the integrated services goals of developing a single point of entry with services available where clients and families are located, implementation of strength-based and recovery-oriented treatment and support, and development of cultural and client diversity capacity.

How Access Relates to MHSA	This proposition and recommendation relate to the MHSA by increasing access to services, reducing incarceration related to mental illness, and reducing involuntary care.

How Access Relates to Community Input	Access to services and availability was the number one theme of the community meetings and was the second most mentioned theme in the stakeholder meetings.

Requirements for Successful Implementation of Access	1. Development of a uniform assessment tool to be used by all providers in the system. 2. Development and implementation of cooperative agreements between community providers and DHHS that permit free exchange of information and services. 3. Training in the philosophy of harm reduction and recovery, strength-based methods of treatment and support, support for persons with co-occurring disorders and other topics that emphasize wellness and recovery. 4. Development of staff capacity to deliver culturally-competent services in multiple languages. 5. Development of a database system that allows for appropriate sharing of client information to all participants in client support services.

Adult Advisory Group (continued)

Total Number of Recommendations Made by Adult Advisory Group	FOUR	**Priority Number of This Recommendation**	TWO

Provocative Proposition (Describes Preferred Future)	Collaboration For the quality of life of our clients and our community, we collaborate and learn from one another every day. Our commitment to collaboration and learning includes: • Providing on-going mechanisms for education, training, and cross-training; working collaboratively; learning from one another; and, creating a common understanding of the various services, the strengths of those services and the key contacts to access them. These mechanisms include all agencies, public and private, that serve clients • Saving money and leveraging resources by finding common solutions for common problems, for example, transportation • Working across agency boundaries and overcoming agency constraints to serve clients. Because we believe collaboration and learning is critical to our ability to serve our clients effectively… • Our executive managers and managers collaborate with one another and hold one another and their organizations accountable for collaborating, achieving outcomes for clients, and continuing to learn about how best to achieve desired outcomes for clients. • As a part of how we do business, we expect to work with other staff members within and outside DHHS to serve the client as a whole person. Because 70-80% of mental health clients have co-occurring disorders… • DHHS employees from different branches and specialties work together in teams, to provide integrated treatment to address clients with mental health and alcohol and other drug issues. This uses resources more effectively, reduces duplication of efforts, and increases success rates for clients • DHHS assists community providers with training and education so they can effectively integrate their mental health and substance abuse programs.

Adult Advisory Group (continued)

Recommendation: Collaboration	Better Serve Clients Through Collaboration. 1. Create multi-disciplinary teams. 2. Match authority with accountability. 3. Make the Key Guiding Principle be that "We are all Service Providers." 4. Create Middle Management Teams. 5. Use Community Storefronts. 6. Include Adult Clients as Part of the Team. Reorganize to Support Client Teams. 1. Provide systematic support to multi-disciplinary teams. 2. Enhance creativity and service. 3. Address co-occurring disorders for mental health and alcohol and other drugs. Create a Mission/Outcome-Driven Performance Management System. 1. Create mission/outcome-driven performance management system. 2. Focus on outcomes. Plan for a Smooth Transition. 1. Plan the transition. 2. Build commitment to collaboration.

Adult Advisory Group (continued)

Detailed Recommendation: Collaboration	Better Serve Clients through Collaboration. 1. Create Multi-disciplinary Teams • Create multi-disciplinary teams of both public and private providers to offer services at the front end. The client only reports to one group. • One team would serve groups of clients. For example, a client reports to *one* team for Food Stamps, MediCal/ California Medical Services Program (CMSP), primary medical care, mental health services, public health, and employment services. • By including Food Stamps and MediCal eligibility workers and In Home Supportive Services representatives on the multi-disciplinary teams, the professionals like public health nurses, case managers, Child Welfare Services. social workers, and clinicians could intervene at earlier stages—before the client's behavior has deteriorated to the level of in-patient mental health services, prison, or jail. • Consider clients as part of the team. 2. Match Authority with Accountability. • In order for such collaboration to work, multi-disciplinary teams would need the ability and authority to make decisions to better serve clients (for example, continuing education and training, collaborative work, attending meetings, sharing branch staff, job enrichment opportunities, and logistical support). • Streamlining the decision making process would better serve the collaborative work. 3. Make the Key Guiding Principle be that "We are all Service Providers." • The multi-disciplinary teams and administrators would hold themselves mutually accountable to this principle. In other words, they would ask themselves and one another, "Does this action or decision match our guiding principle?" • This collaboration would recognize the acquired wisdom of team members.

Adult Advisory Group (continued)

Detailed Recommendation: Collaboration (continued)	Collaboration (continued) 4. Create Middle Management Teams. • Middle managers team meetings would set up ways to find methods to integrate, serve people better, and solve problems. • This would need strong direction from executive management. 5. Use Community Storefronts. • Multi-disciplinary teams would operate out of storefronts all over the county to meet the clients' needs. • Collaboration among team members would be essential to catching problems early in a client's life. Eligibility workers hear about and observe problems at the earliest stages and would be crucial to multi-disciplinary teams. 6. Include Adult Clients as a Part of the Team. • Provide education, support, mentoring, and early intervention to families by empowering adult clients in their parental roles, thereby decreasing future costlier services.

Adult Advisory Group (continued)

Detailed Recommendation: Collaboration (continued)	Reorganize to Support Client Teams. 1. Provide Systematic Support to Multi-Disciplinary Teams. • DHHS would provide consistent and systematic support and resources to multi-disciplinary teams. • DHHS would create an organization where managers and supervisors provide resources and support for multi-disciplinary teams to provide integrated, supportive services to clients. (See Robert K. Greenleaf, et al, Servant Leadership: a Journey into the Legitimate Power and Greatness). 2. Enhance Creativity and Service. • To obtain maximum creativity from multi-disciplinary teams and to enable them to collaborate with others in the various DHHS branches and providers outside DHHS, executives and managers would focus on making sure the teams were able to serve clients. This would entail decreasing supervisory and decision-making layers. • Case managers would be part of the multi-disciplinary teams. The focus would be on the client at all times. 3. Address Co-Occurring Disorders for Mental Health and Alcohol/Other Drugs. • Because 70 to 80% of mental health clients have co-occurring disorders involving mental health and alcohol/other drugs, the multi-disciplinary teams would serve these clients based on a harm reduction model.

Adult Advisory Group (continued)

Detailed Recommendation: Collaboration (continued)	Create a Mission and Outcome-Driven Performance Management System. 1. Create a Mission and Outcome-Driven Performance Management System. • DHHS would develop a performance management system so that it supports achievement of the mission and outcomes at every level. • Executive managers would to commit to collaboration in order to achieve the mission. 2. Focus on Outcomes. • Use evidence-based practice to conceptualize the service plan at the front end and to evaluate programmatic outcomes at the back end. • Focus on outcomes, not activities (for example, the HUD application for homeless dollars has lists of meetings and attendance). Promote the use of quantitative and qualitative data to measure performance. Plan for a Smooth Transition. 1. Plan the Transition. • The transition into a new way of doing business would be smooth, using this initiative as a springboard into the transition. • A group of stakeholders would work as a team to assist with the transition. Hire an external consultant to help plan and implement the transition or, hire an outside/independent evaluator to work with an oversight board. 2. Build Commitment to Collaboration. • Build an internal mechanism to support the notion of organizational collaboration. Collaboration would occur when line staff is vested in the mission.

Adult Advisory Group (continued)

How Collaboration Relates to AB 1881 Strategic Plan	One of the goals of integrated services is to integrate the administrative functions of Public Health, Social Services, and Mental Health. This proposes integrating clinical services as well. Implementing this recommendation would take a significant step towards creating an integrated system of care with a holistic view of needs. This is the second goal of integrated services.

How Collaboration Relates to MHSA	Two of the purposes of MHSA are to "increase access to services" and "increase involvement of clients and families in community mental health system. Implementation of these recommendations would help to accomplish the MHSA purposes.

How Collaboration Relates to Community Input	Collaboration and coordination was ranked highest in the summary of prioritized themes from the stakeholder meetings. The specifics included "better interface between systems" and good inter-department collaboration. This proposition and recommendations speak directly to the stakeholders' desire. Availability and accessibility was ranked number one in the community meetings and number two in the stakeholder meetings. Use of multi-disciplinary teams and "storefronts" would help respond to this desire.

Requirements for Successful Implementation of Collaboration	1. Commitment to collaboration at all levels across DHHS. 2. Memorandums of Understanding between providers and DHHS.

Adult Advisory Group (continued)

Total Number of Recommendations Made by Adult Advisory Group	FOUR	**Priority Number of This Recommendation**	THREE

Provocative Proposition (Describes Preferred Future)	Provide Supportive Services for Clients All providers and clients embrace a guiding philosophy that life is enhanced by individual contribution, responsibility, and the opportunity to learn new ideas and to engage in new experiences, including employment, educational opportunities, social interactions and work activities. Our clients have open access to meaningful employment in integrated work sites within the community. They experience the personal dignity that increases the success associated with the Assertive Community Treatment and the Recovery, Wellness and Discovery treatment models. Due to a system of services and supports determined by the individual served, a quality of life that is complementary to the individual's own life, and which does not intrude upon the person's chosen lifestyle results. Our clients are so empowered as to obtain a life that is made meaningful by loving, being loved, friends and relationships.

Adult Advisory Group (continued)

Recommendation: Supportive Services for Clients	Provide Supportive Services for Clients 1. Create an infrastructure (e.g. people and systems) grounded in the philosophy of harm reduction. 2. Create a system that focuses on supporting persons with mental health and alcohol and other drug issues. 3. Create and maintain an integrated delivery system that promotes timely delivery of primary services and follow-up services through an increased number of case managers. 4. Provide Supportive Services through a community-integration approach that is consumer-centered. 5. Enhance the availability of stable, affordable housing obtained through collaboration with Federal, State, and private funding to permit persons with mental illness to experience security during recovery.

Adult Advisory Group (continued)

Detailed Recommendation: Provide Supportive Services for Clients	Provide Supportive Services for Clients. 1. Create an infrastructure (e.g. people and systems) grounded in the philosophy of harm reduction. • Recruit a culturally diverse staff that would participate in ongoing, joint-training opportunities with all providers that support a professional environment. • The infrastructure would encourage the notion of client education, peer counseling and peer-support groups. 2. Create a system that focuses on supporting persons with mental health and alcohol and other drug issues. The treatment component would utilize: • A harm reduction philosophy (e.g. co-occurring disorders) • Joint training opportunities for all case managers and law enforcement • A culturally diverse staff • Client education and peer counseling • Peer-support groups (e.g. anger management, co-occurring disorders) 3. Create and maintain an integrated delivery system that would promote timely delivery of primary services and follow-up services through an increased number of case managers. • The system would include increased case conferencing regarding clients, case management in jails and for people recently released from prison, the establishment of regular meetings between all case managers in the system, including law enforcement and community and school-based traveling case managers. • The system would provide effective, integrated service delivery to all community stakeholders with mental health and alcohol and other drug issues.

Adult Advisory Group (continued)

Detailed Recommendation: Provide Supportive Services for Clients (continued)	4. Provide Supportive Services through a community-integration approach that is consumer-centered. • Clients would be empowered to retain control over their supports and their lives. • Supportive services would be racially and culturally appropriate, flexible as needs change, focused on strengths, able to meet special individual needs, and would be accountable to consumers and their families. • Supportive Services would be "consumer-driven" and provided in "natural and community-based, integrated settings." • All services would focus on the "whole person" supporting strengths and abilities in recovery. The expectation would be that individuals can grow and change. The delivery system would recognize the need to be person-centered treatment through the inclusion of: • Collaborative development of affordable housing • Supportive/supported employment • A holistic treatment approach to all of the clients needs (for example, health screening and housing) • Consumer driven services with multiple choices available • Respectful, non-judgmental delivery of services with the acknowledgment that change is possible • Strength-based system based on the Assertive Community Treatment and Recovery, Wellness and Recovery treatment models. 5. Enhance the availability of stable, affordable housing obtained through collaboration with Federal, State, and private funding to permit persons with mental illness to experience security during recovery.

Adult Advisory Group (continued)

How Supportive Services Relate to AB 1881 Strategic Plan	• See client, family, community at the center of an integrated system of care with holistic view of needs; • Commitment to strength-based recovery; • Focus on positive outcomes; • Develop cultural/client diversity capacity for integration into programs and policy development.

How Supportive Services Relate to MHSA	• Enhancement of purposeful activity, employment, vocational training, social and community activities, education; • Development and enhancement of housing availability to reduce homelessness; • Increased access to services; • Reduction of incarceration related to mental illness; • Increased involvement of clients and families in our community mental health system; • Enhancement of cultural sensitivity and competence.

How Supportive Services Relate to Community Input	• Desire for increased availability and access to services; • Desire for increased community outreach; • Desire for increased collaboration and coordination between service providers; • Desire for enhanced case management and the development of a full spectrum of services.

Requirements for Successful Implementation of Supportive Services for Clients	1. Training and implementation of the *Kennedy Axis V* (Kennedy, 2003) tool to assess clients and determine their level of functioning based on evidence-based practice. 2. Establishment of a workgroup of providers to recommend caseload parameters based on evidence-based outcomes developed through the use of the *Kennedy Axis V* indicators. 3. The inclusion of case managers on multi-disciplinary teams comprised of staff from DHHS (SSB, PHB, MHB/AOD) and community providers. <u>Reference</u> Kennedy, James A., MD: *Mastering the Kennedy Axis V, A New Psychiatric Assessment of Patient Functioning*, Washington, DC, American Psychiatric Publishing, Inc., 2003.

Adult Advisory Group (continued)

Total Number of Recommendations Made by Adult Advisory Group	FOUR	**Priority Number of This Recommendation**	FOUR

Provocative Proposition (Describes Preferred Future)	Prevention and Education Due to systematic, effective educational programs delivered throughout the county to all identified communities (e.g., cultural, geographic, economic, etc.), people in Humboldt County treat mental illness like any other illness. They integrate people with mental illness into their communities. Customized programs for specific groups encourage people to seek help early. Due to early detection and intervention, chronic mental illness is decreasing significantly along with the need for acute services, including jail. These early detection and intervention programs save clients and their families from suffering and help keep families healthy and stable. They save the client from having to go through the trauma of a crisis. This leads to faster recovery for the client. Because of this, costs for treatment are decreasing annually as the use of primary prevention services are increasing.

Recommendation: Prevention and Education	Prevention and Education Create a county-wide program targeting prevention and/or early intervention focusing on mental health and alcohol and other drug issues. This program would disseminate specific information to all community stakeholders regarding early identification of mental health and alcohol and other drug issues. It would provide information and assistance as well as encouragement to seek early treatment.

Adult Advisory Group (continued)

Detailed Recommendation: Prevention and Education	Create a system that would focus on educating the populace about mental health and alcohol and other drug issues. The educational outreach would address such issues as: • Types of disorders (for example, Post-Traumatic Stress Disorder, Manic Depression, and Dual-Occurring Disorders) • Early symptom recognition • Information and referrals • Available Resources/Services • How to access all systems • De-stigmatizing mental health and alcohol and other drug disorders and treatment • Continuous trainings The system would provide multi-lingual outreach to all segments of the county. This system would not only disseminate information but would solicit feedback for system improvements. Some of the targeted groups would include: • People in all geographic locations in the county • Specific ethnic/cultural groups • Pre-school to university students • Community service providers • Older adults • Physicians • Hospitals • Clinics • Parents • Clergy • Family Resource Centers

Adult Advisory Group (continued)

Detailed Recommendation: Prevention and Education (continued)	This outreach should be jargon free and occur through a variety of methods including: • A specific web site • On-site presentations • Web-based presentations and trainings • Newspaper, radio and other media • Access to a liaison twenty-four hours a day via phone, e-mail, and in person to gain information regarding access and systems navigation.

How Prevention and Education Relate to AB 1881 Strategic Plan	One of the goals of integrated services is to "create public education and outreach efforts." This proposition and recommendation provides direction and specifics for how to go about doing this for the adult population.

How Prevention and Education Relate to MHSA	One of the goals of MHSA is to "reduce incarceration related to mental illness." Through increased understanding and early intervention, the need for acute services, including jail, will decrease.

How Prevention and Education Relate to Community Input	Training and education was ranked third in the summary of the prioritized themes from the community meetings and the stakeholder meetings. The specifics under each included "greater understanding of what mental health means."

Requirements for Successful Implementation of Prevention and Education	1. People believe prevention and education is important. 2. Form a multi-agency cabinet to facilitate strategic planning and identify training opportunities. 3. Leverage the expertise and experience of the Health Education Specialists in the Mental Health Branch. In other words, use them throughout DHHS.

Older Adult Advisory Group

Preface

Humboldt County has a significantly large aging population that will continue to grow. This is a population that is currently underserved. We recommend that funding allocations should directly correspond to age demographics and economic need.

Total Number of Recommendations Made by Older Adult Advisory Group	SIX	**Priority Number of This Recommendation**	ONE

Provocative Proposition (Describes Preferred Future)	Access and Availability of Services Client-centered services are provided: • In the primary language of the client and are culturally appropriate • In collaboration with their natural support system • In natural settings where older adults are present • By multi-disciplinary teams • In both face-to-face and through tele-technology delivery systems • With transportation supports that meet clients' functional needs.

Recommendation: Access and Availability	Access and Availability of Services Create county-wide mental health services that are accessible and available to older adults. Ensure multi-disciplinary case management and transportation services to and from natural settings (e.g., homes, senior centers, Adult Day Health Care, and board and care facilities) for older adults in all parts of the county. Mental health services for older adults will support agency collaboration and blended programs. Clients and their support systems will have access to mental health services twenty-four hours a day, seven days a week, through face-to-face and tele-technology services.

Older Adult Advisory Group (continued)

Detailed Recommendation: Access and Availability of Services	1. Create a system where mental health services would be blended with other highly-used services and provided in natural settings where older adults are likely to frequent. • Mental health services would be provided in licensed facilities (e.g., board and care, skilled nursing facilities) and on-site at primary care doctors' offices. • Doctors, clinicians, social workers, nurses and case managers would travel to natural settings where older adults are likely to be (e.g., in their homes, senior centers, Adult Day Health Care, and board and care facilities) to do assessments, provide case management and mental health services. • Psychological services (e.g., support groups, one-on-one psychological therapy, short-term counseling) would be available at senior centers and other natural settings. • Blended programs would be supported by eliminating the waiver process. • Existing funding sources would be utilized to provide mental health services and Adult Day Health Care services in the same setting. 2. Ensure transportation supports are aligned with older adults' functional levels and accommodate different levels of ability. This system would include case managers providing transportation to necessary support services, and for daily living activities (e.g., shopping). Low-cost senior vans—like Fortuna model—could be utilized to reach this goal.

Older Adult Advisory Group (continued)

Detailed Recommendation: Access and Availability of Services (continued)	3. Utilize a multi-disciplinary, collaborative, and culturally competent approach to service delivery by: • Integrating public health, mental health, and social services (for example, Adult Protective Services) • Providing a mechanism for team members to share client information (for example, waiver from client) • Having nurses available to dispense medications expediently • Training case managers to recognize 5150s—a "warm person" doing interventions rather than/or in collaboration with a "uniformed person" • Assigning case managers based on the client's primary need • Having mental health clinicians who are bi-lingual/multi-lingual • Considering the use of the former Older Adults Mental Health Program model for in-home services. 4. Develop, or link with existing, tele-support and tele-medicine sites (for example, San Francisco-based "Friendship Line") for clients, family members, and providers that would be toll-free; bi-lingual/multi-lingual; and available twenty-four hours a day, seven days a week. Tele-support/medicine would also provide the following: • A crisis-line that would elicit help with an actual physical response (for example, intervention by a trained professional, police) • A warm-line to help people link to senior resource information and referrals, specific to older adult needs, and to triage mental health concerns • A compassionate, human voice, used to dealing with older adults • A tele-nurse • Tele-support for primary care providers to access a psychiatrist.

Older Adult Advisory Group (continued)

How Access and Availability Relate to AB 1881 Strategic Plan	This recommendation supports the Department of Health and Human Services AB 1881 commitment and goals by providing holistic, integrated programs to clients and families where they are located.

How Access and Availability Relate to MHSA	This recommendation supports the Mental Health Services Act by increasing access to services, involving clients and families in treatment planning, and reducing involuntary care.

How Access and Availability Relate to Community Input	This recommendation echoes the priorities expressed in the community meetings, stakeholder meetings, and surveys.

Requirements for Successful Implementation of Access and Availability of Services	1. More locations—in natural settings—where services are available 2. Memorandums of Understanding or Shared Facility Agreements with collaborating agencies 3. Increased numbers of all service providers (e.g., case managers, health care providers, clinicians, etc.) 4. Tele-medicine and tele-support sites or links with existing tele-medicine providers (e.g., San-Francisco-based "Friendship Line") 5. A trained, culturally-sensitive, and culturally and linguistically diverse staff. 6. Frequent and cheap transportation options for seniors—busses, vans and drivers 7. Investment in case managers' access to agency vehicles to transport clients

Older Adult Advisory Group (continued)

Total Number of Recommendations Made by Older Adult Advisory Group	SIX	**Priority Number of This Recommendation**	TWO

Provocative Proposition (Describes Preferred Future)	Quality, Quantity, and Increased Capacity There are conjoined mental health and primary care services for older adults. Psychiatric care is based on prioritized needs using a universal assessment (e.g., Global Assessment of Functioning and DSM4) in such a manner that trained geriatric specialists meet crises with quick response. The age requirement to receive services is lowered to age 50+ as needed.

Recommendation: Quality, Quantity, Increased Capacity	Quality, Quantity, and Increased Capacity Assure active and regular participation in collaboration between the Mental Health Branch, private health and mental health providers, and the broader community. This on-going exchange of needs, information, and best-practices would enhance the capacity of existing providers, increase the ability to attract additional geriatric providers, and allow older adults access to a broader base of resources, more quickly, and in a variety of settings.

Older Adult Advisory Group (continued)

Detailed Recommendation: Quality, Quantity, Increased Capacity	Quality, Quantity, and Increased Capacity 1. Provide Priority Access. In an effort to ensure quick access to mental health services for older adults, "Golden Tickets," or priority passes to appointments and services, could be issued by primary care physicians, social workers, Adult Day Health staff, and case managers. Using an agreed-upon, universal assessment tool (e.g., Global Assessment of Functioning), care providers would evaluate clients (via phone or in-person) and determine their eligibility for a Golden Ticket. 2. Deliver High-Quality Care. The integrated system would deliver high-quality care by overlapping mental health and primary care needs. Services would be all-inclusive—based on older adults' functional levels—and age requirements to receive services would be lowered to age 50+ as needed. Services would be accessed in a timely manner—within hours for acute episodes, within a week for non-acute episodes. Wellness screening efforts would continue with additional screening for depression and alcohol and other drug use. Great care would be given when labeling clients, as labels will stay with them forever and may impact their future eligibility for services. The former Older Adults Mental Health Services model, as well as the previously designed Walk-in/Same Day Services triage system would serve as good integrated services models.

Older Adult Advisory Group (continued)

Detailed Recommendation: Quality, Quantity, and Increased Capacity (continued)	3. Increase Capacity. More providers, and therefore more provider visits would be available to older adults. More doctors, psychiatrists and family nurse practitioners would accept MediCal. More psychiatrists specializing in older adult mental health issues would work for Mental Health and at least one full-time staff member would do home visits. Mental Health would recruit and retain more providers and geriatric professionals by utilizing our "Rural Underserved" status and by possibly partnering with Humboldt State University to hire providers' spouses. An educational model, similar to the Dental Health Certification program at College of the Redwoods, would educate local people in a local setting and to fill mental health staff positions. A geriatric training program would be linked with the Certified Nursing Assistant, Masters of Social Work and/or Nursing Programs at Humboldt State University. On-going, user-friendly educational opportunities (e.g., Humboldt/Del Norte Consortium for Medical Care) regarding Geriatrics and Geriatric Mental Health would be available for providers; Geriatric Certifications would be available for primary care physicians and Mental Health Branch staff. More funding would be allocated to pay geriatric specialists.

Older Adult Advisory Group (continued)

How Quality, Quantity, Increased Capacity Relate to AB 1881 Strategic Plan	Integrated mental health and primary care services helps to involve the broader community, thereby creating an holistic system of care.

How Quality, Quantity, Increased Capacity Relate to MHSA	This supportive collaboration encourages the involvement of clients, families, and other support systems; reduces stigma; and increases access to services.

How Quality, Quantity, Increased Capacity Relate to Community Input	Community members repeatedly stressed the need for services to be more widely available and integrated.

Requirements for Successful Implementation of Quality, Quantity, and Increased Capacity	1. Development of a common, certified training program to standardize the use of the Global Assessment of Functioning (GAF) Tool 2. Mental Health Branch agreement to accept the GAF score to facilitate priority access to services 3. Cooperation and communication between the Mental Health Branch and community providers (e.g., a Mental Health Administrative Representative on the Community Health Alliance and a Primary Care Providers Representative on the Mental Health Advisory Board

Older Adult Advisory Group (continued)

Total Number of Recommendations Made by Older Adult Advisory Group	SIX	**Priority Number of This Recommendation**	THREE

Provocative Proposition (Describes Preferred Future)	Education There are expanded educational programs regarding geriatric mental health issues in both public and professional venues. Providers and clients mutually better understand mental illness and the services available for treatment, thereby reducing stigma.

Recommendation: Education	Education Create an educational program for all ages (pre-school through older adult) targeting service providers, educators, law enforcement, and community members that will educate people regarding mental health and the older adult population. Use media, including newspapers, TV, web sites, and radio to reduce the stigma associated with mental illness and encourage people to seek help early.

Older Adult Advisory Group (continued)

Detailed Recommendation: Education	1. Community Education Create a speakers bureau that would be available to the general public, community and service groups, service providers, agencies, teachers and caregivers to offer broad-based education and information regarding mental health in an effort to reduce stigma and encourage people to seek care early. Additional educational information and materials would be available via a web site, low-cost TV/internet access, Public Service Channels, radio, and newspapers. Efforts would be made to reach people who cannot use/do not have access to internet services. 2. Service Providers Specific geriatric health and mental health training programs would be developed for doctors and other service providers to help them recognize diminishing capacity associated with aging, as well as other older adult-specific mental health issues (e.g., the distinction between dementia and depression) and resources. The Mental Health Branch would offer and require more Continuing Education Units regarding geriatrics and mental health. 3. Law Enforcement Police officers would receive mental health training through the College of the Redwoods Police Academy curriculum. Efforts would be made to ensure law enforcement and providers communicated via a common language and understanding of services and systems. More case managers would be trained to recognize 5150s and assist police in interventions.

How Education Relates to AB 1881 Strategic Plan	This proposition creates a public education and outreach campaign, and provides a system of prevention, support and treatment for the older adult population.

How Education Relates to MHSA	This proposition increases the community's awareness of services available for the older adult population, thereby reducing stigma and rates of incarceration.

Older Adult Advisory Group (continued)

How Education Relates to Community Input	This proposition relates to the community's desire for increased mental health educational efforts for clients, family members, providers, and the general public.

Requirements for Successful Implementation of "Education"	1. Adequate funding, time, and coordination 2. DHHS and agency stakeholder collaboration and cooperation 3. Identification of a lead agency to coordinate a speakers bureau 4. Allocation of DHHS's training funds towards geriatric health education 5. Establishment of a central management agency in order to collaboratively secure grants and pool funding sources

Older Adult Advisory Group (continued)

Total Number of Recommendations Made by Older Adult Advisory Group	SIX	**Priority Number of This Recommendation**	FOUR

Provocative Proposition (Describes Preferred Future)	Data Collection and Access A multi-tiered database is shared among cooperating agencies upon the client's consent, that increases access to appropriate services in a timely fashion (e.g., a model similar to the Housing and Urban Development Management Information System). The shared database lessens clients' frustrations since they only have to tell their story one time, and repetitious paperwork, duplicated and contra-indicated treatments (e.g., repeated tests, medications) are eliminated. The database system gives clients control over their records and allows them to determine agencies' access to tiered-levels of information. The shared database builds greater inter-agency connections and cultivates professional relationships, thereby improving services for clients.

Recommendation	Data Collection and Access Create a single, centrally-managed, data-collection system that is client-centered and is instantaneously accessible by staff from multiple agencies (e.g., case managers, organizational providers, emergency response services, family support centers, law enforcement, and jails) that involved in clients' lives.

Older Adult Advisory Group (continued)

Detailed Recommendation: Data Collection and Access	1. Database System Create a centrally-controlled, relational database with compartmentalized data (e.g., demographic and socio-economic data; general health overview; mental health history; crisis history/traumas; prognosis and current condition; contagious disease status; medication history; and justice system information) with tiered levels of information and access. Data would be easily edited and quickly updated. 2. Client Control Ensure clients have control over agencies' access to different tiers of data via automated releases of information using a unique identifier/electronic password (e.g., Area Agency on Aging software model). Clients would have the ability to change agencies' information access status quickly; there would be no cumbersome paperwork process. Older adult clients could have their unique identifiers on medi-alert-like bracelets. 3. Inter-Agency Connections Increase agency connections and collaboration by standardizing the criteria for collecting data and sharing information, thus streamlining the service delivery process.

How Data Collection and Access Relate to AB 1881 Strategic Plan	This data collection system contributes to the integration of administrative functions in the Department of Health and Human Services, and also supports the creation of a single point of entry for clients and families.

How Data Collection and Access Relate to MHSA	This data collection system increases timely access to services and reduces incarceration related to mental illness.

How Data Collection and Access Relate to Community Input	This data collection system supports "collaboration and coordination" which was a priority identified at both stakeholder and community meetings. It also increases "availability and accessibility" of services.

Older Adult Advisory Group (continued)

Requirements for Successful Implementation of Data Collection and Access	1. Identification and adoption of a common model/software system. Look at existing models (e.g., Health Care Financing Administration and Sonoma County's Health Management Information System) 2. Department of Health and Human Services maintenance of the database system 3. Establishment of a work group to address confidentiality issues and determine database parameters. 4. Agreement to a standardized intake process for all agencies

Older Adult Advisory Group (continued)

Total Number of Recommendations Made by Older Adult Advisory Group	SIX	**Priority Number of This Recommendation**	FIVE

Provocative Proposition (Describes Preferred Future)	Culturally Appropriate Services/Access The Mental Health Branch provides culturally competent services and approaches each individual uniquely. All clients are served regardless of race, ethnicity, social class or sexual orientation, while recognizing Humboldt County's unique sub-cultures. Human rights issues are identified and addressed. Programs are available to encourage staff development and to recruit diverse individuals that represent populations served.

Recommendation	Culturally Appropriate Services/Access Hire providers that represent different cultural groups and are discreet, using appropriate-age interpreters when necessary. Ensure providers are aware of cultural stigma attached to mental illness and possible fears of the medical community. Providers would investigate clients' medical status thoroughly and honor their cultural values.

Older Adult Advisory Group (continued)

Detailed Recommendation: Culturally Appropriate Services/Access	1. Providers Service providers would be hired to represent different cultural groups in the community. All providers would receive education regarding cultural competency. Providers would use discretion and approach each individual client uniquely, making no assumptions. Providers would recognize the stigma attached to mental illness in many cultures and ensure an accurate diagnosis by completing a thorough medical assessment, using same-age interpreters if necessary (not children or teen family members) to ensure older adult clients' honesty, privacy and accuracy of information. 2. Clients Service providers would recognize the unique Humboldt County sub-cultures (e.g., Vietnam Veterans, homeless, marijuana growers/users) and how their worldviews impact how they access services. Service providers would recognize that in some cultures, clients might hide their mental illness from their family and community. Providers would honor and incorporate clients' choice to visit non-western/traditional healers. Professionals would understand that mental health conditions may mean different things to different cultures (e.g., hearing voices may be seen as a blessing or honor in Asian/Pacific Islander cultures).

How Culturally Appropriate Services/Access Relate to AB 1881 Strategic Plan	Providers would represent and respect older adult clients' diversity and integrate this into policy development.

How Culturally Appropriate Services/Access Relate to MHSA	Culturally sensitive services to diverse older adults would ease and improve access to services.

Older Adult Advisory Group (continued)

How Culturally Appropriate Services/Access Relate to Community Input	This proposition for culturally appropriate and sensitive services matches the input gathered at both community and stakeholder meetings.

Requirements for Successful Implementation of This Recommendation	1. Hire culturally and linguistically diverse staff, representative of the population served, and train current staff to be cultural sensitivity 2. Agencies could assign staff to be on the Human Rights Commission

Older Adult Advisory Group (continued)

Total Number of Recommendations Made by Older Adult Advisory Group	SIX	**Priority Number of This Recommendation**	SIX

Provocative Proposition (Describes Preferred Future)	Services for Dementia Dementia is recognized as a physiological condition and an expanded spectrum of services is available to older adults. A collaborative service provider system exists to ensure accurate diagnoses and access to mental health and other support care for older adults.

Recommendation (Innovative Ways to Create that Preferred Future)	Services for Dementia Create a training program that addresses assessment and treatment issues, and increases caregiver, client, and provider collaboration.

Older Adult Advisory Group (continued)

Detailed Recommendation: Services for Dementia	1. Collaboration A collaborative system between Mental Health, primary care physicians and community-based organizations would serve older adults with dementia—service responsibilities would be shared. Access to support and respite services for family members and primary care givers would be promoted and provided through the collaboration. Dementia education would be offered to providers, recognizing that collaboration substantiates diagnoses. 2. Assessment/Treatment The wellness paradigm would expand to include dementia to ensure that clients with a dementia diagnosis would have access to mental health services. Health professionals would recognize that dementia can co-occur with mental illness or a head injury and that older adults experiencing dementia-related behavioral issues may be served by Mental Health Branch staff. The Mental Health Branch would utilize medical and cognitive testing in order to make an accurate diagnosis; assessment centers in the San Francisco Bay Area and Martinez are available for tele-medicine and could be used.

How Services for Dementia Relate to AB 1881 Strategic Plan	When implemented, this proposal expands the spectrum of services available and puts a positive focus on a significant mental health issue.

How Services for Dementia Relate to MHSA	By reducing involuntary care, this proposal increases access to services.

How Services for Dementia Relate to Community Input	Throughout the community input process, diagnosis and evaluation issues were perceived to impact service access. This proposal expands service access through a collaborative process.

Older Adult Advisory Group (continued)

Requirements for Successful Implementation Services for Dementia	1. Contracts with regional mental health centers to have dementia diagnostic clinics available 2. Mental Health Branch acceptance of multiple diagnoses and diminishment of categorical services 3. Development of an educational consortium for different levels of providers 4. Creation of a blue-ribbon panel to identify funding sources for dementia services

HUMBOLDT COUNTY

Department of Health and Human Services

AB 315

Integrated Services Initiative

2007 – 2010

Strategic Plan

Phillip R. Crandall, Director

June 2008

Humboldt County AB 1881
Phase II Strategic Plan

Introduction

Humboldt County began Phase I of this Health and Human Services Agency authorized Integrated Services Initiative in February 1999 through legislation (AB 1259) introduced by Assembly Member Virginia Strom-Martin. The purpose of AB 1259 was to allow Humboldt County, with the assistance and participation of the appropriate state departments, to implement an integrated and comprehensive county health and human services system. In 2004 AB 1881, authored by Assembly Member Patty Berg, authorized continuation of Humboldt County's transformational work. The current proposed legislation, AB 315 (Berg), makes this Integrated Services Initiative permanent.

Since 1999, Humboldt County has strived to maximize its resources, both fiscal and staffing, towards the integration of state department programs and initiatives, some of which are promising practices towards serving children, families, adults and older adults in the context of their community and culture in a holistic manner.

Towards this goal of integration of parallel programs and state initiatives (e.g. Mental Health Services Act/Child Welfare Services improvement projects), Humboldt County has worked collaboratively to eliminate or reduce barriers that despite the state's intent, may result in less than optimal care related to these overlapping and vulnerable populations.

Over the past eight years, Humboldt County Department of Health and Human Services (DHHS) has demonstrated that through its integrated health and human services delivery structures and processes significantly higher quality, more efficient, effective, holistic and outcome-based practices can be planned, funded and implemented.

Vision

Humboldt County is a nurturing, supportive, healthy environment for its children, families, adults and communities.

Mission Statement

The Humboldt County Department of Health and Human Services is committed to work in coordination with public and private providers to:

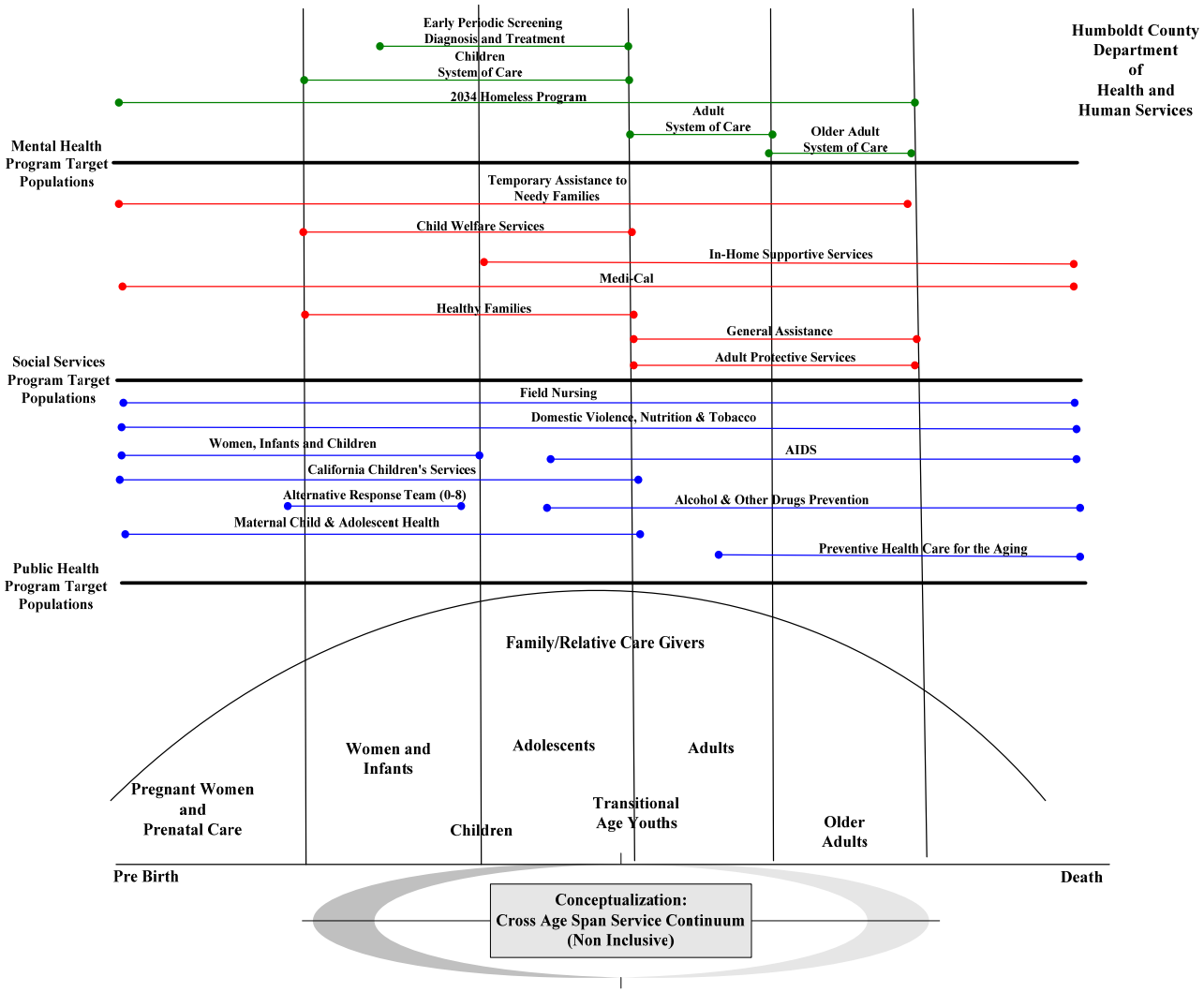
- Improve administrative functioning
- Improve service coordination and access to improve individual, family and community functioning
- Promote, develop and maintain a continuum of services that encourage prevention and early intervention activities
- Link these activities to more intensive services

Operational Principles

1. Branches with interrelated programs for children, families and adults will deliver coordinated, efficient services and maximize the resources available to deliver those services.
2. Services will be decentralized in close proximity to clients to the maximum extent feasible.
3. The integrity of specialized services will be preserved.
4. Services will be tailored to match the multicultural and multilingual diversity of our community and will be developmentally appropriate.
5. The partnership between County services and community-based organizations will be strengthened.
6. Services will be provided through a system incorporating outcome evaluation to ensure accountability for resource management and adherence to regulatory and statutory compliance.
7. All newly identified monies will be reinvested into the health and human service system.

Organizational Transformation: Rationale

In recent years there has been a noted increase in state/federal initiatives, legislation and reports (e.g., Mental Health Services Act/Child Welfare Services Stakeholder Final Report/AB 636/The Presidents New Freedom Initiative, Crossing the Quality Chasm) related to the need for significant and fundamental changes in health, mental health and social services delivery systems. An underlying theme of these various initiatives/reports is the need for significant system reform that **transcends simply "improving**" health and human services across traditionally separate systems to mutually served clients. An illustrative example of these siloed services across age spans is provided below:



Further, these reform initiatives generally speak to the need to transform health and human services systems in terms of:

- Increased client and community stakeholder involvement;
- Increased culturally relevant and inclusive practices;
- Systems delivery based on Evidenced Based Practices;
- Systems delivery based on community values;
- Systems reformation focused on quality improvement and;
- Systems accountability in terms of outcomes linked to improved community health, individual and family recovery or self sufficiency.

Despite these initiatives/recommendations, there is not a comprehensive “blueprint” that defines, operationalizes and links health and human services delivery systems transformation initiatives across federal/state/county departments and age spans.
Transformation has been defined as more than just reorganizing but a quantum change that reflects a radical redesign and new strategic intent for an organization. Mazade (2005) offers a conceptual attempt to define the conditions for implementing transformation and articulated the following readiness factors:

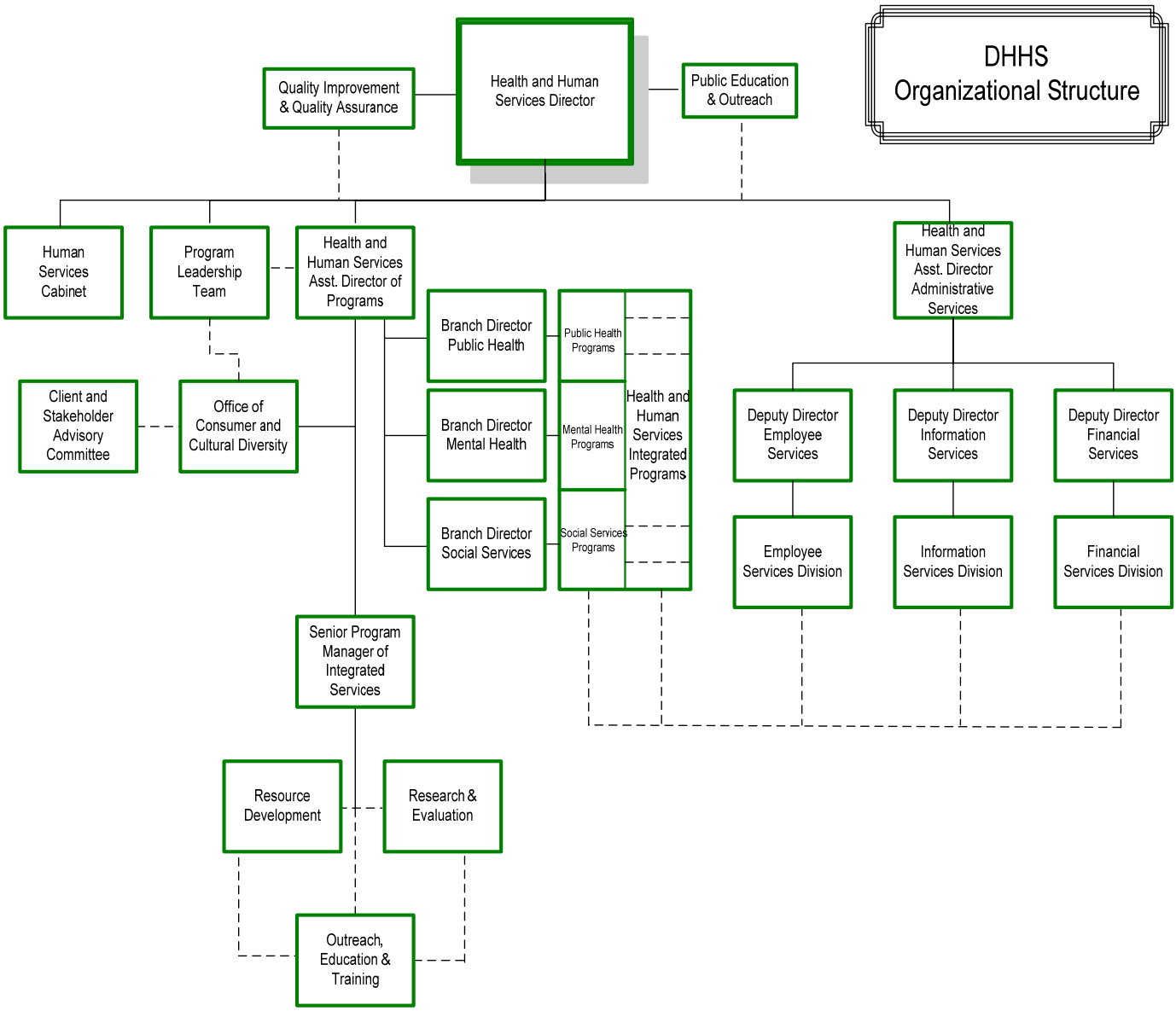
- Is there sufficient energy to launch and accelerate the change;
- Is there a compelling vision;
- Is there a place in the organization to support the change;
- Is there a process of change management to support the effort?

Humboldt County’s integrated initiative efforts over the past eight years reflect Humboldt County’s developmental efforts to establish and operationalize a “road map to transformation” at the County services level.

Phase I Implementation

At the start of the Initiative implementation in 1999, a core strategy contained in Humboldt County's Phase I Strategic Plan was to conduct an assessment of its multi-departmental organizational structure and reorganize to promote increased efficiency in administration and increased access to funding.

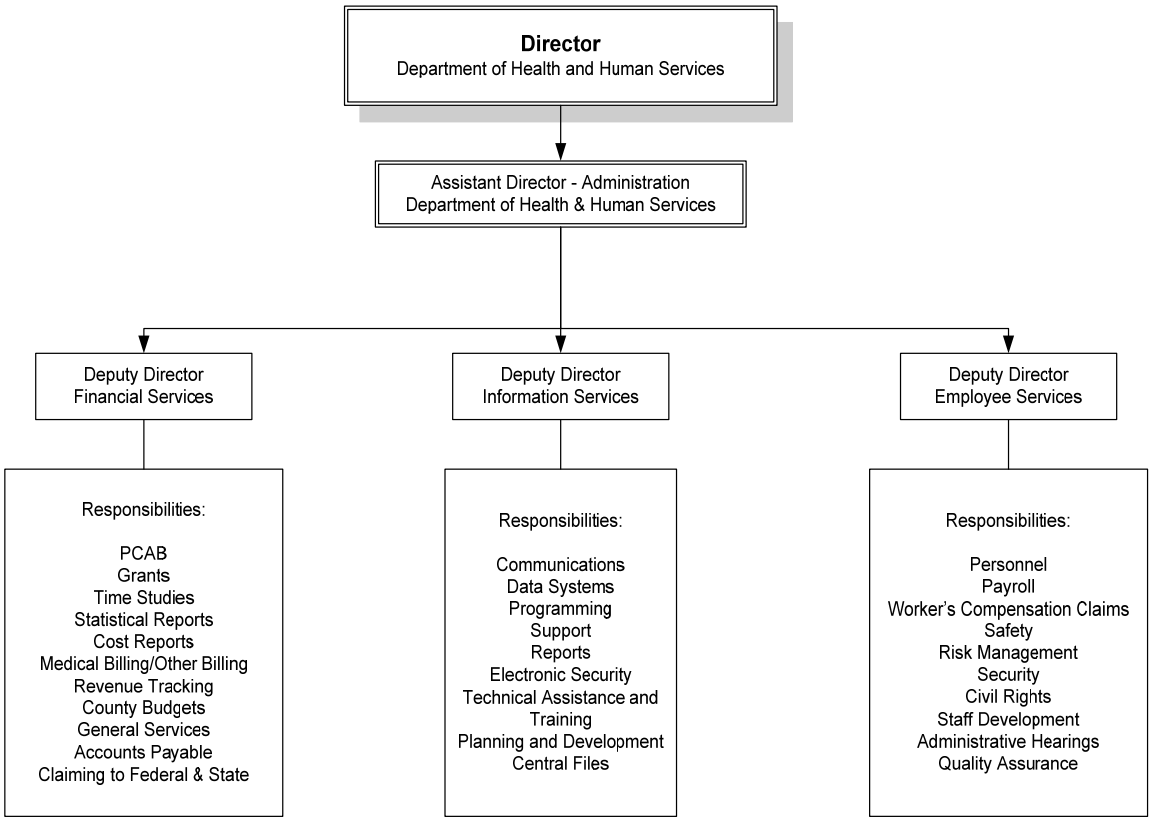
In relation to this organizational restructuring strategy, Humboldt County over a period of several years, integrated six departments (Social Services, Mental Health, Public Health, Employment Training, Veterans Services and Public Guardian) to form the Department of Health and Human Services. This reorganization has been efficient in relation to positioning Humboldt County for systems transformation outcomes. A chart of this redesigned health and human services organizational structure is contained below. The structure reflected in the chart has been developed to enhance the integrated administrative and program support structures required to reduce program and State initiative fragmentation.



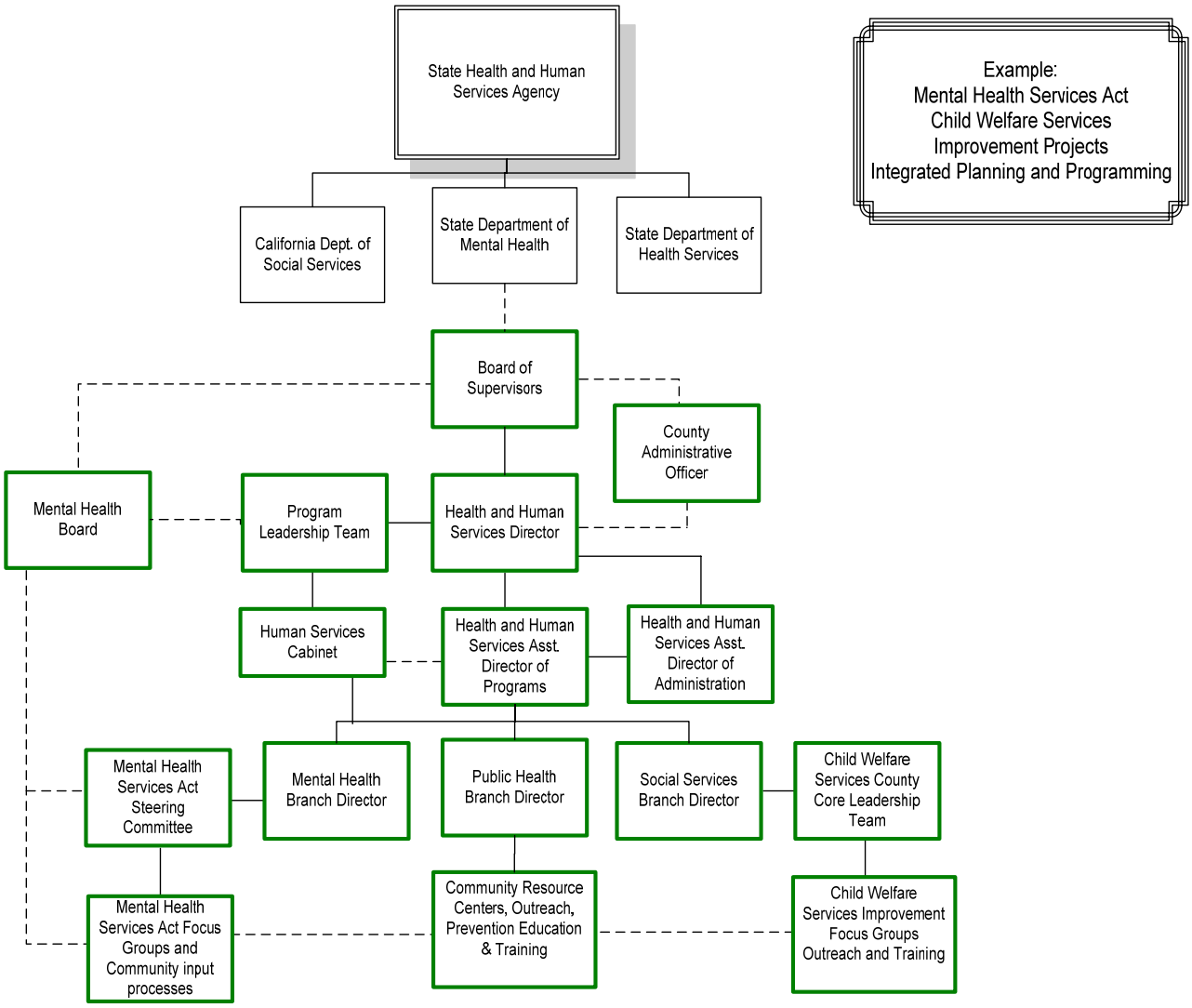
Phase I of Humboldt County's organizational consolidation (1999-2004) focused on integration and co-location of Humboldt County's administrative infrastructure consisting of information services, employee services, and financial services. The organizational chart below provides an overview of the functions of each of these consolidated health and human services administrative divisions:

Department of Health and Human Services

ADMINISTRATIVE SUPPORT STRUCTURE



A process flowchart that is descriptive of how Humboldt County Department of Health and Human Services has approached state initiative planning and programming from an integrated services initiative perspective is presented below. The flowchart is an example of how planning and programming for clients and their families involved in multiple service systems and state initiatives (e.g. Child Welfare Services improvement projects/Mental Health Services Act) are integrated.



Phase II Implementation

Humboldt County's Phase II (initiated in 2005) organizational efforts "build" on Phase I organizational restructuring efforts towards increasing the department's infrastructure needed for the development of centralized program support structures and processes that are required to support systemic transformations across the department's three primary Branches (Mental Health, Social Services, Health) and its community stakeholders. These program support structures consist of an integrated:

- Office of Client and Cultural Diversity
- Research and Evaluation Support
- Training, Education and Supervision Support
- Resource Development Support

The program support structures for integrated services include:

1. **Office of Client and Cultural Diversity:**

    - Support, guide and encourage implementation of activities that promote client and cultural competence; guided by values of wellness, recovery, inclusion, respect and equality.
    - Creating a system that is ready to embrace inclusion of clients, families and youth partners.
    - Recommend to PLT training and staff development needs for inclusion of improved and culturally competent client family partnerships in the workplace.

2. **Research and Evaluation Support:**

    - Provide data specific to issues/programs as requested by DHHS.
    - Conduct/provide literature reviews on Evidence Based Practices for approved projects.
    - Provide formative and summative outcome data; produce audience specific outcome reports on targeted programming.
    - Establish fidelity and outcome measures for approved projects.
    - Develop and collect methodology to gather needed client and cultural information.
    - Conduct needs assessments on approved projects.

3. **Training, Education and Supervision Support:**

    - Provide/contract for pre-launch training and education to branches and stakeholders.
    - Provide or coordinate post-launch or on-going training and education needs.
    - Develop training to better understand the complex needs of families, engaging for early intervention and supporting connections in the community.
    - Develop training to address client and cultural diversity.
    - Develop curriculum to promote clients, families and youth partnerships.
    - Provide pre-licensure clinical supervision and work force development support.

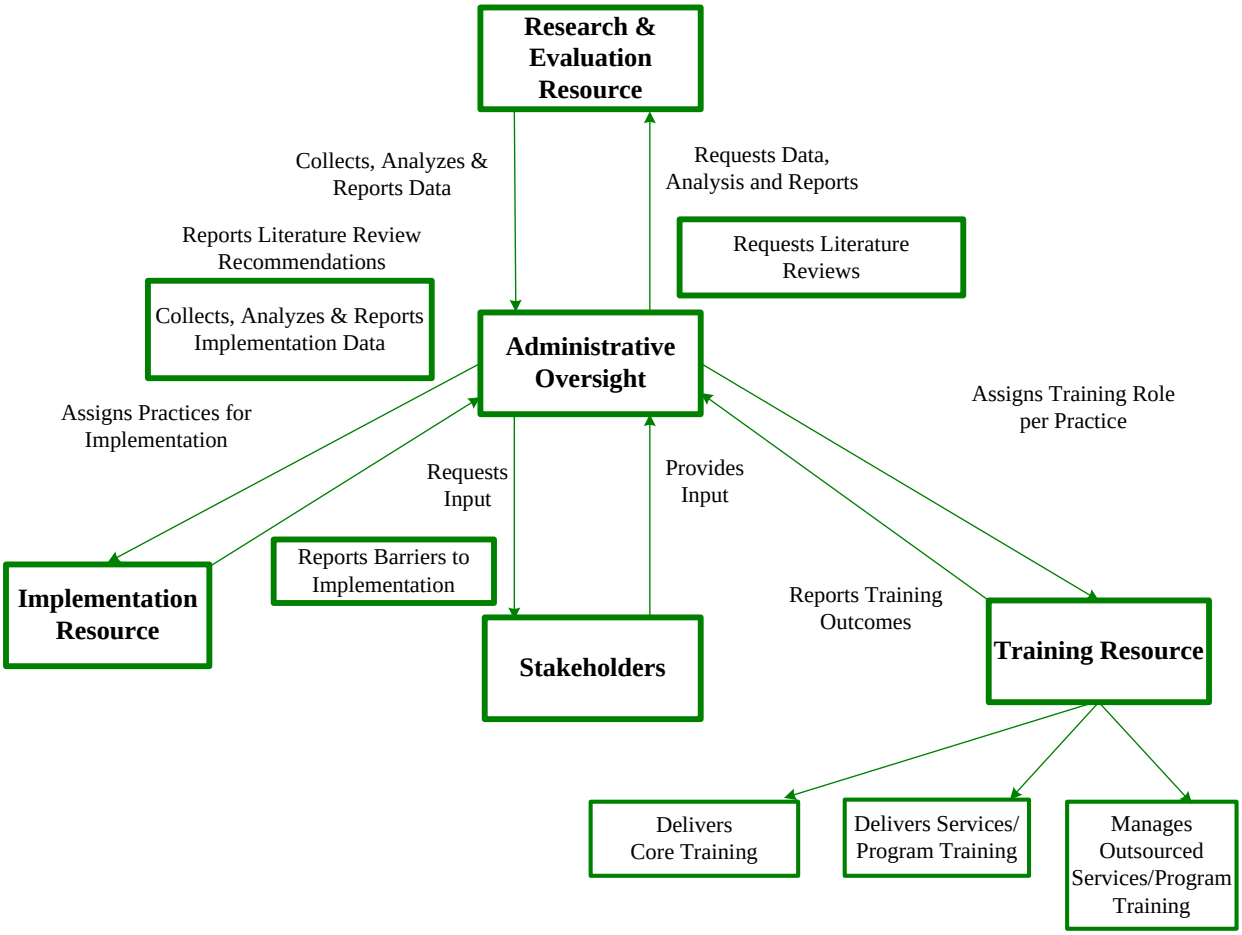
4. **Resource Development Support:**

    - Provide a road map that integrates goals of major initiatives, identifies service gaps, and prioritizes needs for future funding initiatives.
    - Track funding and grant initiatives that may target these needs.
    - Develop funding application with integrated development teams.

- Develop integrated information regarding Humboldt County to be used in funding applications by branches and/or DHHS.

In addition to the above structures, interrelated and dynamic processes that link these program support divisions across the Branches have been designed and launched. These processes are a unique approach in terms of our organizational transformational work and represent Humboldt County's developmental efforts towards the identification of interrelated systematic government sector "Rapid Cycle" processes required to initiate Evidence Based or outcome driven programs required to transform health and human services delivery systems. A flow chart outlining these processes is contained below:

Humboldt County Rapid Cycle Change Matrix



Evidenced Based Practices

The above "Rapid Cycle" process has evolved in relation to the need to transport and launch Evidence Based Practice Models and focus on outcome driven systems capacity as part of Humboldt County's service integration efforts. Six initial Evidence Based Practices implemented as part of our Phase II (2005) efforts to develop cross-departmental services are listed below:

1. **Incredible Years (IY):** A parenting treatment and prevention program for parents with children ages 2-12 who exhibit conduct or behavior problems.

2. **Functional Family Therapy (FFT):** Family treatment for youth ages 11-18 who are at risk and/or presenting with delinquency violence, substance abuse, conduct behavior problems and family conflict.

3. **Aggression Replacement Training (ART):** Treatment for adolescent youth who show or are at risk of aggressive behavior.

4. **Family to Family (FtF):** Developing family resources and *Team Decision Making* models for families whose children are in or at risk of out-of-home placement.

5. **Parent Child Interaction Therapy (PCIT):** Intensive treatment designed to work with parents and children (ages 2-7) together to teach parents the skills necessary to manage their children's behavioral problems.

6. **Multidimensional Treatment Foster Care (MTFC):** A foster care placement and after care program for youth ages 12-18, chronic juvenile offenders extending 6 months for placement and up to 12 months after care services (suspended due to need to restructure Humboldt County's foster care delivery system to assure costs can be supported.)

Humboldt County Health and Human Services is committed to piloting Evidence Based Practices in targeted prevention, early intervention and treatment strategies. This long-term strategic decision will be assessed for outcome and fiscal efficiencies and be expanded if outcomes support this approach. Evidence Based Practices are viewed as a promising foundation for successful community and family interventions.

Integrated Service Co-Location Strategies

The department is pursuing a two pronged approach towards maximizing program integration and ultimately, service transformation which involves centralization of administrative and program support services as well as co-locations of major branch services where appropriate; and co-located decentralized services in partnership with community stakeholders in a developmental approach towards service delivery transformation.

The service "decentralization" process is a Phase II strategy that is in many ways more complex than departmental co-location as it involves new and diverse community partnerships (e.g. Community Resource Centers/community stakeholder collaboratives, etc.) and a fundamental strategic shift in approaching community health issues.

Family and Community Resource Centers are non-profit, community based agencies that provide support and resources to community members. The supports and resources offered by the fourteen centers vary depending on community needs, geographic location

and funding. The types of services provided by Resource Centers may include playgroups, parenting classes, food and clothing distribution, counseling, case management, senior lunches, and community building events.

Resource Centers are key partners in improving the health and safety of Humboldt County. DHHS and the Resource Centers have identified numerous ways to combine efforts to improve outcomes for families. These efforts include DHHS and the Resource Centers' staff meeting monthly; DHHS assigning liaisons to work with individual Resource Centers; public health nurses and child welfare social workers being geographically assigned to work with individual resource centers; cross training staffs; and Resource Centers offering and participating in DHHS-promoted Evidence Based Practice programs.

In addition, DHHS has provided funding for the Resource Centers' infrastructure, staffing and training to enable the centers to participate in Child Welfare Services Differential Response. Currently, the resource centers provide services to families referred from Child Welfare Services who are at risk for child abuse and/or neglect. Resource Center staffs are also participating in the department's team decision making process. This is a process by which the significant people in a child's life come together to discuss the best solutions for a child at risk for being removed from their family or being moved to another placement.

Community Resource Centers are also key players in the rollout of our Mental Health Services Act programs. Community centers are acting as our partners on several programs and are key informants as we move forward on prevention services.

This strong community collaboration has resulted in improved services throughout our community and a better understanding the mission and responsibilities of our department.

Challenges

The department is clear that its Phase II Strategic Plan encompass developmental and complex transformational work that in many instances require gradual systemic change over the next decade.

In addition, the current regulatory and statutory barriers that impede county system program and planning responses required to implement various state initiatives will need further state department assistance to overcome.

The current challenge before the Humboldt County Department of Health and Human Services is to develop and fund transition strategies toward services and structures that "accommodate" the siloed state Initiative or System Improvement Plans intents in the short term while concurrently developing the Phase II organizational waivers and/or program restructuring options required for systems transformation.

Strategies

With Health and Human Services Agency, state department, philanthropic support and technical assistance:

1. Design, refine, implement, assess and fund the core transformational organizational program support structure(s) and rapid cycle processes required to facilitate Phase II of Humboldt County's Integrated Services Initiative.

2. Work to support Humboldt County's holistic approaches in the implementation of state initiatives (and various system improvement plans) and help develop transformational service designs including necessary waivers that are supportive of Humboldt County's efforts in terms of organizational integration and cross system strategic plan goals.

Phase II Strategic Plan Goals

As a result of ongoing integrated planning the department has established updated Phase II Strategic Plan goals which:

- Target integrated programming, evaluation and fiscal planning for all state initiatives.

- Link to health and human services mission and operating principles.

- Are strength based, recovery oriented, client and stakeholder inclusive, responsive to emerging community needs and have a foundation inclusive of evidenced based practices/practice based evidence that are consistent with our diverse cultural, ethnic and community values.

- Link to county peer to peer development team approach(s) with similar transformational oriented counties where possible.

- Enhance the department's transformational infrastructure capacities through the development of integrated and centralized cross-branch:

    1. Outcome and evaluation capacity
    2. Training capacity
    3. Agency resource initiative and grant response capacity
    4. Public education and outreach capacity
    5. Quality improvement and quality assurance capacity
    6. Client and cultural diversity inclusiveness capacity

These Phase II goals have been formatted in age span "categories" to facilitate developing critical integration and transformational structures, processes and outcome driven programming of various initiatives. These categories are listed below:

1. Strategic plan goals that are primarily targeted at children, youth and family populations.
2. Strategic plan goals that are primarily targeted at adult/older adult populations.
3. Strategic plan goals that are primarily targeted at community health issues and initiatives.

Child, Adolescent, TAY and Family Focused Goals

- Implement integrated foster care approaches for Humboldt County.

- Assess and integrate transitional age youth services across branches and inclusive of the Mental Health Services Act, THPP, ILP and the Workforce Investment Act.

- Continue to assess methods and outcomes of developing a differential response capacity to at-risk 0-8 children and families inclusive of social services/mental health/public health and community partners.

- Design and implement system changes to assure that children and youth involved in foster care receive mental health and health access and/or service referrals as indicated upon entry into foster care system.

- Design a systems' approach towards the goal that no child or youth leaves Humboldt County due to a lack of local behavioral health services availability.

- Continue to improve service integration through the consolidated DHHS/probation (SB 933) foster care placement review ability.

- Develop an enhanced integrated Health and Human Services and community response template targeting children born with positive drug toxicologies and their families inclusive of social services/mental health/public health and community partners.

- Improve medical and dental access, mental health services access and treatment for all children and youth.

- Improve shared and independent housing options/resources for emancipating transition age foster care youth inclusive of youth with serious emotional disorders.

- Continue to implement Family-to-Family community strategies with an emphasis on team decision making in all placement decisions.

- With CDSS assistance maximize Child Welfare Services restructuring and Mental Health Services Act work force support by addressing MSW pre and post graduates training and placement options consistent with AB 315 holistic cross- systems approaches.

- Further develop community resource center/family resource center capacity and stakeholder partnership with DHHS to assist with enhanced community capacities to support families.

- With state assistance, implement strategies to increase health, dental, mental health, alcohol and other drug services to families up to 300% of the federal poverty level through increased access to health insurance coverage.

- Continue to increase service linkages to behavioral health, health, CWS and explore enhanced funding strategies to families as defined in Temporary Assistance to Needy Families.

- Continue to build partnerships with local tribes and other culturally and ethnically diverse populations to improve the safety of all Humboldt County children and families in a culturally respectful manner.

Adult/Older Adult Focused Goals

- Continue to implement and assess the outcomes of our integrated services model for the incapacitated general assistance population across the Mental Health/Social Services Branches.

- Design and implement integrated community based services across the Social Services, Public Health and Mental Health Branches to support and reinforce maximum independence for all adults with serious and persistent mental illness.

- Develop and pursue strategies to increase the affordable housing stock available for adults with serious and persistent mental illness.

- Continue to design and implement integrated services for shared In-Home Supportive Services/Adult Protective Services populations across Social Services/Mental Health/Public Health Branches.

- Continue to develop program linkages between Social Services, Mental Health and Public Health and explore enhanced funding strategies for In-Home Supportive Services to the elderly and disabled.

Community

- Collect, analyze, assess and share information related to health conditions, risks and community resources to improve health and mental health outcomes.

- Analyze existing policies, regulations, resources and strategic priorities to promote sound health policy development.

Methods of Achieving Strategic Plan Goals: State and County Processes

In recognition of the complex and developmental structures and processes related to achieving systematic cross departmental transformation, Humboldt County will engage in the following "barrier elimination" processes towards achieving its goals:

1. Engage in face to face meetings with the Health and Human Services Agency, state department representatives and philanthropic entities to improve understanding and support for the conceptual framework of Humboldt County's Phase II Strategic Plan.

2. Through mutual agreement between the state agencies, philanthropic entities and Humboldt County's Department of Health and Human Services, target specific strategic plan goals within each state entity's capacity and engage in process/product and funding discussions that:

    A. Clearly articulates the goal;

    B. Identifies state/county statutory, regulatory and/or funding barriers towards achieving the goal;

    C. Results in the development of a state/county plan to eliminate the barrier(s) that is inclusive of specific state/county planning, within targeted timeframes;

    D. Links the achievement of goal(s) to necessary state/county Departments oversight structures or bodies as necessary to achieve the goal within the context of state initiatives, legislation, and waivers/negotiated agreements, maximizing state/county and philanthropic collaboration throughout the process.

APPENDIX

Historical Review – Phase I Humboldt County AB 1259 Goals (1999-2004)

In 1999, Humboldt County established the following ten goals in its Phase I implementation of AB 1259:

1. Establish community resource centers.

2. Establish and implement a unified county "single intake" and service plan (with technical assistance from Department of Health and Human Services and involved state departments).

3. Increase the ability to fund sustainable services to seriously emotionally disturbed (SED) minors and adults in locked correctional settings.

4. Increase the mental health alcohol and other drug services to "working poor" families through increased access to Healthy Families Initiative benefits.

5. Develop (with technical assistance from Department of Health and Human Services and involved state departments) a consolidated outcomes package for all state and federal funded initiatives.

6. Develop and implement a consolidated SB 933 foster care placement review ability.

7. Increase funding access to Title XIX and Title IV-E for eligible services provided by mental health professionals, probation officers and social workers.

8. Develop a "consolidated" Title IV-E training plan package.

9. Increase linkages and explore enhanced funding strategies and services to needy families as defined in TANF.

10. Increase linkages and explore enhanced funding strategies for in-home supportive services to the elderly and disabled.

Between 1999-2004, progress was made on seven of these goals as described below:

(Goal #1) Establish Community Resource Centers.

In collaboration with Humboldt County's First Five Commission, six family resource centers were funded and are progressing well into early implementation phases. The Department of Health and Human Services has an established family resource center "liaison" team to improve the communication between County Health and Human Services and community

collaboratives in relation to improving access to services and building community capacity to develop prevention and early intervention services.

The activities of the family resource center team within the Department of Health and Human Services has been a powerful tool that is increasing the fundamental understanding within the department of the value and opportunity inherent in working with communities to address local concerns.

(Goal #3) Increase the ability to fund sustainable services to seriously emotionally disturbed (SED) minors and adults in locked correctional settings.

As a result of AB 1259, Humboldt County has achieved significant progress in relation to increasing sustainable funding to minor and adult populations in locked settings. This was achieved through the development of an AB 1259 Negotiated Agreement (NA) with the State HHSA and involved the collaboration of the California Department of Social Services (CDSS) and the State Department of Mental Health (SDMH).

Specifically, through the NA, SB 163 wraparound funding was made available to provide strength based mental health and alcohol and drug treatment to minors placed in Humboldt County's New Horizons Regional Facility, ensuring consistent and expanded services to this population and allowing for the county's limited realignment funds to be dedicated to the adult incarcerated population.

(Goal #6) Develop and implement a consolidated SB 933 foster care placement review ability.

Again, as a result of AB 1259, the NA clarified the process by which Humboldt County could establish an integrated placement team to ensure that enhanced foster care placement, placement review/visitation and re-integration could occur. The establishment of this co-located and fully staffed team from Health and Human Services (Mental Health and Social Services Branches), Probation, Humboldt County Office of Education and other cooperating entities has enhanced care and funding for high risk wards, dependents and SED minors at a level that meets or exceeds the requirements of SB 933 visitation legislative mandates. Further, this AB 1259 integrated approach to foster care placement and oversight has significant service integration and cost efficiency implications for all California counties, is a cornerstone for Humboldt County's Child Welfare Services (CWS) redesign strategies, and is available to other counties for replication.

(Goal #7) Increase funding access to Title XIX and Title IV-E for eligible services provided by mental health professionals, probation officers and social workers.

In relation to AB 1259, the State Health and Human Services Agency provided access to planning meetings with various State departments in order to facilitate accomplishment of Humboldt County's goals. Enhanced and sustainable funding for these populations was a goal that required collaboration and consultation with CDSS and SDMH. Through this AB 1259 process, Federal Financial Participation revenue enhancement through Title XIX/EPSDT was obtained in relation to services provided by Probation and Social

Services. While the premise was a derivation of an urban mode1 (i.e. the establishment of Organizational Provider Networks), Humboldt County's approach consisted of establishing the conditions under which the Probation Department and Social Services Branch of the Department of Health and Human Services could access this entitlement consistent with the services being within Title XIX's scope, and being provided to eligible populations by eligible providers. The CDSS/SDMH meetings resulted in the Probation Department becoming an Organizational Provider in Humboldt County's Mental Health Branch network and the Social Services Branch claiming directly through Mental Health as a Branch under our consolidated Health and Human Services "umbrella agency". The State Department meeting process also articulated the "mechanics" of these approaches to ensure compliance with regulations pertaining to these services.

(Goal #8) Develop a "consolidated" Title IV-E Training Plan package.

Through targeted technical assistance by CDSS, the conditions under which cross branch and interdepartmental training could be partially reimbursed under Title IV-E were accomplished. As a result, Humboldt County Department of Health and Human Services has developed protocols that establish the methods to claim to this revenue source for previously unreimbursed staff and community trainings. This cross departmental training is essential to enhancing the quality of services to our mutual target populations and provides a mechanism for strengthening collaboration through mutual education and other group "process related" benefits.

(Goal #9) Increase linkages and explore enhanced funding strategies and services to needy families as defined in Temporary Assistance for Needy Families (TANF).

While a broad and complex goal, the AB 1259 Organizational consolidation, the cross training and inter Branch education related to enhancing understanding of each Branch's (Mental Health, Social Services and Public Health) services, target populations, and revenue streams have resulted in many cross Branch linkages and enhanced services to the TANF population. This has resulted in more efficient use of and increased claims relating to Mental Health/Public Health/Social Services Allocations that serve TANF eligible families and children. In addition, the linkage has been established between TANF and Workforce Investment Act (WIA) eligible populations and has resulted in a planned co-location of various "work related" programs including Social Services' Welfare to Work/CalWORKs programs, Mental Health's Barriers to Employment programs and previously "unlinked" Employment Training programs that serve mutual target population families and high risk or out of school youth.

(Goal #10) Increase linkages and explore enhanced funding strategies for in-home supportive services to the elderly and disabled.

As a result of AB 1259 and its overall mission of eliminating service barriers towards efficient provision of Health and Human Services to our residents, significant progress has been made in relation to this Elderly and Disabled target population. In order to enhance the quality of services, reduce service fragmentation and fraud, and concurrently increase

revenue access, several previously unlinked and/or new services were co-located and now provide integrated and cross disciplinary services to this vulnerable target population. These co-located services include Social Services Branch In-Home Supportive Services (IHSS) and Adult Protective Services (APS) social worker and eligibility staff, older adult Mental Health staff, Public Health nursing staff, and the Public Authority Registry staff established under AB 1682. In addition to co-location and cross training and the resultant increase in the quality of care, the County has realized its first decline in costs relating to this target population.

Additional 1999-2004 AB 1259 related Integrated System accomplishments included:

- Humboldt County's first (residential capacity) mother/child substance abuse treatment program was established.

- A Consolidated Prevention Strategic Plan was developed that will provide the Department with a blueprint towards enhancing primary and secondary prevention approaches.

- The development of cross-branch CWS Children's Shelter and urgent care services was completed and is yielding emphasized collaborative service planning between the Mental Health and Social Services Branches for high risk CWS children and families.

- Humboldt County adopted a cross-branch administrative consolidation of Information Services, Employment Services and Financial Services toward the goals of reduced duplication, enhanced claiming and reducing our exposure to risk management areas.

- With integrated services assistance from our Mental Health Branch, Child Welfare Services has demonstrated significantly enhanced State benchmark compliance, has established methods of tracking outcomes, and implemented other quality improvement practices.

- Humboldt County has continued the development of an integrated mentally ill homeless program.

- Humboldt County's Community fiscal and service partnerships in the establishment of the Multiple Assistance Center (MAC), targeting homeless families and individuals was established with the Center opening in Spring of 2005.

- Humboldt County Health and Human Services has partnered with Community Based Organizations for enhanced Family Preservation and Mental Health services, expanding the safety net for at risk families and children.

- Cross Branch transition age service planning for Foster Care youth, both wards and dependents, across our agency is under way.

- Humboldt County was selected by CDSS as a "Cohort One" CWS Redesign implementer.

California Strategic Plan on Suicide Prevention:

Every Californian Is Part of the Solution

California Department of
Mental Health

California Strategic Plan on Suicide Prevention:
Every Californian Is Part of the Solution

Based on Recommendations of the
Suicide Prevention Plan Advisory Committee

This *Strategic Plan on Suicide Prevention (Plan)* was approved by the Governor's Office of the State of California on June 30, 2008.

Arnold Schwarzenegger
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Kimberly Belshé
Secretary, Health and Human Services Agency

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In September 2006, Governor Arnold Schwarzenegger directed the California Department of Mental Health (DMH), through a veto message to Senate Bill 1356 (Lowenthal), to administratively develop a statewide strategic plan on suicide prevention. The DMH and the California Health and Human Services Agency were to build on work done by the California Suicide Prevention Advocacy Network and coordinate with all interested constituency groups and state and local agencies to develop the plan by May 1, 2008. The DMH convened the Suicide Prevention Plan Advisory Committee to provide recommendations for the plan.

The Advisory Committee met over approximately nine months to craft the strategic directions and recommended actions contained in this document. In addition to the committee meetings, two stakeholder workshops were held in September 2007 to ask the public, including youth, families, and survivors of suicide attempts, to provide input on the draft plan's preliminary recommendations.

We deeply appreciate the Advisory Committee's hard work and acknowledge the personal commitment and many contributions of the individuals listed on the following pages.

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INTRODUCTION

The statistics about suicide are alarming. Suicide is the tenth leading cause of death in California. Every year approximately 3,300 Californians lose their lives to suicide. More suicide deaths are reported in our state than deaths caused by homicides. On average, nine Californians die by suicide every day. Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds.

> *"On average nine Californians die by suicide every day."*

The causes of suicide are complex and include an array of biological, psychological, social, environmental, and cultural risk factors. Too often, there is lack of coordination between service systems and providers and a lack of knowledge about how to recognize the warning signs of suicide. For far too long, suicide has been viewed as a taboo subject. Fear of stigma and discrimination surrounding suicide can be so pervasive that it often deters people from seeking help.

Suicide is a devastating tragedy in terms of the lives lost and the emotional heartbreak that family members and other loved ones endure. This tragedy is even more distressing because suicide deaths are preventable.

Traditionally, suicide has been considered primarily a concern of the mental health system, largely due to the connection between mental illnesses, such as depression, and the elevated risk of suicide. However, in 2001, the President's New Freedom Commission called for a change that would place mental health

into the context of the broader public health system. The transformed system would provide quality care for those in need, but it would also promote resiliency, recovery, and health.

In response to this change and in combination with other events, Governor Arnold Schwarzenegger in 2006 charged the Department of Mental Health (DMH) with the development of a strategic plan on suicide prevention. The DMH embarked upon this work in partnership with the Suicide Prevention Plan Advisory Committee composed of mental health experts, advocates, providers, researchers, and representatives from various nonprofit and government agencies. The Advisory Committee also included other important voices—survivors of suicide attempts and suicide loss.

The *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution* (Plan) is built upon the vision that a full range of strategies, starting from prevention and early intervention, should be targeted to Californians of all ages, from children and youth to adults and older adults. To effectively reduce suicides and suicidal behavior, communities need prevention services to promote health and address problems long before they become acute, as well as a coordinated system of services to effectively respond to crisis situations.

This Plan serves as a blueprint for action at the local and state levels. The Plan is intended to guide the work of policy makers, program managers, providers, funders, and others in bringing systems together to better coordinate their efforts, and to enhance needed prevention and intervention services as well as postvention, or services provided after a suicide or suicide attempt that offer follow-up care for survivors.

The Plan consists of four major parts:

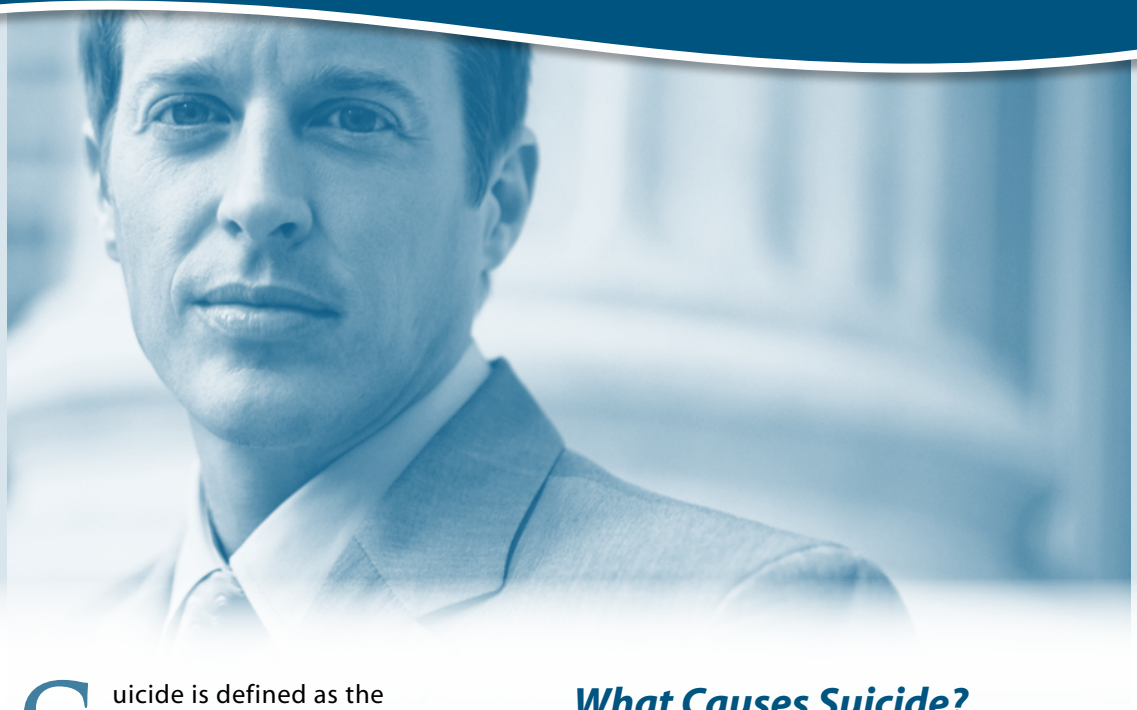
- Part I presents information about suicide's impact and magnitude from different sources and different perspectives.
- Part 2 describes successful and promising strategies, practices, and policies that have been used to prevent suicide.
- Part 3 provides the Advisory Committee's recommended actions to reduce suicide deaths and the incidence of suicidal behaviors in California. Many of the recommendations require a long-term effort, while others can be implemented more quickly.
- Part 4 lists the next steps for local and state action.

An Executive Summary of the Plan is also available that provides a brief overview of Parts 1 and 2 as well as the complete list of strategic directions, recommended actions, and next steps.

This Plan should be viewed as a dynamic document that will be periodically reviewed and revised to reflect evolving needs in California. Over time, it is anticipated that the full spectrum of strategies, from prevention through intervention, will be more comprehensively addressed.

Suicide prevention must be a priority in our state. While many challenges lie ahead in carrying out this work, tremendous opportunities also exist. With thousands of lives at stake each year, every Californian needs to be part of the solution.

PART 1: THE PROBLEM AND THE CHALLENGE



Suicide is defined as the intentional taking of one's own life.[a] It is the "final and most severe endpoint" along a continuum of self-harming behaviors.[1] The broader term of suicidal behavior also includes self-inflicted, potentially injurious behaviors.[2] Clearly, it is important to monitor the whole range of self-harmful or injurious behaviors because they may indicate an increased risk of suicide in the future. Suicides may be hidden from vital statistics data. They may include a lethal overdose of prescription or illegal drugs, single car collisions with a fixed object, or incidents when an individual engages in a life-threatening behavior to the degree that it compels a police officer to respond with deadly force.

What Causes Suicide?

The causes of suicide are complex and vary among individuals and across age, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors (Table 1).

Many people who attempted or completed suicide had one or more warning signs before their death (Table 2). While warning signs refer to more immediate signs or symptoms in an individual, risk factors for suicide are generally longer-term factors that are associated with a higher prevalence of suicide in the population.[3] Recognition of warning signs has a greater potential for immediate prevention and

NOTES

[a] Assisted suicide is beyond the scope of this Plan.

Table 1: Risk Factors for Suicide.

Bio-psycho-social Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance abuse disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relationship or social loss
- Easy access to lethal means
- Local clusters of suicides that have a contagion influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health and mental health services and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution to a personal dilemma)
- Exposure to suicide through the media and the influence of others who have died by suicide

Source: Suicide Prevention Resource Center

Table 2: Warning Signs of Suicide.

Signs of acute suicidal ideation:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves, e.g., seeking access to pills, weapons, or other means
- Talking or writing about death, dying, or suicide if this is unusual for the person

Additional warning signs:

- Expressing feelings of hopelessness
- Showing rage or anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Indicating a feeling of being trapped – like there is no way out
- Increasing use of alcohol or drugs
- Withdrawing from friends, family, or society
- Experiencing anxiety, agitation, inability to sleep, or sleeping all the time
- Showing dramatic changes in mood
- Expressing no reason for living, or no sense of purpose in life

Source: Suicide Prevention Resource Center

intervention when those who are in a position to help know how to appropriately respond.

Feelings of hopelessness and an inability to make positive changes in one's life are two consistent psychological precursors to suicidal behaviors.[4,5] Many of those who die by suicide are described by family or friends as having been depressed or as having problems with a current or former intimate partner.

Trauma has a significant impact on suicide risk across the life span. A survey of over 17,000 patients at a health clinic in San Diego found that a history of adverse childhood experiences was associated with a significant increase in the prevalence of attempted suicides.[6] For example, individuals reporting that their parents had separated or divorced were twice as likely to have attempted suicide, and those who were emotionally abused as children were five times as likely to have attempted suicide. For each additional adverse experience, the risk of attempted suicide increased by about 60 percent. This study also found a high prevalence of depression and substance abuse, suggesting that a history of adverse childhood experiences is associated with a host of negative outcomes.

What Are the Protective Factors Against Suicide?

Protective factors can reduce the likelihood of suicide by counterbalancing some of the risk factors (Table 3).

Examining populations with lower suicide rates can help understand potential protective factors and focuses for prevention strategies. Social (including religious), political, and economic factors may help explain different rates of suicide between countries.[7] According to the World Health Organization, the highest suicide rate in the world is in Hungary (66.0) and the lowest is in Mexico (2.5).[b] Differences in rates of depressive disorders, alcohol consumption, proportion of older adults, levels of social isolation, and religiosity may all play a role in the rate of suicide.[7]

In the United States (U.S.), suicide rates among African American women, particularly in middle age, are very low.[8] In California, the lowest suicide rate is among Latinos between 55 to 64 years of age.[9] Sociocultural differences between population groups and between

Table 3: Protective Factors Against Suicide

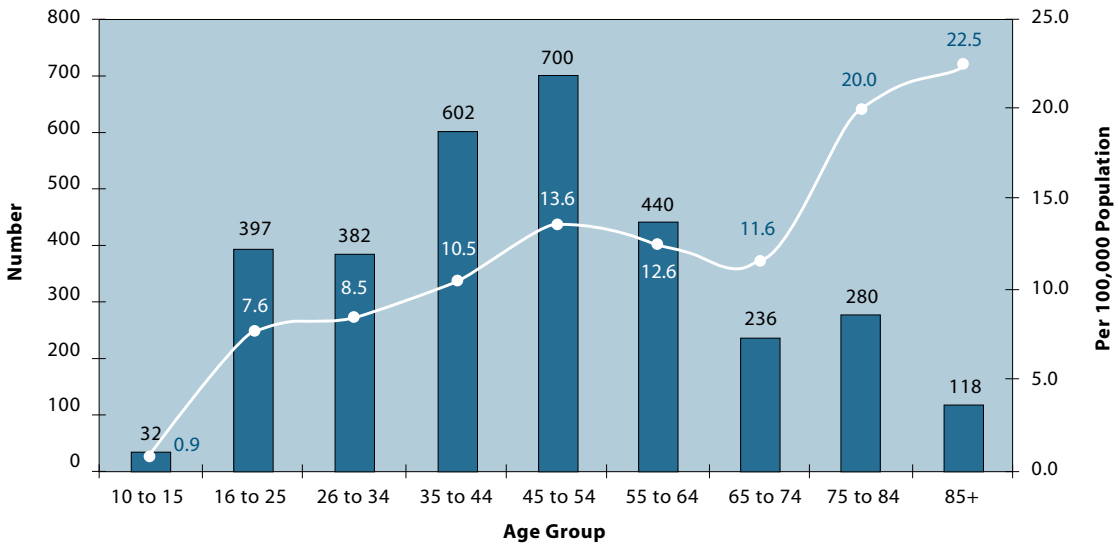
- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Source: Suicide Prevention Resource Center

NOTES

[b] These data should be interpreted cautiously, as they are compiled from various sources and studies. They may have employed different criteria and methods, which may result in under-reporting of actual suicide deaths.

Figure 1. Suicide Death Rates and Number of Deaths in California by Age, 2005.



Source: California Department of Public Health

individuals, including social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important underlying factors.[7]

> *"The rate of suicide increases significantly with advanced age."*

Who Dies by Suicide?

According to data from the CDPH, the age-adjusted[c] rate of suicide within the general population of the state is 8.8 per 100,000.[d] The most recent California County Health Status Profiles report indicates that the highest average number of suicide deaths from 2003 to 2005 was in Humboldt County (20.0), and that Los Angeles County had the lowest rate (7.2). In 2004, over 16,000 individuals were hospitalized for self-inflicted injuries in California (46.0).[9]

Age

The *rate* of suicide increases significantly with age (Figure 1). In California, adults over the age of 85 have the highest suicide rate in the state, at 22.5.[9] However the largest *numbers* of suicide deaths occur in the age range of 45 to 54, as shown in Figure 1. Of the 3,187 individuals who died by suicide in 2005, over 40 percent (1,302) were adults between 35 to 54 years of age.

Depression and chronic illness are significant risk factors for suicide among older adults.[10] In addition to heightened suicide risk, depression is linked to multiple adverse health outcomes, including premature mortality and diminished quality of life.[11] Depression rates are particularly high among older adults receiving

NOTES

[c] An age-adjusted rate allows for comparisons between groups with different age distributions.

[d] Throughout this report, all references of suicide rates are per 100,000 population.

Table 4. Ten Leading Causes of Death, California 2005, All Races, Both Sexes (County of Residence)

Rank	Age Group												
	<1	01-05 [a]	06-09 [b]	10-15	16-25	26-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 684	Unintentional Injury 222	Unintentional Injury 89	Unintentional Injury 191	Unintentional Injury 1,563	Unintentional Injury 1,203	Unintentional Injury 1,744	Malignant Neoplasms 4,936	Malignant Neoplasms 9,323	Malignant Neoplasms 12,953	Heart Disease 18,998	Heart Disease 25,367	Heart Disease 64,689
2	Short Gestation 453	Congenital Anomalies 76	Malignant Neoplasms 47	Malignant Neoplasms 74	Homicide 985	Homicide 577	Malignant Neoplasms 1,562	Heart Disease 3,499	Heart Disease 6,189	Heart Disease 8,991	Malignant Neoplasms 16,422	Malignant Neoplasms 8,528	Malignant Neoplasms 54,613
3	Maternal Pregnancy 174	Malignant Neoplasms 62	Congenital Anomalies 16	Homicide 73	Suicide 397	Malignant Neoplasms 409	Heart Disease 1,164	Unintentional Injury 2,019	Unintentional Injury 1,191	Chronic Low Resp. Dis. 2,622	Chronic Low Resp. Dis. 5,139	Cerebro-Vascular 6,431	Cerebro-Vascular 15,551
4	SIDS 151	Homicide 37	Chronic Low Resp. Dis. 7	Congenital Anomalies 39	Malignant Neoplasms 282	Suicide 382	Suicide 602	Liver Disease 1,116	Diabetes Mellitus 1,173	Cerebro-Vascular 1,986	Cerebro-Vascular 5,015	Alzheimer's Disease 4,920	Chronic Low Resp. Dis. 13.167
5	Placenta, Cord, Membranes 90	Heart Disease 19	Heart Disease 7	Suicide 32	Heart Disease 118	Heart Disease 280	HIV 468	Chronic Low Resp. Dis. 703	Chronic Low Resp. Dis. 1,140	Diabetes Mellitus 1,678	Diabetes Mellitus 2,360	Chronic Low Resp. Dis. 3,722	Unintentional Injury 10,926
6	Neonatal Hemorrhage 89	Influenza & Pneumonia 19	Homicide 6	Heart Disease 25	Congenital Anomalies 56	HIV 97	Liver Disease 420	Suicide 700	Chronic Low Resp. Dis. 1,046	Influenza & Pneumonia 772	Alzheimer's Disease 2,347	Influenza & Pneumonia 3,680	Alzheimer's Disease 7,694
7	Resp. Distress 89	Chronic Low Resp. Dis. 8	Influenza & Pneumonia 6	Chronic Low Resp. Dis. 9	Complicated Pregnancy 29	Liver Disease 57	Homicide 385	Diabetes Mellitus 660	Liver Disease 1,039	Unintentional Injury 705	Influenza & Pneumonia 2,291	Diabetes Mellitus 1,500	Diabetes Mellitus 7,679
8	Bacterial Sepsis 68	Chronic Low Resp. Dis. 6	Benign Neoplasms 4	Benign Neoplasms 8	Chronic Low Resp. Dis. 26	Diabetes Mellitus 55	Chronic Low Resp. Dis. 267	HIV 451	Suicide 440	Liver Disease 682	Unintentional Injury 1,035	Hypertension 1,351	Influenza & Pneumonia 7,537
9	Unintentional Injury 65	Perinatal Period 6	Chronic Low Resp. Dis. 3	Influenza & Pneumonia 7	Diabetes Mellitus 25	Congenital Anomalies 54	Diabetes Mellitus 219	Chronic Low Resp. Dis. 391	Influenza & Pneumonia 369	Nephritis 436	Parkinson's Disease 883	Unintentional Injury 887	Liver Disease 3,819
10	Intrauterine Hypoxia 62	Meningitis 5	Diabetes Mellitus 1	Diabetes Mellitus 6	HIV 15	Chronic Low Resp. Dis. 51	Influenza & Pneumonia 107	Viral Hepatitis 254	Nephritis 307	Hypertension 388	Hypertension 882	Athero-sclerosis 845	Suicide 3,188

Source: California Department of Public Health

[a] Septicemia also ranked 10th. [b] Liver Disease, Meningococcal Infection, Perinatal Period, and Septicemia also ranked.

in-home care or living in institutions and among those with chronic diseases such as asthma, chronic obstructive pulmonary disease, arthritis, and heart disease.[11]

Older adults are becoming an increasing proportion of the state's growing population, particularly as the baby boomers approach age 65. In 2000, the population of people over the age of 65 was over 3.6 million; in 2010 it is projected to be over 4.4 million; and in 2020, it may exceed 6.3 million.[12] Thus, it is becoming increasingly important to pay attention to the high rates of suicide among older adults.

Another way to understand the data is to consider leading causes of death in California (Table 4). Although the rate of suicide among older adults is high, suicide is not one of the ten leading causes of death among adults aged 65 and older. Among youth and young adults between 16 to 25 years of age, suicide is the third leading cause of death.

Table 5. Age-Adjusted Suicide Death Rates by Race/Ethnicity and Sex, California, 2005.

Race/Ethnicity	Males	Females
Whites	19.3	5.9
African Americans	9.1	2.9
Asians	7.9	2.9
Latinos	7.5	1.4
2+ races*	5.9	3.3
All Races Combined	14.1	4.0

Source: California Department of Public Health **This rate is considered statistically unreliable.*

Nationally, more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and chronic lung diseases combined.[13] Among specific groups, including females from 10 to 19 years of age and males between 15 to 19 years of age, national data indicate an increase in suicide rates in recent years.[14]

Data from a University of California (UC) survey illustrates the prevalence of suicidal behavior among young adults. Among students participating in the survey, nine percent reported serious suicidal ideation, and up to 80 percent of those had not received mental health services.[15] The incidence of suicidal behavior, including attempts, the number of students taking psychotropic medications, and the number of mental health and crisis visits to student health centers increased significantly between 2000 and 2005. The students identified at the highest risk for completing suicide included graduate students; gay, lesbian, bisexual, transgender, and questioning (GLBTQ) students; international students; and racially and ethnically underrepresented students.

Sex

In California, males are three times more likely to die by suicide than females.[9] After the age of 14, rates of suicide are significantly higher among males regardless of age, race, or ethnicity (Table 5).

However, it is important to note that women attempt suicide three times as frequently as men and are more likely to be hospitalized for self-inflicted injuries, primarily from poisoning or hanging.[9] Sixty percent of hospitalizations for self-inflicted injuries are among females. Several studies have reported that women are both more likely than men to attempt suicide and also to have a history of sexual abuse.[6,16,17]

The difference between the sexes in suicidal behavior begins to emerge in adolescence (Table 6). Surveys of eighth grade students in California, Arizona, Nevada, and Wyoming found that girls were more likely to report suicidal ideation and attempts than boys and that girls were also more likely to feel like they had less control over their environment.[5]

In addition to mortality rates, the public health burden of suicide is also measured in terms

Table 6. Suicide Death Rates by Age and Sex, California, 2005.

Age Groups	Rates among males	Rates among females
All Ages	14.1	5.9
1-4	-	-
5-14	0.4	0.2
15-24	10.9	2.6
25-34	13.0	3.8
35-44	15.8	4.9
45-54	19.8	7.5
55-64	19.3	6.3
65-74	19.5	4.9
75-84	39.6	6.1
85 and older	53.5	6.6

Source: California Department of Public Health

of years of potential life lost and value of lost earnings. One study that used this approach found that middle-aged men contribute disproportionately to the burden.[19] The study suggested that concerns around stigma and help-seeking behavior may contribute to this problem among men.

Race and Ethnicity

Rates of suicide differ significantly among racial and ethnic groups (Figure 2). The most recent available data in California indicate that in 2005 Whites had the highest rate of suicide followed by Native Americans (American Indians), Pacific Islanders, African Americans (Blacks), Asians, people identifying as two or more races, and Latinos.[9] These rates vary among counties. It is important to note that even a small increase in the number of deaths can dramatically increase the rate in population groups that are relatively small in number, as evidenced by the increase in the suicide rate among Pacific Islanders in 2003 (Figure 2).

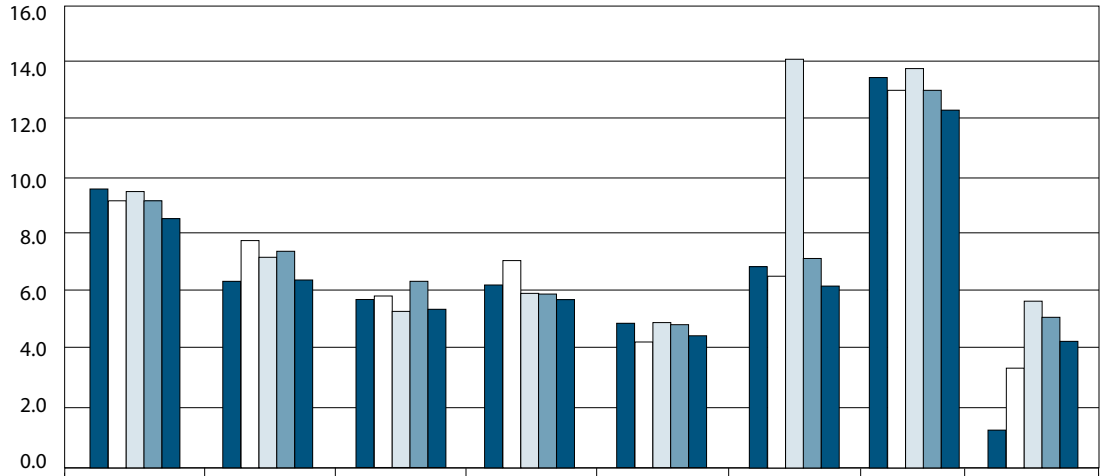
California data are consistent with national data, which indicate that Whites account for 84 percent of all suicide deaths.[20] However, despite the very high suicide rates among White males, few prevention programs target this demographic. This group is also one of the least likely to seek mental health treatment.[21]

Historically, African Americans have had lower rates of suicide than other racial and ethnic groups. However, national studies have noted that the suicide rate among African American males under the age of 35 has increased significantly over the last two decades, particularly among young men in the northern and western states.[22]

Among Latinos, suicide attempts are most prevalent in young females under the age of 18; data from the national Youth Risk Behavior Surveillance study of youth in grades seven, nine, and eleven found

AGE-ADJUSTED DEATH RATE

Figure 2. Age-adjusted Suicide Death Rates By Race/Ethnicity, California Residents, 2001-2005.



	Total	American Indian*	Asian	Black	Latino	Pacific Islander*	White	Two or More Races*
2001	9.7	6.5	5.6	6.1	4.9	7.0	13.4	1.3
2002	9.4	7.9	5.7	7.0	4.3	6.8	13.0	3.5
2003	9.7	7.4	5.2	5.9	4.9	14.3	13.7	5.9
2004	9.4	7.6	6.3	5.8	4.8	7.3	13.0	5.3
2005	8.8	6.6	5.3	5.7	4.4	6.3	12.3	4.5

*Includes unreliable rates for American Indian, Pacific Islander, and Two or More Races.

Source: California Department of Public Health

that more Latina students, nearly one quarter, reported suicidal ideation and behaviors than their White or African American female peers.[23,24]

Limitations of Race and Ethnicity Data

It is important to note that the suicide rates for American Indians and Pacific Islanders are considered unreliable due either to small population size or the relatively small number of events that are reported (less than 20 per year). However, national data indicate that American Indian and Alaska Native youth are at disproportionately high risk of suicide compared to non-Native youth. Suicide is the leading cause of death among American Indians and Alaskan Natives between 15 and 24 years of age, and from 1999 to 2004, young men in this population had a higher suicide rate (27.99) than any other racial and ethnic group of the same age.[20]

The discrepancy between the low number of reported incidents of suicide among certain racial/ethnic groups in California and what is known from national data suggest the need for improved research and surveillance activities that target these groups. It is critical to understand that suicide prevention research and surveillance activities need to determine whether there may be a significant difference between California's population and that in other states, or whether data reporting and analysis need to be strengthened for all population groups that may currently be underreported.

Mental Illness

The National Violent Death Reporting System found that nearly half of suicide cases involve at least one documented mental health diagnosis.[10] It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder.[25] Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder (a spectrum that includes major depression and bipolar disorder), up to 20 percent die by suicide.[26] The risk tends to be highest among those who have frequent and severe recurrences of symptoms.[27]

Suicide is the leading cause of death among individuals with schizophrenia. Nearly 6 percent complete suicide, with most suicide deaths occurring early in the illness, and up to 40 percent attempt suicide at least once.[28,29] Co-occurring substance and alcohol abuse exacerbates the risk of suicide. In one national study, individuals diagnosed with major depressive disorder that used drugs or engaged in binge drinking were significantly more likely to report suicidal thoughts and to attempt suicide than those with major depressive disorders who did not abuse alcohol or drugs.[30]

Issues of stigma and discrimination related to mental illness and suicide may negatively impact accurate identification and reporting of suicide deaths. Ascertaining suicidal intent in determining cause of death is often a challenge. This challenge can be exacerbated by concerns about the impact of a determination of suicide on the families and others who lost a loved one and by concerns about confidentiality, particularly in small communities.

Criminal Justice System Involvement

Nationally, the number of individuals with mental illness who are in jails and prisons is higher than those that are in psychiatric hospitals.[31] More than half of all prison and jail inmates have a mental illness. This rate is three times that of the general population.[32]

Suicide is the third leading cause of death in California prisons.[144] Like other prison systems nationally, suicide deaths in California's prisons are predominantly among White males.

> *"Suicide is the third leading cause of death in California prisons."*

The U.S. Department of Justice reports that between 1994 and 2003, suicide was the second leading cause of death for individuals in custody.[33] Nationally, suicide accounted for 32 percent of local jail inmate deaths between 2000 and 2002. Suicide rates in local jails were three times that in state prisons. Violent offenders were nearly three times more likely to die by suicide than other inmates in jails.

In both jails and prisons across the country, White inmates have significantly higher rates of suicide than other races.[33] In prisons, male and female inmates die by suicide at similar rates. However, in jails, men are over 50 percent more likely to die by suicide than females. Finally, 80 percent of suicides occur within the cell.

In prisons, the periods of highest risk for suicide are during the first month of incarceration and the first few weeks after release.[34,35] Nearly half of jail suicides occur within the first week of custody. Almost one quarter of these are on the date of admission or the following day.[33]

One study found that in 40 percent of the 196 intimate partner homicide cases in California that occurred in 1996, the perpetrator also completed suicide.[36] In these cases, the use of a gun and a perpetrator who was a White male were both significant predictors that the perpetrator would also complete suicide. Among older people who died by intimate partner homicide-suicide, the reasons were typically related to poor health or financial concerns.

Veterans

An analysis of data from national health surveys and the National Death Index from the middle 1980s to 1990s found that male veterans were twice as likely to die by suicide as the general male population, especially those who were White, less educated, and had physical disabilities.[37] Data collected prior to the Iraq War estimated that suicide rates among veterans currently using Veterans Affairs (VA) facilities were 45.0 per 100,000 among those over the age of 65, and as high as 83.0 per 100,000 for those under age 65.[38] Extrapolating from more recent national data, the VA estimates that there are 1,000 suicides per year among veterans receiving care through the VA health care system and as many as 5,000 per year among all veterans.[38] Some of the groups at highest risk include those with severe mental illnesses, combat-related post-traumatic stress disorder (PTSD), traumatic brain injury, traumatic amputation or disfigurement, military sexual trauma, and spinal cord injuries.

> *"Male veterans are twice as likely to die by suicide as the general male population."*

A study of patients in the VA health care system found that among veterans receiving treatment for depression, the rate of suicide was seven to eight times that of their counterparts in the general population (a rate of 88.25 among veterans versus a rate of 13.5 among the general population in 2004).[39] This study found that several trends in suicide deaths among veterans are different from those found in the general population. For example, the risk is higher among younger, rather than older, individuals, particularly in the presence of conditions such as PTSD. Furthermore, the relative suicide rates of male and female veterans are not as far apart as those in the general population.

Surveys of military personnel stationed in Iraq and Afghanistan indicate that as many as 17 percent met the criteria for major depression, generalized anxiety, or PTSD.[40] This is significantly higher than the rates among the general population. Of those personnel, less than 40 percent sought mental health care, and many reported being concerned about stigma and discrimination because of their mental health problems.

The danger of untreated mental illness among veterans is illustrated by the fact that among populations with high rates of suicide - older adults, those with a mental illness or substance abuse disorder, and those who are homeless – a large number are also veterans. The VA estimates that approximately one-third of all adults who are homeless are veterans.[41] Nearly half of homeless veterans have a mental illness, 70 percent suffer from alcohol or other drug abuse, and 56 percent are African American or Latino.[41] The number of homeless Vietnam-era veterans is greater than the number that died in that war. To address this problem and to prevent it from growing in the future, California's suicide prevention planning must take into account the unique needs of veterans who have recently, or will soon be, returning from the active field of war.

Homeless Individuals

Although individuals who are homeless often meet many of the criteria for elevated suicide risk, such as serious and untreated mental illness, social isolation, poverty, and substance abuse, the data about suicide in this population is limited.[42] Collecting accurate data about suicidality among individuals who are homeless presents a methodological challenge for many of the same reasons that put them at higher risk.

The Access to Community Care and Effective Services and Supports (ACCESS) program, a national Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project, served over 7,000 individuals experiencing serious mental illness and chronic homelessness at 18 sites nationally. Among a sample of these individuals, over 50 percent reported that they had attempted suicide, over 25 percent reported an attempt that resulted in hospitalization for their injuries, and eight percent reported an attempt in the previous 30 days.[43] The lifetime prevalence of suicidal ideation was 66 percent. Younger age, co-occurring substance abuse, and presence of psychiatric symptoms were all significantly associated with suicide attempts. Those who reported a recent attempt also reported higher rates of inpatient mental health care utilization.

Other studies have also found that individuals who are homeless longer than six months may be at particularly high risk of suicide.[44] Furthermore, suicide rates are highest among individuals 30 to 39 years old, although co-occurring substance abuse significantly increases the risk among older individuals.[45] Among homeless and runaway youth, factors such as depression, history of physical and sexual abuse, and having a friend who attempted suicide may all contribute to an increase in suicide risk.[46]

Immigrants

Several factors may influence the rates of suicide among certain groups, including accessibility of mental health services, especially services that are culturally and linguistically appropriate. Different cultural attitudes about suicide and mental health may also play an influential role in the willingness to seek help for mental health problems. For specific immigrant and refugee populations, factors related to acculturation and family conflict may play an important role.[24]

Riverside County is one of the fastest growing counties in California, primarily due to immigration. One study examined over 100,000 death certificates from first generation White immigrants who had died between 1998 and 2001.[47] There was

significantly higher mortality from suicide among non-Hispanic White immigrants (including those born in Europe, the Middle East and North Africa), than U.S. born individuals of the same ethnicity.

Another study of coroner case records from the same time period examined some of the factors associated with the higher suicide risk among immigrants. Those at highest risk of suicide were more recently arrived; divorced, separated, or widowed; male; middle aged or older; and White.[48]

Rural Populations

Rural states have the highest rates of suicide in the country, particularly among adult and older adult males and youth. One study found that among people diagnosed with bipolar disorder, those who live in rural areas have higher rates of suicide attempts than their urban counterparts.[49] Possible contributing factors to this higher rate include the availability and quality of mental health services, increased impact of stigma due to reduced anonymity in smaller communities, higher poverty rates, and the larger percentage of older adults in the population.[49,50]

One study compared the suicide rates in urban and rural counties in California with the per capita number of health (licensed physicians) and mental health providers in those counties.[51] The study confirmed that the rates of suicide were higher in rural counties, and also that the rate of suicides by firearm were higher the more rural the county. However, the rate of suicide was not correlated with the per capita number of health and mental health providers in the counties. This study was not able to address the issue of the quality and accessibility of appropriate services in rural areas. More research needs to be done to determine if issues of quality and accessibility play a role in the higher suicide rates in rural areas.

> *"Lesbian, gay, and bisexual individuals, particularly adolescents and youth, have significantly higher rates for suicidal behavior."*

Sexual Minority Populations

Data from multiple national studies (including the National Longitudinal Study of Adolescent Health, National Lesbian Health Care Survey, National Latino and Asian American Survey, and the Urban Men's Health Study) have demonstrated that lesbian, gay, and bisexual individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts.[52,53,54,55,56]

Research within California confirms the national data:

- In a survey of over 2800 men who either identified as gay or bisexual or as having had sex with other men in four U.S. cities, including Los Angeles and San Francisco, over 20 percent of respondents had made a suicide plan and another 12 percent had attempted suicide at least once, typically before age 25.[57] This represents a three-fold increase in risk among gay and bisexual men compared to men in the general population.

- Ten percent of respondents in a survey of over 500 Los Angeles County men between ages 18 to 24 who identified as gay, bisexual, or questioning,

or having had sex with a man, reported having seriously considered suicide.[58] This group was also characterized by low rates of access to health care and health insurance coverage.

- A San Francisco survey of over 523 transgender individuals found that nearly one-third of the respondents had attempted suicide.[59] This study is unique in that it identified gender discrimination and physical victimization as independent risk factors for suicide attempts.

> *"Suicide is the second leading cause of postpartum maternal deaths."*

Coping with stigma and discrimination based on sexual orientation can be a particularly challenging issue for adolescents and young adults. A survey of over 1,700 California youth ages 12 to 18 years found that those who identified as lesbian, gay, or bisexual were at elevated risk for a range of health and mental health problems, especially those youth who reported being less comfortable with or uncertain about their sexual orientation.[60]

Social support in a community of peers is especially important to this vulnerable population, especially when family and school environments are stressful. One longitudinal study of lesbian, gay, and bisexual youth between ages 15 to 19 in the New York City area found that the strongest predictive factors of suicide risk were a history of parental psychological abuse and more gender atypical behavior in childhood, especially among males.[54]

Among gay or bisexual men, factors associated with higher risk included a perceived hostile environment related to their sexuality, less education, lower income, and lower employment.[57] Native Americans, older men, and men who were bisexual or did not identify as any specific sexual orientation had the highest prevalence of suicide attempts. Attempts were also higher among men who reported adverse childhood experiences, such as parental substance abuse, repeated childhood physical abuse, and childhood sexual coercion. This study found that the age of disclosure of sexual orientation has been steadily declining over time, but that reported harassment has increased dramatically among younger generations.

Women with Perinatal Depression

According to the National Women's Health Information Center, a service of the U.S. Department of Health and Human Service's Office on Women's Health, perinatal depression occurs during pregnancy or within the first year after childbirth. Although the exact prevalence of perinatal depression is not known, it is believed to be one of the most common complications women experience during and after pregnancy. Since some of its symptoms are very similar to typical changes that occur around pregnancy and birth, perinatal depression may be under-recognized.

Although suicide rates among women who are pregnant or recently gave birth are lower than the general population of women, suicide is the second leading cause

of postpartum maternal deaths.[61] Up to 14 percent of women report suicidal ideation during pregnancy and the postpartum period.[61] Women who have a history of depression are at 70 times greater risk of suicide than those without this psychiatric history.[62] Throughout the first year after giving birth, over 30 percent of women who report postpartum depression continue to have depressive symptoms, and less than half improve within the first three months after giving birth.[63]

There may also be a link between maternal depression, recurrence of depression, and later behavioral problems in the child. Extended maternal depression can have a negative impact on attachment between mother and child, which may put the child at increased risk of developing behavioral problems.[64] Although perinatal depression was not specifically addressed in the Adverse Childhood Experiences Study, the study did find that children who grew up in a household where someone had a serious mental illness were more likely to attempt suicide at least once in their lifetime.[6] Therefore, it is important that pregnant women are screened for factors that may put them at higher risk for perinatal depression, including a history of depression and/or postpartum depression, throughout the year following birth in order to successfully recognize and treat maternal depression and also to reduce the likelihood of adverse impacts on the child.

The National Women's Health Information Center reports that postpartum psychosis is more rare than postpartum depression, occurring in approximately one or two out of every 1,000 births. It can include delusions, hallucinations, sleep disturbances, obsessive thoughts about the baby, and rapid mood swings. Postpartum psychosis typically begins within the first six weeks after childbirth. The risk of postpartum psychosis tends to be higher among women who have a serious mental illness, specifically bipolar disorder or schizoaffective disorder.

Means of Suicide

In a study of survivors of suicide attempts, almost half reported that less than one hour had passed between their decision to complete suicide and the actual attempt. Another 24 percent indicated it was less than five minutes.[65] The crisis leading up to suicide and suicide attempts is often short-lived, containing some impulsivity and ambivalence.[66] Restricting access to lethal means can put time between the impulse to complete suicide and the act itself, allowing opportunities for the impulse to subside or warning signs to be recognized and interventions to occur.

According to data from the CDPH, firearms are used in over 40 percent of suicides in California, followed by hanging (26 percent) and poisoning (19 percent). These three methods account for more than 85 percent of all suicide deaths. Almost half of males who died by suicide used a firearm, whereas the most common method used among females is poisoning (37 percent). Poisoning is the leading means of self-

inflicted, non-fatal injury, with alcohol and drug overdoses accounting for 77 percent of all poisoning incidents. The CDC defines a poison as any substance that is harmful to the body when eaten, breathed, injected, or absorbed through the skin. Poisoning occurs when too much of some substance has been taken, and generally the deaths that occur involve abuse of prescription or illegal drugs.

Addressing access to controlled substances and firearms is one way to prevent many suicides. The National Violent Death Reporting System (NVDRS) found that in 82 percent of firearm suicides among youth under 18, the firearm belonged to a family member, underscoring the importance of attention to safe storage of firearms in the home.[10] In many states, laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System.[67]

One explanation that has been suggested for the substantially higher rate of completed suicides among males is that females use means that may have a lower probability of lethality, such as poisoning. Among females, hanging or suffocation accounts for 71 percent of suicide deaths between 10 and 14 years of age, 49 percent of suicides between 15 and 19 years of age, and 34 percent between 20 and 24 years of age.[14] A review of over 600 coroner records in Riverside County, California, from the years 1998 to 2001, found that although women were over four times more likely to use poisoning than men, hanging was equally likely to be used by both sexes.[68] Furthermore, although women were 73 percent less likely to use firearms than men, firearms were the second most common means that women used.

The results of this study are supported by more current statewide data in California. Males and females are equally likely to use hanging as a method (26.5 percent and 26.2 percent respectively), and among females firearms are used in over 20 percent of suicide deaths.[9]

National data indicate that the use of lethal means, other than firearms, have increased, particularly among certain age and sex groups. Poisoning deaths accounted for 28 percent of the increase in the national suicide rate between 1999 and 2004.[h,69,70] In this same five-year period, the rate of suicide by hanging or suffocation increased, especially among adults ages 20 to 29 and 45 to 54.[70]

Given that the means to complete suicide by hanging or suffocation are usually more widely accessible and more difficult to control, prevention programs need to address access to lethal means in concert with education about suicide and psychosocial interventions that target groups at high risk.

Some research has suggested that individuals have a preference for a given means, and that if prevented from using it, an attempt may not occur.[66] The contagion effect,[e] personal ideas, and cultural factors all are likely to come into play when an individual is determining means.

NOTES

[e] The contagion effect is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

The Cost of Suicide and Suicide Attempts

The emotional cost of suicide has both immediate and far-reaching effects on families and communities. It is estimated that each suicide seriously impacts at least six other people.[71] In addition to grieving the loss of the individual who took his or her own life, survivors – family members, caregivers, and friends – may themselves be at increased risk of suicide. The stigma associated with suicide may lead to reluctance to talk about the problem or to seek out social supports and mental health services.

> *"Each suicide seriously impacts at least six other people."*

Beyond the human suffering and emotional toll of suicide and self-inflicted injuries, there are also financial costs. The economic burden of suicide is spread throughout a variety of systems, including education, hospitals, primary care, mental health, and corrections. To estimate these costs, a formula has been derived based on costs incurred by individuals that attempted or died by suicide, families, employers, government programs, insurers, and taxpayers.[72] Estimates of the cost of self-injuries take into account hospitalizations and follow-up treatment; coroner and medical examiner costs; and transport, emergency department, and nursing home costs. Lifetime productivity estimates take into account lost wages, fringe benefits, and costs related to permanent or long-term disability for each individual who attempts or dies by suicide.

Using this formula based on suicide data from 1999 to 2003, the average medical cost per suicide in California was $4,781 and the average lifetime productivity loss for each individual was more than $1.2 million. The resulting cost of suicide deaths in a given year is nearly $15 million per year in medical costs and $3.8 billion in lost lifetime productivity for the individuals who die by suicide in a given year.

In 2003, there were over 16,000 hospitalizations for suicide attempts in California. The average medical cost per hospitalization was more than $12,000, and the average work-loss per case was over $14,000.[73] This amounts to $204 million in medical costs and over $230 million in lost productivity. The resulting cost of suicide attempts in a given year in California is $435 million.

Based on these figures, the combined estimated cost for suicides and suicide attempts in California is $4.2 billion per year.

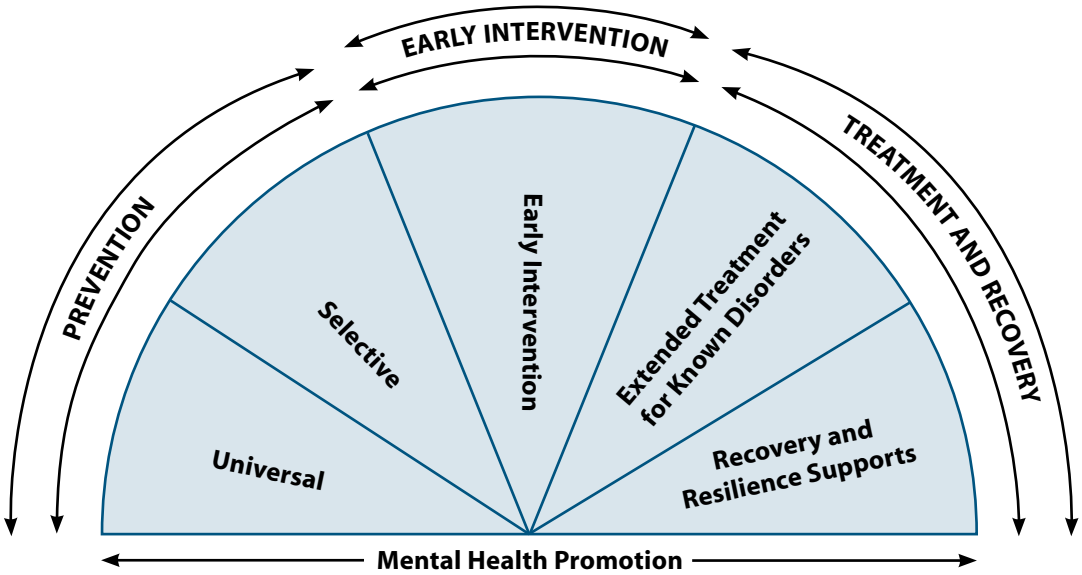
PART 2: STRATEGIES FOR SUICIDE PREVENTION

Suicide prevention encompasses a wide range of prevention, intervention, and postvention strategies that reduce suicidal behavior and its impact on family, friends, and communities. This spectrum includes mental health promotion strategies that offer education, foster resilience, and enhance protective factors in individuals and communities; build the capacity of providers and systems to offer appropriate services, including interventions to address mental health problems early and to reduce suicidal behaviors; and follow-up care services for those who have survived a suicide attempt and for family members and others who have suffered the loss of a loved one. Suicide prevention must also include research and surveillance to further understand demographic, cultural, social, and biological factors that reduce risk factors and promote help-seeking behavior. Evaluation is an essential element to ensure that programs are effective, as well as a program improvement tool. Recommendations for effective suicide prevention strategies have been reviewed in several key documents, such as the National Strategy for Suicide Prevention.[74,75,76]

Creating a System of Suicide Prevention

A system of suicide prevention would include a range of gender-specific services and programs designed to effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds. The success of the system will be judged not solely on the value of any one component or service but rather how well the parts are coordinated and build upon one another. Linkages are critical because it can be anticipated that increased community outreach and education efforts to promote mental health, build resilience, and increase awareness of the

Figure 3: Mental Health Intervention Spectrum Diagram.



Source: Adapted from Mrazek and Haggerty (1994)[145] *and Commonwealth of Australia (2000)*[146]

suicide warning signs may result in increased service demands further along the Mental Health Intervention Spectrum (e.g., screening and assessment to early intervention and crisis services; see Figure 3). Fragmentation of systems presents a fundamental challenge to continuity of care that can cost lives.[77]

To ensure that the system for suicide prevention is effective, it is critical to assess the assets and gaps, make a plan, implement, and reassess. To create such a system, coordination and partnerships must occur at multiple levels. Collaborative models need to be developed to ensure that professionals from different disciplines and service systems that have important roles in preventing, assessing, and treating suicidal behavior can communicate with one another and coordinate their activities.

Coordination at the State Level

To achieve maximum benefit and efficiency throughout our large state, it is imperative that a centralized, coordinating body for the various suicide prevention activities is charged to effectively reach and serve the diverse populations of California.

This strategy has been effective in other states. Maryland implemented a model state prevention and awareness program and now has the fifth lowest suicide rate in the nation.[78] Coordinating programs at the state level has resulted in increased federal funding for suicide prevention activities and successful coordination of training for gatekeepers throughout the state. Other states, such as Colorado, Florida, and Nevada, have established an office to coordinate suicide prevention activities statewide.

On February 6, 2008, the California Department of Mental Health, in collaboration with Assembly Member Mary Hayashi, announced the establishment of an Office of Suicide Prevention (OSP). OSP will provide

a single point of contact and a central point of dissemination for information, resources, and data about suicide and suicide prevention programs. It will serve as a liaison with national partners, such as the Suicide Prevention Resource Center and the Substance Abuse and Mental Health Services Administration, as well as other states. The office will ensure that activities build upon resources and materials where they already exist, and it will provide expert consultation on local suicide prevention plans and activities.

The California Office of Suicide Prevention will support integration of resources and activities for suicide prevention through various state and county systems and organizations. It will centralize coordination of strategic suicide prevention, intervention, postvention, and research activities throughout the state, including dissemination of model training curricula and service guidelines targeted to different professional groups and settings. It will provide leadership in developing learning communities among the diverse partners throughout California and among stakeholders within the counties, through disseminating and coordinating resources for community planning, leadership training, and building program capacity. Additionally, the Office of Suicide Prevention would be a partner in the development of social marketing efforts focused on increasing community awareness and education, addressing stigma, and reducing suicidal behaviors.

> *"The California Office of Suicide Prevention will support integration of resources and activities throughout state and local systems."*

Finally, the office will oversee the development of a research agenda to fill gaps in knowledge about suicide and suicidal behavior of Californians from diverse backgrounds, and it will aid in the evaluation of interventions to ensure they are effective. It will also coordinate periodic review and update of this *Strategic Plan on Suicide Prevention*, including tracking selected indices of suicidal behavior over time.

Coordination at the Local Level

Many of the partners in a local system of suicide prevention are entities with county, municipality, or district-wide jurisdictions. Local coordination efforts need to include assessment, planning, implementation, and evaluation of the wide range of suicide prevention efforts needed at the community level.

Universal (community-wide) and targeted social marketing strategies are a critical component of the prevention efforts. Campaign activities should be designed to outreach to populations at risk, educate the general public on warning signs and resources, and engage with local media outlets on appropriate reporting guidelines. The messages and materials used should be culturally and linguistically appropriate as well as specific to the age and gender of the target population. Greater success may be achieved by coordinating public education efforts with supportive programs and policies.

Many effective practices integrate suicide prevention into existing community settings and services and utilize key points of contact or "gatekeepers," such as community health

workers or promotoras, school staff, primary care providers and staff, and Area Agency on Aging personnel and volunteers.[1,79] These strategies are particularly effective for groups that are underserved by the traditional mental health system and are more likely to be identified by or seek help through other community supports. Some strategies offering a more effective response to suicide prevention and suicide include co-location of mental health services and primary care services, integrating mental health services into school-based clinics and aging services, and cross-discipline suicide assessment and intervention training. Working with youth development programs at schools, recreation centers, churches, and other locations also serve as possible venues for teaching problem-solving skills, conflict resolution, and building resiliency; all of which play a role in suicide prevention.

To effectively prevent suicide, it is critical that each county have well-coordinated crisis response services. These services should be able to respond to acute crisis situations involving emergency department and hospital staff, mental health providers, and law enforcement personnel. Crisis response services should also include hotlines and mobile outreach teams so that help is readily available when and where needed. Easily accessible and up-to-date directories of local suicide prevention and intervention resources would benefit individuals at risk, the general public, and providers in different systems.

"Peer support models can play an essential role as part of a coordinated system."

Safety plans for facilities, such as school campuses, increase preparedness to effectively respond to a crisis, including suicide attempts.

Hospital emergency departments often treat individuals with self-inflicted injuries. However, discharge planning procedures for emergency departments vary in their provision of referrals for professional mental health assessments and follow-up services.[80] There needs to be consistency across hospital, emergency department, and other inpatient settings to implement protocols for follow-up care and effective referral to ensure the continuity of care that can save lives.

Peer support models can play an essential role as part of a coordinated system by improving quality of life, fostering recovery and resiliency, and preventing a crisis from developing. Support services provided by those who have experienced suicidal feelings, thoughts, and attempts, and who have survived and rebuilt their lives, can play a vital role in preventing suicide and in preventing the trauma that often accompanies the need for acute, emergency interventions. Peer support programs typically offer short-term, residential crisis services administered by peers; warm lines[f]; programs to promote health, wellness, and recovery; and forums to educate the public about mental illness and mental health.

The factors surrounding a suicide death are often complex, and the stigma of suicide may influence the accuracy of reporting, which can impact the ability to identify systemic changes

NOTES

[f] Warm lines are phone lines staffed by peers that provide support and education. Warm lines are generally intended to help prevent a situation from developing into a crisis.

that may be necessary to prevent future deaths.[81] A review of the local data and findings would be helpful to determine where additional attention to existing policies, services, or practices needs to be focused.

Enhancing Mental Health Early Intervention and Treatment

Intervention activities should target periods of time when research and surveillance data have indicated that suicide risk is high, such as initial onset of a mental illness and immediately after a hospital discharge.[29,82] However, one of the most promising ways to prevent suicide and suicidal behavior is through recognition of early signs of mental health problems stemming from depression, loneliness, and other needs.[7] Psychosocial therapy that strengthens problem-solving skills can help to address the feelings of hopelessness and of being overwhelmed and unable to change negative situations that lead to increased risk of suicide.[4] Due to the strong link between severity or recurrence of episodes of serious mental illness and risk of suicide, consistent and appropriate treatment is crucial to suicide prevention.[27] In addition to risk factors among the general population, individuals diagnosed with a serious mental illness have other specific risk factors, such as severity of symptoms and numerous relapses.[29]

> *"Surveys of individuals who have used hotlines indicate that levels of emotional distress and thoughts of suicide are decreased by the calls."*

Many mental illnesses are associated with an elevated risk of suicide, therefore identifying and treating mental illness early in its onset is an important prevention strategy. There is some evidence for the value of routine screening in certain primary care settings to identify early signs and symptoms of mental illness.[83] The U.S. Preventive Services Task Force, an independent panel of experts that develops recommendations for clinical practice, recommends the use of screening tools for depression in adults in primary care settings.[84] However, the Task Force found that the evidence for the effectiveness of screening for suicide risk in primary care settings is limited.[85]

Screening for depression during routine postnatal primary care visits is associated with a three-fold increase in detection of postpartum depression among women.[86] Multiple depression screening tools have been developed that are targeted for the primary care setting. The "PHQ-9 Two-Question Screen" includes a nine-symptom checklist that the primary care professional uses to assess potential mental health problems, including depression. Another example is the "four Quadrant Model" based on a similar model that the National Council for Community Behavioral Healthcare developed in 1998. This model separates individuals undergoing screening into four quadrants or categories of behavioral health and physical health, depending on the severity of their needs in each area. The model addresses a broad spectrum of health and mental health issues and co-occurring disorders, including various stages of depression.

With enhanced screening efforts comes the responsibility to ensure that prevention programs and community services and supports that are culturally and linguistically competent, participant-driven, recovery-based, and trauma-informed are available to people who need them. A focus group study administered by the California Network of Mental Health Clients found that where there is a lack of voluntary, community-based mental health services and supports, many mental health clients who seek services fear that overly restrictive modes of treatment will be the only services available in a suicide crisis.

Sharing Information between Systems

Recent events have highlighted the issue of confidentiality laws and information sharing related to mental health. The *Report to the President on Issues Raised by the Virginia Tech Tragedy* found that there is variability in understanding confidentiality laws that can result in confusion and barriers between legitimate information sharing among service providers and systems.[67]

Confidentiality laws can be complex and often differ from state to state. States that allow for disclosure of mental health information usually limit it to diagnosis, prognosis, and information regarding treatment, generally medication.[87] Additionally, providers, clients, family members, and others disagree about when disclosure is appropriate. Confidentiality issues are of particular concern for the mental health system because of the ongoing problems of stigma and discrimination associated with mental illness. Until this larger problem is addressed, confidentiality issues will continue to be a significant challenge for strategies that seek to integrate systems and services.

Targeted Approaches

Several suicide prevention strategies enhance targeted crisis intervention services for individuals who may be contemplating suicide, or target specific population groups who may be at high risk of suicide. Targeted approaches are an important component of a system of suicide prevention that is responsive to diverse needs within communities.

Suicide Prevention Hotlines

Suicide prevention hotlines are an effective way for people in crisis to reach out for help, and those who use the lines report that they are helped by the calls. Surveys of individuals who have used hotlines indicate that reported levels of emotional distress and suicidal ideation are decreased by the end of the calls.[88,89] However, hotlines that are not accredited may differ in whether suicide risk assessment procedures are completed and in thoroughness of the assessment, which can result in uneven quality of response across locations.[88] Although the DMH requires each county's Mental Health Plan to operate a 24-hour, toll-free telephone line that provides information about accessing services and problem resolution processes, these lines may not include suicide prevention assessment and intervention.

The National Suicide Prevention Lifeline (800-273-TALK) is a 24-hour, toll-free hotline funded by SAMHSA. The National Lifeline consists of over 125 accredited call centers in 45 states around the country. When a caller accesses the Lifeline, the call is immediately routed to the closest affiliated call center. Callers can remain anonymous, minimizing concerns about stigma that may inhibit people in need from seeking mental health services elsewhere. To address the needs of callers who do not speak English as their primary language, the Lifeline operates

a network of nine Spanish-language call centers across the nation, two of which are in California, and all Lifeline call centers have free access to a live language interpretation service that includes over 170 languages.

To become a member of the Lifeline, call centers must be accredited by an organization, such as the American Association of Suicidology, or licensed or certified by their county or state. This process ensures that responders are trained in evidence-based risk assessment procedures and that these procedures are consistently administered to all callers. The accreditation standards that the Lifeline accepts were developed with the involvement of national and international experts in suicide prevention to ensure incorporation of the latest research and information.[90] Call centers applying for accreditation for the first time may receive technical support from the organization that will review their application. Once accredited, call centers can apply for National Lifeline membership that includes a modest annual stipend, coverage of the phone line costs to calls placed to the Lifeline number, and ongoing technical assistance to ensure continuing, uniform quality across the network.

"In 2007, approximately 20 percent of calls that originated in California were answered by suicide prevention hotlines in other states."

Currently, eight hotlines in California are members of the National Lifeline. Although anyone in California can call the Lifeline number, depending on their location, they may not reach a call center in their area or even in the state.

Data from the National Lifeline indicate that in 2007, approximately 20 percent of calls originating in California were answered by hotlines in other states. California-generated calls that come from counties that do not have a Lifeline-accredited call center are routed to accredited call centers in other counties based on their availability and capacity (e.g., staff availability, busy lines, billing limitations). In a typical day, in addition to handling all the local calls in the Los Angeles area, the Didi Hirsch Community Mental Health Center takes calls from Santa Cruz, Fresno, Shasta, Sacramento, San Mateo, Kern, and Napa counties. When the Didi Hirsch Center cannot answer a call, such as when all its lines are busy, these California callers are served by a call center in Nebraska.

If calls are not answered locally, responders may not be able to refer individuals in crisis to local resources for follow-up care. California needs to increase the capacity of suicide prevention hotlines so that callers from every county can access a local, accredited call center. A long-term commitment to continuity and quality is needed to enhance the availability and capacity, including multiple-language capacity, of suicide prevention hotlines.

Hotlines have also been used to target prevention activities for specific populations. The San Francisco Institute on Aging Center

for Elderly Suicide Prevention operates the Friendship Line. The line offers phone-based services, such as 24-hour crisis intervention and elder abuse prevention, as well as grief counseling, well-being checks, and information and referral services.

Several hotlines target youth. For example, the Trevor Project is a national crisis and suicide prevention hotline that focuses on lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. This service is provided 24 hours per day, seven days per week and is free and confidential. The Trevor Project also hosts a website with education resources such as training models and teaching guides, and an online forum that serves as a virtual warm line.

Finally, the VA and SAMHSA have collaborated to provide suicide prevention hotline services that are targeted to veterans. Individuals may now call the National Lifeline and choose a prompt to identify their veteran status. They are immediately transferred to a hotline staffed by mental health professionals at a VA facility in upstate New York, who will have information about VA resources throughout the nation.

Population-Specific Interventions

Due to the unique characteristics of different age groups and ethnic populations and their disparities in access to services, effective approaches to suicide prevention need to include outreach and intervention strategies that specifically target these specific groups.[91,92]

Older Adults

Depression is a significant risk factor for suicide in older adults, and it is also a condition that may go unrecognized and thereby remain untreated.[93] Frequently, signs of mental health problems are missed because they are mistaken as a normal part of aging, or they are misdiagnosed as cognitive impairments that are increasingly common with advanced age.[11,94,95] Finally, where mental health problems are recognized, the stigma associated with mental illness may influence the likelihood of seeking mental health treatment.[95]

> *"The majority of older adults who died by suicide visited their physician within one month of their death."*

Although the majority of older adults visited their primary care physician within a month of their suicide, most of them were not receiving mental health treatment. Traditional mental health service systems are often not the most effective way to reach and serve older adults who may be at risk, and primary care services need to be improved.

Multiple evidence-based programs have been developed that target older adult mental health. Currently, ten programs are listed on the SAMHSA National Registry for Evidence-Based Programs and Practices (NREPP).[96] Most of these programs contain components for outreach, engagement, and education that are embedded within existing community structures and services that older adults commonly use.

Other effective approaches integrate mental health services into primary care, such as co-locating health and mental health services. The Prevention of Suicide in Primary

Care Elderly Collaborative Trial (PROSPECT) combines treatment guidelines for depression in primary care settings with comprehensive care management for older adults diagnosed with depression.[96] Trained clinicians work closely with the primary care provider, the older adult patient, and their family around treatment protocols and education. One outcome of this program was a statistically significant reduction in suicidal ideation among participants.[97]

IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for patients 60 years or older who have major depression or dysthymic disorder.[96] The intervention is a collaborative care approach in which a nurse, social worker, or psychologist works with the primary care provider, a depression care manager, and the patient to develop a multi-modal course of treatment that includes medications, exercise, identifying positive activities to engage in, and education about late life depression. IMPACT has been evaluated with racially, ethnically, and linguistically diverse older adults, including Whites, Latinos, and African Americans. Outcomes of this intervention include significant reductions in depression and improvements with work, family, and other social relationships. The IMPACT model has also been shown to be more cost effective than usual medical-based care for depression in older adults.[11]

There is also a need to address Medicare and insurance reimbursement issues that may create barriers to mental health services for older adults.[94,98] The Program of All Inclusive Care for the Elderly (PACE) provides a model for coordinating Medicaid and Medicare financing with community-based social, mental health, and primary health services to provide an alternative to nursing home care.[96] An interdisciplinary treatment team oversees the implementation of the individualized treatment plan for each older adult enrolled in the program. Results from this program include decreased use of acute services, improved health and quality of life, and lower mortality rates.

Survivors of Suicide Attempts and Suicide Loss

Engaging those who have been directly impacted by the tragedy of suicide can be a powerful tool to prevent suicide and future attempts and to support those who have lost a friend, colleague, or loved one to suicide. A growing body of literature substantiates the effectiveness of services and supports offered by individuals directly impacted by mental illness, such as warm lines and peer-run support centers.[99] Organizations like the California Network of Mental Health Clients and the National Alliance on Mental Illness are important sources of support, advocacy, and education for mental health clients and their family members.

In response to the high rate of suicide in Humboldt County, the California Network of Mental Health Clients recently organized Suicide Alternatives Workshops that bring together survivors of suicide attempts, family and friends of those who have died of suicide, clergy, mental health clients, mental health professionals, and physicians. The workshops are held monthly and provide ongoing community education, outreach and peer support, and recommendations for local policy and practice.

Another promising practice is web-based self-help, which is a cost effective approach to providing information and resources to those who have access to the Internet. Examples include the National Empowerment Center

(www.power2u.org), a national consumer technical assistance center. Another example is "Beyond Blue," the national depression intervention initiative in Australia that hosts a website that offers self-assessment tools and resources to find mental health care, post notices on a bulletin board, and learn more about research (www.beyondblue.org).

Several programs, many of which are school-based, have been developed that facilitate peer support among high-risk youth. The Trevor Project hosts an online peer support venue for lesbian, gay, bisexual, transgender, and questioning youth. Models for implementing a range of youth peer support programs are available on the website for SAMHSA's National Registry for Evidence-based Programs and Practices.[96]

> *"Many evidence-based practices have not been tested among diverse populations."*

Racial, Ethnic, and Cultural Communities

The U.S. Surgeon General has reported significant disparities in access, availability, and quality of mental health treatment services for racial and ethnic populations as compared to Whites.[100] These disparities are evident in the paucity of culturally and linguistically appropriate mental health services and supports, including inconsistency in language access in services, hotlines, and informational materials, and in the fact that many evidence-based practices have not been tested among diverse population groups.

Cultural differences matter substantially. African Americans are more likely to be incorrectly diagnosed than Whites and are also more likely to leave psychiatric treatment earlier.[100] This situation may be due in part to the possibility that African Americans may present their symptoms and respond to treatment differently from what most clinicians are trained to expect.[100] Furthermore, African Americans are substantially less likely than Whites to have access to treatment providers who are of the same race.[100] Fears of racism may exacerbate the problems of stigma and discrimination around mental illness.

Other cultural factors may adversely impact the mental health and suicide risk of immigrants and refugees, such as intergenerational conflicts related to acculturation, family pressures around academic achievement, and adverse experiences from the home country, including war, torture, and genocide.

California is a diverse state. Data from the 2000 Census indicated that the majority (53.3 percent) of California's population identified as non-White, and 40 percent spoke a language other than English at home.[101,102] A quarter of the population was born outside of the U.S., and the majority of Asians and almost half of Latinos are foreign born.[103] A combined 63 percent of these populations are concentrated in the San Francisco Bay Area and Los Angeles. To address the needs of this diverse population, mental health and suicide prevention services

need to identify and develop culturally appropriate outreach and engagement activities and diagnosis and treatment strategies.

Promising strategies include engaging diverse communities through natural community leaders and helpers, such as faith leaders, community health workers (e.g., promotoras), or indigenous healers. If trained to recognize and respond to warning signs of mental illness and suicide risk, these individuals are in a position to promote early intervention for individuals at risk who may not otherwise seek professional help. A process of community engagement to determine the strategies used and to evaluate their effectiveness, for example, through community participatory action research methods, can increase the validity, acceptability, and sustainability of culturally appropriate mental health and suicide prevention practices within diverse communities.[91] Interventions need to be specific, targeted, and culturally relevant, including the role of families, faith communities, traditions, and other values and attitudes that address perspectives on suicide and mental illness.

To address disproportionately high suicide rates in Native American communities, particularly among youth, effective approaches must be developed through an inclusive process. Although few evidence-based practices have been tested in Native American communities, tribes are actively engaged in developing and adapting best practices.[104,105]

For example, the Jicarilla Apache of Northern New Mexico developed a community intervention program involving tribal leadership, community members, youth, clinicians, university researchers, and the Indian Health Service that resulted in a 60 percent decline in suicides over a ten-year period.[106] Additionally, tribal programs in Phoenix and Alaska have implemented successful suicide prevention strategies that include training that incorporates not only suicide prevention and intervention, but also culturally-specific, traditional approaches and perspectives.[106]

The Zuni Life Skills Development program is a school-based curriculum designed to reduce suicide risk and enhance protective factors among Native American adolescents.[96] The curriculum includes topics such as building self-esteem, decreasing stress, increasing communication and problem-solving skills, and recognizing and eliminating self-destructive behaviors. Lessons are taught by a team of teachers and community resource leaders to ensure a high degree of cultural and linguistic relevance. The Zuni Life Skills Development curriculum served as the basis for the broader Life Skills Development curriculum that is now in use with other Native American populations.

It is also important that mental health and health providers reflect the diversity of the population they are charged with serving, including language diversity, so that people of all cultures, ethnicities, and languages can feel comfortable seeking services that they are confident will appropriately and effectively address their needs. More research is needed about effective models and to test existing practices for their effectiveness among diverse populations.

Children, Youth, and Young Adults

It is important to promote protective factors against suicidal behavior in young people. A review of interventions by the Centers for Disease Control's (CDC) Task Force on Community Preventive Services reported that early childhood home visitation programs can prevent adverse outcomes, such as child abuse and neglect.[107] Furthermore, therapeutic foster care reduces violence among chronically delinquent juveniles. This is an important outcome, since 25 percent of serious violent offenses in the U.S. are committed by youth between the ages of 10 and 17 years. This task force did not evaluate the impact of these programs on suicide. However, the approaches promote protective factors and mitigate risk factors that can also lead to an increased risk of suicide in this vulnerable population.

Because school is where many youth spend a large part of their days, school staff are in the position to detect the early stages of mental health problems and potential suicide risk. By 2000, 77 percent of schools in the United States had implemented a suicide prevention program.[79] Some programs use early intervention strategies, such as screening instruments that detect warning signs of self-harm and suicidality. Mental health and suicide prevention programs that are school-based can be successful in encouraging students at risk to seek help, and to follow through on referrals to mental health services. The programs can also be successful in developing protocols to handle a suicide crisis that minimizes the chances of a contagion effect.

School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem-solving skills, conflict resolution, and nonviolent handling of disputes. One study found that a universal[9] intervention program (the Good Behavior Game) that focused on socializing first and second grade students toward reducing aggressive, disruptive behavior was associated with significant decreases in later onset of suicidal ideation and attempts.[108]

This approach may be particularly important for adolescents and youth who are coping with the stigma and prejudice associated with exploration of sexual orientation and gender identity. One study found that heterosexual students reported higher levels of protective factors, such as family connectedness, adult caring and involvement, and feeling that the school was a safe place, than homosexual students.[109]

Unfortunately, many young people who are at high risk of suicide may have already stopped attending school or may have contact with the juvenile justice system. It is critical to develop strategies to reach out to these individuals through community groups and places where young people congregate. It is also important to train the program staff who provide services to at-risk youth to ensure they are able to recognize the warning signs of suicide and how to intervene early.

Nationally, many more children and youth need specialized mental health services than actually have access to them.[83] Several strategies have been recommended to improve service delivery and training of providers, particularly in primary care, who routinely come into contact with adolescents

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[9] Universal refers to an intervention that addresses an entire population, in this case, all first and second grade children enrolled in the schools were involved in this study, not solely those identified as at higher risk.

and youth who may be at heightened risk of emotional disorders or suicidal behavior. Examples are co-location and training of child mental health specialists to work in primary care settings, and enhanced training in medical school and for providers in practice.[83]

> *"Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it."*

The tragic events at Virginia Tech raised national awareness of the need for earlier and better comprehensive mental health services on college campuses. Some of the key findings of the *Report to the President on Issues Raised by the Virginia Tech Tragedy* (2007)[67] are included as follows:

- Sharing critical information among education officials, health care providers, law enforcement personnel, and others can address obstacles resulting from confusion about confidentiality laws.
- Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it.
- There must be effective coordination of providers who are sensitive to the issues of safety, privacy, and provision of care to ensure that people with mental illness are integrated into the community.
- Full implementation of emergency preparedness and violence prevention plans is needed to address problems of school and community violence.

SAMHSA has launched a suicide prevention initiative that targets adolescents and youth. The Campus Suicide Prevention Grant Program provides funds to assist colleges and universities in their efforts to prevent suicide attempts and completions and to enhance services for students with mental health problems, such as depression and substance abuse that put them at risk for suicide and suicide attempts. Program requirements include providing suicide prevention training and education programs for students and campus personnel, enhancing the network of campus mental health services to include the broader community where needed, developing campus-based hotlines or linking hotlines with the National Lifeline, and disseminating materials to the campus community, as well as families, to educate them about the warning signs of suicide and to counter stigma and encourage help-seeking behaviors.

In addition, the State/Tribal Youth Suicide Prevention Grant Program provides funds to states or tribes to develop a public/private coalition among youth-serving institutions and agencies, including schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth-supporting organizations. This coalition is responsible for implementing a youth suicide prevention plan that includes enhanced assessment, early intervention, and treatment for at-risk youth.

Increasing the availability of mental health and suicide prevention services on college campuses is an important step in preventing suicide among young adults. Reports from the California Department of Education and the University of California, among others, have recommended implementation of strategies to achieve this step.[15,110] However, a suicide prevention system for young people must include strategies that start much earlier than the presentation of suicidal ideation or acute mental health problems.

> *"A system of suicide prevention must include strategies that start well before the presence of suicidal ideation and acute mental health crises."*

Correctional Facilities and Law Enforcement

Many effective programs offer models for partnership between the criminal justice and mental health systems, for example, jail diversion and re-entry programs. By building local partnerships between and within the criminal justice system and at the community level, suicide risk among inmates can be reduced along with the medical cost of treating acute problems, which will provide a safer setting for inmates as well as staff.[111]

To address the mental health needs and suicide risk of individuals who, being released from jail, were repeat offenders, or were being discharged from an inpatient psychiatric facility, one community in Monroe County, New York, developed a coalition of community care providers, the county mental health department, local criminal justice systems, the courts, and the university psychiatry department to coordinated outreach and services.[112] Over 100 individuals received services through the program. Outcomes of this project included no suicide attempts, assaults, or other reportable incidents during the study period among subjects, and the reduction in jail and hospital expenses amounted to approximately three times the program's cost. The findings from research and data on the needs of this population provide strong support for implementing programs in jails and prisons as well as programs that support re-entry into the community.

According to the California Department of Corrections and Rehabilitation, California's prison system paroles over 100,000 inmates every year.[113] Many of these inmates will require community services to maintain their health, mental health, and well-being after release. Recently, the California Legislature has required the Department of Corrections and Rehabilitation and community agencies to work together to provide better re-entry programs and services for parolees. Collaboration between the prison system, community social services, and the community mental health system is necessary to support this effort to provide continuity of care,

particularly as California's prison system continues to shift toward a recovery and rehabilitation model for inmates with severe mental illnesses.

Employers

Integrating suicide prevention into work settings is recommended to reach a large number of adults who may be at risk, but who are not currently utilizing or likely to seek out mental health services. Resources need to be developed and disseminated to employers that provide guidance about how to recognize and assist employees who may be exhibiting warning signs of suicidal behaviors, who are coping with family members or friends of individuals presenting with suicidal behaviors, or who are themselves survivors of suicide. Recently, the Partnership for Workplace Mental Health, which includes the American Psychiatric Association, the American Psychiatric Foundation, and business leaders, launched *Employer Innovations Online* (www.workplacementalhealth.org). This searchable online database provides resources, models, assessment tools, and detailed information for employers to develop strategies to address workplace mental health issues.[114] Another resource is the National Business Group on Health, an organization that provides information and resources on health and mental health issues in the workplace.[115]

Employers should be encouraged to access these resources as well as to build and maintain a directory of local prevention, treatment, and support services and make them readily available, in a non-stigmatizing manner, to all employees. Another approach is to build outreach and education about suicide prevention and mental health into existing support networks, such as employee assistance programs, to reach people who might not otherwise seek help.

Veterans and the Military

Given the magnitude of the problem of suicide among veterans, it is critical that the military and the reserves are partners in implementing the *California Strategic Plan for Suicide Prevention*, including the California National Guard and the VA medical centers in the state. Strategies to address suicide prevention among veterans must take into account the prevalence and characteristics of stigma and fears of discrimination in the military that constitute barriers to needed care. Strategies must also address access to mental health services, especially for veterans who may live far away from a VA Health Center. The increasing volume of need for mental health services among the thousands of veterans returning from Iraq and Afghanistan must also be met.

Beginning in fall 2003, the Army convened Mental Health Advisory Teams to annually review data on mental illness and suicide among deployed soldiers, assess quality and access to mental health care, and provide recommendations for improvements.[116] Recommendations from early MHAT reports led to the Army Suicide Event Report, a reporting and tracking mechanism that collects extensive data about suicides and attempts. The development of the VA Suicide Prevention Lifeline is another step toward addressing veterans' specific and urgent mental health needs.

Multi-Level Public Health Approach

The Air Force Suicide Prevention Program is an evidence-based practice that was developed in response to a rise in the suicide rates in the Air Force in the early 1990s.[117] The program uses a multi-level intervention targeted at reducing risk factors and enhancing protective factors, including reducing stigma around seeking help, promoting education about mental health, changing policies, and shifting social norms. Eleven initiatives were implemented, including the following:

- Strong messaging from the Air Force Chief of Staff that promotes social support between officers, supervisors, and coworkers and the value of seeking mental health services early.
- Requiring personnel to receive suicide prevention training, and encouraging each Air Force installation to tailor training programs to the needs of the local community.
- Improving surveillance through an online database and developing a survey that provides specific feedback to help tailor interventions to each community.
- Developing local crisis and critical incident response management teams.
- Coordinating and integrating services among faith-based programs, mental health services, family support centers, child and youth programs, family advocacy programs, and health and wellness centers.

The program resulted in significant increases in Air Force personnel that were trained in suicide prevention and educated about violence prevention.[118] After implementation of the program, there were significant reductions in suicides, homicides, accidental deaths, and moderate and severe family violence. The success of this model indicates that systemic interventions that change social norms about seeking help from being a sign of weakness to a sign of strength, and institutionalization of training about suicide prevention can have substantial impact on promoting mental health and reducing a range of adverse outcomes.

The universal, multi-layered strategy exemplified by the Air Force Suicide Prevention Program is a good example of an approach that has been used to successfully address other public health problems, such as reducing cardiovascular disease.[119] Efforts to address the broader, modifiable risk factors that predispose individuals to heart disease were developed in parallel with technological advances that improved outcomes for people who have already developed the disease. Along with activities such as education about recognizing the warning signs of a heart attack, widespread training in cardiopulmonary resuscitation, and the development of new medicines and technologies were strategies that educated the public about the benefits of a healthy lifestyle and of reducing or eliminating behaviors that contribute to long term risk. Changes in public policy, such as laws related to smoking, supported this shift in cultural and social norms that has reduced the risk of a range of diseases.

There is a difference between the traditional, clinical-based approach to suicide prevention and the public health approach that was

employed by the Air Force Suicide Prevention program. The clinical approach rests on identifying and treating individual risk factors when evidence of disease is present. Typical suicide prevention strategies have focused largely on recognizing warning signs and individual-level risk factors rather than considering the important role of population-level mental health promotion with all individuals on a continuum of risk. Interventions are broad, multi-layered, and occur both well before a problem arises as well as at various phases after it is present. The Air Force Suicide Prevention program demonstrates that when a public health approach is applied to the problem of suicide and a broad range of prevention and early intervention strategies are put into place, the likelihood of multiple negative outcomes, including suicide, mental illness, and violence, are all reduced.[118,119]

Implementing Training and Workforce Enhancements

Effective suicide prevention strategies depend on a trained workforce and an educated public. It is imperative to ensure that providers in multiple service fields are equipped to recognize and intervene when suicide risk is present. Training and service guidelines need to be implemented, targeting the specific concerns and opportunities for intervention that are present in different settings, including primary care, mental health clinics, classrooms, juvenile justice facilities, substance abuse treatment programs, older adult and long term care programs, and the venues served by law enforcement and probation officers.

Establishing Guidelines for Professionals

A substantial precedent exists for establishing guidelines for training and service in selected occupations. For example, the American Psychiatric Association has developed guidelines for mental health professionals, and the SPRC has developed a curriculum for suicide prevention programs within law enforcement departments.

SAMHSA and the SPRC have developed materials that support the development of guidelines in campus settings. For example, *Promoting Mental Health and Preventing Suicide in College and University Settings* provides recommendations for institutions of higher education to assist with the implementation of suicide prevention programs.[120]

Finally, tools for assessment of suicide risk in emergency departments have been developed, as well as guidelines for emergency department providers around care and discharge planning for individuals who survived a suicide attempt.[82,121] Currently, SAMHSA, the SPRC, and the National Suicide Prevention Lifeline are working with the American Academy for Emergency Psychiatrists and the Emergency Nurses Association to raise awareness for providers and develop and disseminate training for emergency medical providers.[h]

Health, Mental Health, and Social Services

Health clinics, i.e., primary care and prenatal care, mental health centers, emergency response systems, crisis centers, and alcohol and drug programs, are key access points. Personnel in these systems need to have consistent guidelines for effective assessment and treatment interventions.

Unfortunately, there are many missed opportunities for prevention and early intervention among people who are at risk

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[h] For more information, visit the websites for SAMHSA (www.mentalhealth.samhsa.gov), SPRC (www.sprc.org), and the National Suicide Prevention Lifeline (www.suicideprevention lifeline.org/).

of suicide. Improved training guidelines and service protocols will better prepare providers to appropriately respond when suicide risk is present. Equally critical is the need to appropriately assess for mental health conditions that are associated with significant increase in suicide risk, such as depression. Although routine screening has been shown to be effective in identifying and successfully treating depression among adults and older adults, it is important that screening be accompanied by policies ensuring confidentiality and protection from discrimination, along with the availability and accessibility of appropriate, quality, follow-up services.

> *"Mental health professionals in California do not have a licensing requirement specifically focusing on suicide risk assessment and treatment."*

In one study of physician visits by patients presenting with either major depression or an adjustment disorder, physicians asked questions about suicide in only 36 percent of visits.[122] Physicians were more likely to ask questions about suicide if they had personal experience with depression or if the patient prompted the discussion. Health providers may be reluctant to ask questions about suicide risk if they do not feel adequately trained in suicide assessment and treatment, or if they do not know how to refer patients to a mental health provider who can provide these services. Educating health professionals to recognize and treat depression and other conditions that present a heightened risk of suicide and providing them with the tools to consistently and properly address suicide can prevent suicide deaths.[122,123]

A survey of over 300 emergency departments in California found that most rely on external mental health professionals, such as mobile crisis, private psychiatric evaluation teams, or social workers to provide suicide assessments and referrals.[80] Yet mental health professionals in California do not have a standard competency or licensing requirement that specifically focuses on assessing, treating, and caring for patients at risk for suicide. The majority of respondents identified a need for increased access to mental health professionals to be able to adequately help individuals who enter emergency departments in mental health or suicide crises.

Older adults have the highest rate of suicide, and depression is a significant risk factor for suicide among older adults. It is critical that medical professionals who treat older adults and staff working in older adult services, long-term care, and adult protective services programs, should be trained to recognize warning signs and risk factors of depression and suicide in older adults.

Staff working in social services, child protection, foster care, and juvenile justice interact daily with high-risk youth and are in a critical position to identify and intervene when adverse childhood experiences have taken place or suicidal ideation and behavior are present. To appropriately identify and reduce suicidal behavior, staff in these systems need to be trained in age-appropriate prevention and early intervention strategies that are effective for the populations they serve.

Law Enforcement

Law enforcement officers are often the first on the scene when a suicide crisis emerges. They also come into contact with family members and other loved ones of individuals who have died by suicide. Several evidence-based training models exist that educate officers about the signs of mental health problems and suicide risk and how to appropriately intervene while maintaining public safety.[32] For example, the Crisis Intervention Team (CIT) program provides officers with training that includes a simple eight-question assessment tool, along with techniques for de-escalating a crisis. CIT has been implemented in many locations nationwide, and has been shown to reduce officer injury rates five-fold.[124] Many local law enforcement agencies report that it is even more effective than a traditional mobile crisis response team because police are typically first responders who are on the scene within 10 to 15 minutes.[125]

Educating the Public to Take Action to Prevent Suicide

Personal or cultural beliefs about suicide and mental illness, concerns about stigma and discrimination, and feelings of hopelessness can dissuade people from seeking help. Strategies that promote help-seeking behavior encourage people to reach out to family, friends, and resources in their communities when they are in need. These resources may include mental health services, peer support groups, community helpers such as promotoras, and faith-based organizations.

Community Gatekeepers

Gatekeepers are defined as those who regularly come in contact with individuals who may be contemplating suicide. Gatekeeper models provide education and training in identifying the warning signs of mental health problems and suicide risk and how to refer people to services that can help. The gatekeeper model is an effective strategy for reaching high-risk individuals who may not otherwise seek mental health services and supports or whose risk factors may not be visible to health and mental health professionals.

Gatekeeper training targets a broad range of people in the community. The following is a list of possible community gatekeepers, including those identified in the National Strategy for Suicide Prevention:[13]

- School health personnel
- Employers and supervisors
- Clergy and faith-based community leaders
- Natural community helpers such as promotoras, senior center staff and volunteers, and staff from cultural resource centers
- Personnel and volunteers in older adult services and long-term care, including home health care, adult protective services, in-home support services, congregate or home delivered meals, and caregiver support services
- Hospice and nursing home staff and volunteers
- Personnel in group homes and licensed care facilities
- Emergency health care personnel, including first responders such as Emergency Medical Technicians.

The above list is general; training strategies

should consider the target population and ensure that individuals most likely to interact with those at risk in the community are included in the planning process. For example, in rural areas staff can be targeted in settings where individuals at high risk may be found, such as farm credit offices, unemployment offices, youth and women's shelters, DWI courts, and others.[50]

> *"Public policies that restrict access to lethal means and educate people about safe handling of lethal materials can save lives."*

Reducing Access to Lethal Means

Reducing access to lethal means is an important component of suicide prevention when it is integrated with other local, regional, and state-level activities that take into account target populations and consideration of methods that are frequently used in a particular locality.[126] Having a gun in the house is associated with higher risk of suicide among both adults and adolescents, and regions of the country with high rates of gun ownership also have higher overall suicide rates.[127,128] Using gun storage safety precautions, such as gun locks, storing guns unloaded, and storing ammunition in a separate, locked container, are associated with lower numbers of both suicide deaths as well as unintentional injuries.[128] Studies show that more restrictive firearm legislation, such as Child Access Prevention laws, has led to a significant decrease in suicide rates.[129,130] Public policies that restrict access to lethal means and educate people about how to safely handle potentially lethal materials – from firearms to medications – can save lives.

Information from the SPRC indicates that multiple efforts are under way in other states to address access to lethal means. Maine, New Hampshire, and Oregon provide educational materials and training about screening for access to lethal means in potentially suicidal patients who are in a primary care or emergency department setting, and how to provide counsel about reducing access to lethal means. Montana and Wyoming distribute free gun locks at community events.

There are examples of how reducing access to a particular form of lethal means can reduce the overall rate of suicide.[66] In England domestic coal-based gas once contained toxic levels of carbon monoxide, and many suicides occurred by this method. After the early 1960's, the gas was detoxified and the overall suicide rate declined by one-third. Installation of a barrier on the Duke Ellington Bridge in Washington, D.C. led to a reduction in the overall suicide rate in the city despite the presence of an equally high bridge one block away. National changes in firearms laws in Canada were followed by a reduction in suicide by firearms, particularly among youth; however, rates among older men, who are most likely to own guns, were not changed, and use of other methods by youths increased.

Most suicides by jumping occur from high-rise residential buildings.[131] However, in certain locations an iconic structure may attract a disproportionate number of suicide attempts.

This phenomenon may develop in part from media coverage about suicides from these structures, romanticized ideas about what it is like to die by that method, or identification with symbolism behind that particular location or means of death.

Barriers designed to prevent suicide by jumping, such as the safety railings that have been erected on the Eiffel Tower and the Empire State Building, are effective in reducing or eliminating suicides at those sites. This issue has been the source of considerable local controversy in areas where suicides by jumping are a problem. Barriers can be controversial due to their cost relative to the number of lives lost, aesthetics, impacts on tourism, and perceptions about the inevitability of someone completing suicide another way if they are prevented from doing so by a barrier. However, one study of 515 individuals who were restrained from attempting suicide from the Golden Gate Bridge found that approximately 90 percent of them did not subsequently die by suicide or other violent means, suggesting that when suicide is deterred, the vast majority of individuals do not substitute another method.[132]

Approximately 1,200 people have lost their lives by jumping from the Golden Gate Bridge since it opened in 1937. The Marin County Coroner's Office reports that in the 10-year period between July 1997 and June 2007, there were 206 known suicide deaths by jumping from the Golden Gate Bridge.[133] Over 90 percent of the individuals who died were from Northern California, and half were from four of the six counties that are within the Golden Gate Bridge District (Marin, Napa, Sonoma, and San Francisco).

In response, the Golden Gate Bridge, Highway and Transportation District (the District) has implemented several strategies to reduce the number of suicides. These include 11 emergency/crisis counseling telephones along the sidewalk along with signage; traffic surveillance cameras that assist in detecting persons exhibiting suicidal behaviors; and suicide prevention training for bridge patrollers and District personnel. California Highway Patrol officers that patrol the roadway also receive suicide prevention training. The District estimates that these strategies have helped deter approximately two-thirds of individuals who intend to complete suicide by jumping from the Bridge. However, the District recognizes that these non-physical deterrence methods are not always successful. In July 2008, the District will release an environmental study to develop and evaluate options for a physical suicide deterrent system, such as higher railings or a barrier, for the Bridge.[134]

Public Awareness Campaigns, the Media, and the Entertainment Industry

Stigma around mental health is a deeply engrained part of our culture, and discrimination is evident in policy decisions ranging from health insurance coverage and employment to research priorities.[135] Negative portrayals of individuals with mental illness and sensational coverage of a tragic event contribute to stigmatizing attitudes in the general public, which often lead to discrimination. Unfortunately, these depictions of people with mental health problems as unpredictable and even dangerous are common in films, television, and the news media. When not countered with education and awareness about the facts of mental illness, these stories fuel people's fears and promote self-stigma among individuals with a mental illness diagnosis.

> *"It is estimated that nearly two-thirds of those who have significant mental health problems do not seek treatment because of fears of stigma and discrimination."*

It is estimated that nearly two-thirds of those who have a diagnosable mental illness do not seek treatment because of fears of stigma and discrimination.[100] SAMHSA has launched an ongoing anti-stigma campaign that offers resources to states to develop their own targeted anti-stigma materials.136 Localized stigma and discrimination reduction projects are also under way in California through Mental Health Services Act funding. Development of a statewide suicide prevention campaign should complement local and national anti-stigma campaigns, peer-to-peer programs, and personal contact strategies that effectively increase awareness of suicide prevention and how to find help.

There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicidal behaviors, tailoring that message to include population-specific risk factors where appropriate. Such activities include designing messages that educate the public that suicide is preventable, raising awareness of the populations at risk, forging new and creative approaches to engage community partners, and promoting community-based support systems and cultural-specific ways of healing. Use of multiple media channels, including the ethnic media, is necessary to ensure that the message is far reaching. Linking with national campaigns, such as National Suicide Prevention and Awareness Week and National Depression Screening Day, should also be considered to maximize impact and exposure by reinforcing the messaging.

Public health has successfully used statewide social marketing campaigns to promote public awareness and to influence health behaviors on various topics. The California Tobacco Control Program (CTCP) was formed after Proposition 99 passed in 1988, providing California with the funds to initiate a comprehensive anti-tobacco program. The CTCP found that the most efficient way to reach its goal of decreasing tobacco-related deaths and disease is to implement initiatives statewide that seek to change social norms that influence individual behaviors.[137] The CTCP uses an approach of countering negative influences by depicting tobacco use as undesirable and socially unacceptable. The campaign also supports smoking cessation efforts through a helpline and community-based programs. Finally, the campaign includes a media education component to offset depictions of smoking as acceptable in movies and to counter tobacco industry advertising. Some of the results of the program include an increased desire and intention to quit among smokers, and the smoking prevalence in the state has declined by 33.6 percent since the program's inception.

When the number of stories about suicides increase, or a death is reported at length or featured prominently, the contagion effect can lead to an increase in suicides among susceptible individuals.[138,139] Guidelines have

been developed to inform the media about how to cover suicide incidents in a way that balances public safety with what is newsworthy.[140,141] Media coverage should be used as a positive tool to promote greater understanding of the risks and protective factors and how to get help.

National and state public health agencies have developed mechanisms to engage and educate the entertainment industry around health promotion and disease prevention. For example, Hollywood, Health & Society is a Norman Lear Center project that provides the entertainment industry with accurate and timely information for health storylines. The project is funded by the CDC, the National Cancer Institute, the Agency for Healthcare Research and Quality, the Health Resources Services Administration, and the California Department of Public Health. According to a 2001 survey, over half of regular television viewers reported that they learned about a disease or how to prevent it from watching a television show, and about one-third of regular viewers said they took some action after hearing about a health issue or disease on a television show. Finally, SAMHSA has begun to engage the entertainment industry via the VOICE Awards, an annual event that honors the television and movie industry for positive, recovery-oriented portrayals of mental illness.

Improving Program Effectiveness and System Accountability

Surveillance, Research, and Evaluation

Existing local and state data on suicide provide an incomplete picture of the true magnitude of the problem in California. Due to the paucity of disaggregated data, there are gaps in knowledge about how suicide impacts certain racial and ethnic groups. While information is available about a number of effective and promising suicide prevention practices, much more needs to be learned about programs specifically designed to serve certain population groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda must be established to better design responsive policies and effective programs towards reducing the impact of suicide.

California is a large, diverse state with unique demographics. To strengthen suicide prevention, more needs to be known about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military service, and other factors related to identity. Many questions are yet unanswered about the causes and types of suicide, stages of suicidal behaviors (e.g., ideation, planning, attempt, and aftermath), and the impact of exposure to trauma such as adverse childhood events, historical trauma,[i] intergenerational conflicts,[j] and trauma history within an immigrant's country of origin. Understanding the role of multiculturalism and acculturation in the development of risk and protective factors in immigrant communities should be enhanced. More information is also needed about the relationship between suicide and postpartum depression, homicide, and other factors.

To increase knowledge on these issues, California needs to expand its capacity for surveillance, research, and evaluation on suicide and suicide prevention.

NOTES

[i] Historical trauma is the collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide.

[j] Intergenerational conflicts occur between generations and are related to the acculturation process of immigrant families.

Surveillance is the continuous collection of information on the entire population for the purposes of monitoring and describing a problem. Research refers to limited, focused efforts to answer specific questions that cannot be answered easily through surveillance alone. Evaluation aims to determine how best to design and improve programs. These three approaches often overlap and interact, and all are necessary to support effective policies and programs.

> *"Accurate, complete, and disaggregated information needs to be accessible to the public and policy makers."*

Fortunately, California has the necessary partners and elements to take on this work. Multiple state agency databases exist that can be coordinated, connected, and enhanced to fill gaps in knowledge. California hosts a wealth of world-class research universities and institutes. Existing statewide surveys can be expanded to provide a broader picture of suicidal behavior. These surveys include the California Healthy Kids Survey for middle and high schools, the California Behavioral Risk Factor Surveillance and Youth Risk Behavior Surveillance instruments, the California Health Interview Survey, and others.

Accurate and complete information, including disaggregated racial and ethnic data, about suicide prevalence and prevention need to be widely accessible to the public and to policymakers to inform service and system improvements. Nationally, one persistent challenge is that the information that flows into reporting systems may not be uniform and may come from different sources. For example, the death certificate may ultimately be completed and signed by medical examiners or coroners, or by a public official in the legal system, which may result in differences in how suicide deaths are determined and recorded.[7] One solution to this inconsistency is to implement a single set of criteria for identifying and reporting suicide deaths that is widely used across systems. Another is to explore ways to expand or link the data systems that already exist, such as public health and vital statistics, coroner's office, hospitals, crisis centers, mental health, alcohol and drug programs, law enforcement and corrections, and schools.

An example of how data system linkage can increase knowledge about suicide is the CDC's National Violent Death Reporting System (NVDRS). California is one of 17 states currently participating. The California NVDRS links data from death certificates, police reports, and medical examiner or coroner reports to provide a better understanding of the incidents and risks of violent deaths, including suicide. Information from this database is used to identify trends and risk factors that can inform program and policy decisions to more effectively prevent suicide. NVDRS is also used to identify additional information that needs to be collected to pinpoint the factors associated with suicide. Some examples of how states have used the NVDRS include the following:

- Maryland changed its mental health outreach strategies when it learned that men have much higher rates of suicide and lower rates of contact with the mental health system than women.

- South Carolina instituted new screening protocols when it found that two-thirds of youths who committed suicide were involved in the juvenile justice system.

- Oregon now helps medical professionals identify patients at risk in response to findings that 37 percent of older adults visited a physician in the month prior to their suicide.

- Rhode Island now gathers information on specialties of physicians prescribing drugs, because data from its reporting system suggested that inadequate drug counseling may be implicated in suicide by overdose.

- California's use of the NVDRS has documented that the following risk factors were present in eight out of ten suicide deaths in three Bay Area counties, providing a basis for prevention planning:
  - 60 percent had a mental illness.
  - 30 percent documented a role of physical health problems.
  - 25 percent had made previous attempts or had spoken about their intent.
  - 25 percent reported problems with substance abuse.
  - 21 percent were having interpersonal problems with their partner or another individual.
  - Smaller percentages involved issues with employment, finances, and deaths in the family.

Efforts to expand statewide data systems should be complemented by strategies to increase local capacity for data collection, surveillance reporting, and information dissemination. As critical local partners in reporting on suicide deaths, coroners and medical examiners should be engaged in this process.

It is important to explore innovative and community-based research methods. For example, community participatory action research represents a true collaboration between researchers and the communities that are impacted by the research. Communities are integrally involved in identifying research questions, methods, and defining outcomes that are relevant to the community. Other research methods including longitudinal studies, qualitative studies such as focus groups, ethnography, and oral histories, are also important methods that can be developed to clarify how we can improve suicide prevention strategies tailored to local problems.

One promising model is death review teams, which provide a mechanism for communication and collaboration between different service systems that have important roles in a case. Child death review teams address concerns about the underreporting of child homicides by bringing together a multidisciplinary group that includes medical examiners and coroners to determine cause of death and improve surveillance.[142]

In California all 58 counties have a child death review team. The purpose of these teams is to prevent child abuse and neglect by understanding the factors that contribute

to each death and translating the learning into effective policies. Local teams are supported by a state team that oversees local activities, analyzes standardized local data into an annual report, and provides training on important confidentiality, procedural, and technical issues.

> *"Models for evaluating suicide prevention programs must be disseminated to increase the number of evidence-based practices in California."*

Some examples of policies that have changed as the result of child death review teams involve pool fencing and zero tolerance for guns on school property. Several counties have expanded the local child death review team into programs that also offer services and public education around issues such as bereavement, critical incident debriefing, and Sudden Infant Death Syndrome.

Currently, 25 counties have a Domestic Violence Fatality Review team. These teams are supported through a partnership between the California Health and Human Services Agency and the State District Attorney's Office. In 2000 a statewide advisory committee was formed that has developed a Review Team protocol to maintain consistency among review teams across the state. This committee now hosts regional trainings for local death review team participants. This effort has led to the development of a Risk Assessment Checklist for court judges and a database that tracks risk factors associated with domestic violence-related fatalities.

Counties may have other death review teams related to specific settings, such as deaths of individuals under treatment with the public mental health authority and in hospitals.

In San Francisco the recognition that 70 percent of suicide deaths were from traumatic self-injury (i.e., versus poisoning), along with the fact that two-thirds of those who died by suicide were in psychiatric treatment at the time of their death, led to the implementation of joint psychiatric and trauma service review teams at San Francisco General Hospital.[143] Suicide review teams created a feedback mechanism between different systems to improve care and ultimately prevent suicides in the city.

Finally, there is a need to identify and disseminate models for evaluating suicide prevention programs and activities to increase the number of evidence-based programs in California. This need includes collecting outcome measures that are consistent and relevant to improve programs and the experiences of service users. Culturally and linguistically appropriate approaches to suicide prevention need to be strengthened. Alongside statewide stigma reduction efforts, how the social norms change and their effects on rates of suicidal behavior and appropriate help-seeking behavior should be studied.

Several resources support the dissemination of evidence-based suicide prevention practices, such as the SPRC's Best Practices Registry and NREPP. The criteria required for inclusion in these registries (i.e., proven, promising, and emerging) has resulted in reliable sources of information about suicide prevention programs and practices, including whether they have been tested among diverse population groups.

PART 3: STRATEGIC DIRECTIONS AND RECOMMENDED ACTIONS

The California Strategic Plan on Suicide Prevention serves as a platform for developing and offering a comprehensive range of strategies.

The Suicide Prevention Plan Advisory Committee formulated four strategic directions and corresponding recommended actions to set the course for reducing suicides and suicidal behaviors in California. These recommendations are grounded in the data and evidence offered in the two preceding chapters and were refined through the course of many rich discussions by the committee.

The *California Strategic Plan on Suicide Prevention* serves as a platform for developing and offering a comprehensive range of strategies, starting from prevention and early intervention to crisis services and aftercare, for children and youth to adults and older adults from diverse backgrounds. The programs and services generated from this plan must go beyond traditional approaches that solely depend upon identifying and treating individual risk factors. A population-based approach is essential and will require community-wide strategies and responsive organizational and environmental policies and practices. State and local partners spanning multiple disciplines and settings must work together to create the coordinated system of suicide prevention that is needed to make a difference in California. Lastly, ongoing research and evaluation must be viewed as a keystone element to continuously review and assess the efforts and overall direction. The Plan represents the initial five-year phase of this process.

It is fortuitous that this Plan is being released when there is a concerted effort underway through the Mental Health Services Act to focus more on health, wellness, resiliency and recovery, and to reduce stigma associated with mental illness. With so many lives at stake, the time is now to make suicide prevention a priority.

About Core Principles, Strategic Directions, and Recommended Actions

Six core principles are embedded in all levels of planning, service delivery, and evaluation. The Plan is further organized by two levels of focus for suicide prevention: strategic directions and recommended actions.

Strategic directions are broad levels of focus that serve as the central aim that the more specific recommended actions address. These recommended actions are not an exhaustive list, but they emerged as priorities at this point in time to reduce suicide and its tragic consequences on individuals, families, and communities throughout California.

Taken together, the core principles, strategic directions, and recommended actions are intended to lay a foundation for a comprehensive system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems, and identifies and fills gaps in services and programs.

Core Principle 1. *Implement culturally competent strategies and programs that reduce disparities.*

To be effective, systems, organizations, and services for suicide prevention must embrace behaviors, attitudes, and policies that are compatible with diverse belief systems and customs. A key goal is to reduce disparities in the availability, accessibility, and quality of services for racial, ethnic, and cultural groups that have been historically underserved. Planning and service improvement processes should involve members of the targeted racial, ethnic, and cultural groups.

Core Principle 2. *Eliminate barriers and increase outreach and access to services.*

Potential barriers must be addressed in designing and implementing outreach and service programs to ensure improved access for all Californians of diverse backgrounds and abilities. People who live in rural areas often must travel significant distances to access needed services. Many other individuals are isolated by physical and/or psychiatric disabilities, including age-related disabilities that render them homebound or marginalized from needed support systems. Information, programs, and materials need to be accessible and available in a variety of languages and formats. Programs and services must be accessible to those for whom English is not the primary language; with low literacy skills; and with vision, hearing, and cognitive impairments.

Core Principle 3. *Meaningfully involve survivors of suicide attempts; the family members, friends, and caregivers of those who have completed or attempted suicide; and representatives of target populations.*

Those who have survived a suicide attempt and their family members, friends, or caregivers bring important personal experience and unique perspectives to identifying service needs and gaps in the system and to delivering services. Additionally, when service improvements are under way that target specific populations, representatives of these groups must be involved in all aspects of planning and implementation. Peer support and education are invaluable components of a comprehensive system for suicide prevention.

Core Principle 4. *Use evidence-based models and promising practices to strengthen program effectiveness.*

Many existing programs and practices have demonstrated effectiveness, broadly or within specific populations. Attention should be given to replicating and disseminating or adapting these effective program models and promising practices. Program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs. Evaluation data can be an invaluable tool to garner support for program implementation at all levels.

Many programs and providers currently offer needed and effective services to prevent suicide. Where such promising service or program models exist, the focus should be on coordinating and building upon their foundation towards the development of a more comprehensive system of suicide prevention.

Core Principle 5. *Broaden the spectrum of partners involved in a comprehensive system of suicide prevention.*

To align with the call to action that "Every Californian Is Part of the Solution," it is critical that long-term partnerships be developed with a broad range of partners that transcend the traditional mental health system. These partnerships may include the business community, ethnic and cultural community-based organizations, senior centers and aging services, the spiritual and faith communities, private foundations, schools and institutions of higher education, health and human service organizations, criminal and juvenile justice entities, and military partners, such as Veterans Affairs and the National Guard.

Core Principle 6. *Employ a life span approach to suicide prevention.*

Suicide prevention and intervention strategies should be targeted to Californians of all ages from children and youth, to adults, and older adults. The life span approach seeks to prevent a crisis from emerging as well as to provide prevention and early interventions to address problems long before they become acute.

Strategic Direction 1: Create a System of Suicide Prevention

Increase collaboration among state and local agencies, private organizations, and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion and prevention through crisis intervention.

Recommended Actions at the State Level

1.1 Establish an Office of Suicide Prevention to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices, and community planning.

1.2 Engage a coalition of public partners to integrate, coordinate, enhance, and improve policies and practices that prevent suicide. These partners should include:

- Department of Aging
- Department of Alcohol and Drug Programs
- Department of Corrections and Rehabilitation
- Department of Education
- Department of Health Care Services
- Department of Managed Health Care
- Department of Mental Health
- Department of Public Health
- Department of Social Services
- Department of Veterans Affairs
- Managed Risk Medical Insurance Board
- National Guard

1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. The public and private partnerships should include:

- Community-based and ethnic-based organizations
- Community leaders
- Client, family, youth, and peer support advocacy groups
- Employers
- Health and mental health providers
- Insurance industry
- Local educational agencies and institutions of higher education
- Spiritual and faith-based organizations

1.4 Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.

1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level, and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.

1.6 Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.

1.7 Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness, and recovery.

Recommended Actions at the Local Level

1.8 In each county, appoint a liaison to the state Office of Suicide Prevention, and build upon an existing body or convene a new suicide prevention advisory council to collectively address local suicide prevention issues. Membership should reflect a broad range of local stakeholders with expertise and experience with diverse at-risk groups, including:

- Local government and nonprofit agencies, such as mental health, public health, law enforcement, education, and Area Agencies on Aging
- Coroners and medical examiners
- Tribal representatives
- Survivors of suicide attempts and family members
- Mental health clients

1.9 Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the entity designated as the local suicide prevention advisory council. The plan should:

- Identify measurable goals, objectives, and expected outcomes toward creating a comprehensive system of suicide prevention that includes health and mental health promotion through crisis interventions.
- Establish clear protocols for communication, including sharing confidential information, among systems and providers.
- Identify target population groups and strategies or an inclusive process for doing so.
- Create and monitor an effective crisis response system.
- Identify opportunities and embed and expand quality suicide prevention activities in local programs across systems.
- Provide for technical assistance to peer support programs, such as peer-run crisis respite centers and peer warm lines.
- Coordinate with the state Office of Suicide Prevention.
- Provide for periodic review of the county's progress and updates to the plan.
- Identify mechanisms to report on suicide prevention activities in existing county reporting structures, such as those for Mental Health Services Act components and county cultural competence reports.

1.10 Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide.

1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders, and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.

1.12 Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems.

1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

1.14 Ensure that the county has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.

1.15 For counties with an established, accredited suicide prevention hotline call center, work with the Office of Suicide Prevention to explore opportunities to provide training and consultation to other counties to develop their suicide prevention hotline capacity.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across all service providers.

Recommended Actions at the State Level

2.1 Convene expert workgroups to recommend, develop, disseminate, broadly promote, and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

At a minimum, occupations selected for guidelines and curricula development and training should include:

- Primary care providers, including physicians and mid-level practitioners
- First responders, including police officers and sheriffs, emergency department staff and emergency medical technicians
- Licensed mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities
- Social workers and other staff in older adult programs, in-home support services, adult and child protective services, and foster care
- Adult and juvenile system correction officers and probation and parole officers
- Administrators and faculty in elementary, middle, and high schools and in colleges and universities

Service and training guidelines should

include direction and recommendations for the following:

- Promoting health, mental health, and prevention principles
- Addressing barriers related to mental health stigma and discrimination
- Increasing understanding of protective and risk factors, including the role of age, sex, culture, race, ethnicity, and gender identity and sexual orientation in suicide prevention
- Improving suicide risk assessment and treatment
- Establishing specific actions for follow-up care after a suicide attempt and/or discharge from an emergency room, urgent care center, hospital, or at the end of a visit with a physician or health care staff
- Reviewing guidelines in health insurance plans to ensure effective response and services to assess and address suicide risk or suicidal behavior
- Implementing promising practices for law enforcement, such as crisis intervention teams
- Considering how to promote incentives for community organizations to provide suicide prevention training and to employ trained gatekeepers

2.2 Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, graduate

2.3 Following implementation of 2.1 and 2.2, develop and implement a process for determining within five years which occupations are to be targeted for required training and how the requirements will be implemented.

Recommended Actions at the Local Level

2.4 Establish annual targets for suicide prevention training that identify the number of individuals and occupations that will receive training, and the models, including peer support, which will be used for training. Using an inclusive process for input, develop and implement training plans that meet these targets.

2.5 Increase the priority of suicide prevention training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs.

Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

Recommended Actions at the State Level

3.1 Launch and sustain a suicide prevention education campaign with messages that have been tested to be effective for diverse communities and that address warning signs, suicide risk and protective factors, and how to get help.

3.2 Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.

3.3 Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness, and mental health services that support suicide prevention efforts.

3.4 Promote information and resources about strategies that reduce access to lethal means, such as gun safety education and increasing compliance with existing gun safety laws, safe medication storage, and physical and non-physical deterrent systems on bridges or other high structures.

3.5 Disseminate and promote models for suicide prevention education for community gatekeepers.

Recommended Actions at the Local Level

3.6 Build grassroots outreach and engagement efforts to coordinate with and tailor the statewide suicide prevention education campaign and activities to best meet community needs.

3.7 Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.

3.8 Educate family members, caregivers, and friends of those who have attempted suicide, individuals who have attempted suicide, and community helpers to recognize, appropriately respond to, and refer people demonstrating acute warning signs.

3.9 Promote and provide suicide prevention education for community gatekeepers.

3.10 Develop and disseminate directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.

3.11 Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

DImprove data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

Recommended Actions at the State Level:

4.1 Develop a California surveillance and research agenda on suicide, suicide attempts, and suicide prevention to support data-driven policies and evidence-based programs.

4.2 Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.

4.3 Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.

4.4 Coordinate with the Office of Suicide Prevention and county suicide prevention liaisons to make data and reports more accessible to, and in more user-friendly formats for, the public at large and policy makers at all levels to improve understanding of suicide and suicide attempts and to enhance prevention efforts for all population groups.

Recommended Actions at the Local Level:

4.5 Increase local capacity for data collection, reporting, surveillance, and dissemination to inform prevention and early intervention program development and training.

4.6 Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.

4.7 Establish or enhance capacity for a clinical and forensic review of suicide deaths in each county. The suicide death review process should include reporting de-identified data and findings to the State Office of Suicide Prevention and the local suicide prevention advisory council at minimum. The advisory council could use the reports to inform local policy action recommendations. Members of the case review teams should include representatives of the Office of the Coroner/Medical Examiner and as appropriate other officials with legal access to confidential information.

4.8 Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.

PART 4: NEXT STEPS

The *California Strategic Plan on Suicide Prevention* has identified four major strategic directions and numerous recommended actions to reduce the number of suicide deaths and the incidence of suicidal behaviors in California. The plan calls for a substantial coordinated effort by multiple partners to identify and successfully achieve the necessary program, policy, and system improvements. Many of the recommendations require a long-term effort; others can be implemented immediately. The purpose of this section is to outline initial steps that should be taken to implement the recommendations in this plan.

The Suicide Prevention Plan Advisory Committee recognized that to succeed in both the short and long term, it is essential during the first phase of implementation to establish a solid foundation upon which to build. Further, the Advisory Committee acknowledged the need to be deliberate and sequential in implementing the recommendations (e.g., the need to enhance the capacity of the workforce before launching a major campaign that would increase the demand for services). Lastly, the Advisory Committee implored that the funding to support the ongoing services be at a sufficient and sustained level.

Success will be achieved through a collective and well-integrated effort; it cannot be solely dependent upon one funding source nor can the responsibility be shifted to any one entity. The theme, "Every Californian Is Part of the Solution," must ring true throughout the implementation of the strategic plan if suicidal behaviors are to be decreased and lives are to be saved. As a result, the implementation of the recommended actions, and the next steps will be the responsibility of an array of state, local, public, and private partners.

The Office of Suicide Prevention will serve as a coordination point for addressing many of the recommended actions in this plan. Leadership and support from other public agencies and private organizations must also play a paramount role. Thus, in conjunction with a number of key partners, the Office of Suicide Prevention will develop a detailed work plan to initiate its operation.

The DMH and the MHS Oversight and Accountability Commission (OAC), with support from the California Mental Health Directors Association (CMHDA), have recommended that counties direct approximately $14 million in MHSA funds each year for four years to support a statewide suicide prevention effort. A portion of the funding has been earmarked for Student Mental Health Initiative[k] funding for K-12, community colleges, and universities.

To launch this concerted effort to prevent suicide and suicidal behavior in California, the following activities should be considered for the initial five-year implementation phase that will provide a foundation for future work.

Strategic Direction 1: Create a System of Suicide Prevention

State Level

1.A Staff the Office of Suicide Prevention established within the California Department of Mental Health on February 6, 2008.

1.B Develop and issue an action plan that includes an assessment of the current level of activity and detection of major gaps, and identifies objectives toward implementing the initial activities described in this "Next Steps" section.

1.C Establish a technical assistance infrastructure of regional working groups/learning collaboratives, consultation, training, and other support methods, and a resource center to support local suicide prevention systems and efforts.

1.D Establish a statewide coalition of state-level organizations and public and private partners to better address the integration of effective suicide prevention policies, practices, and programs into existing service systems. The initial coalition will include the state agencies identified in Recommended Action 1.2 and be expanded to include the public and private partners identified in Recommended Action 1.3.

1.E Assess the current status of coverage and accreditation for suicide prevention hotlines in California. Beginning with call centers that are members of the National Lifeline, build a consortium of accredited suicide prevention hotlines statewide to expand access to standardized services throughout the state and to ensure full multilingual, cultural, and age-specific crisis coverage for all Californians.

1.F Provide technical support to expand functions for accredited suicide prevention hotline centers, such as training centers for various occupations and professions, including peer support providers and after-care service providers.

NOTES

[k] The Student Mental Health Initiative is aimed to strengthen mental health for students in both K-12 and higher education through training, mental health education, peer support, violence prevention and suicide prevention activities in local education agencies and higher education campuses.

[l] 211 lines provide information about community services and information related to health and human services.

1.G Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention hotline calls in California. At minimum, collect information about calls and outcomes by age, sex, county location, and language.

1.H Provide technical assistance to expand or link accredited hotlines to additional venues and formats, including the Internet, 211 lines[l], Web-based self-help services, and other age-appropriate means to improve access to information on local suicide prevention and early intervention services.

1.I Provide technical support to counties to conduct a comprehensive assessment of suicide prevention services.

1.J Link and provide support to county-level advisory councils dedicated to developing the local coordinated suicide prevention system. Establish and maintain a collaborative relationship among the state and county liaisons.

Local Level

1.K Appoint a liaison to the state Office of Suicide Prevention in each county.

1.L Convene or build upon an existing entity to establish a county suicide prevention advisory council that is dedicated to developing the local coordinated suicide prevention system.

1.M Design and implement a comprehensive assessment of the existing county suicide prevention services and supports and the detection of major gaps that will inform the development of the local suicide prevention action plan, from health and mental health promotion through crisis intervention and after care.

1.N Develop a local suicide prevention action plan through an inclusive community process that includes review of the comprehensive assessment, identification of short-term and long-term objectives, establishment of milestones, and completion of a work plan. Establish the baseline of the targeted policy, program, and system improvements.

1.O Assess capacity of local or, where appropriate, regional accredited suicide prevention hotline(s) and take steps needed to achieve accreditation or build the capacity (e.g., as training centers or after-care service providers; expand or link to web-based formats) of already accredited hotlines.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

State Level

2.A Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow-up care for California's diverse population. Begin with a review of the various occupations and professions identified in this plan to determine the first cohort of training programs to be assessed and enhanced. Identify opportunities for training program enhancements and work cooperatively with appropriate agencies to implement needed improvements.

2.B Convene expert work groups to recommend, develop, and broadly promote standard service and training guidelines and curricula for targeted service providers, including peer support providers, in California. Review licensing and credentialing processes to assess viability of new training requirements.

2.C Coordinate and review surveys on local training needs. Include in the Office of Suicide Prevention's action plan methods for supporting counties in addressing and providing the necessary training, utilizing distance-learning modalities, online services, and other effective methods. Secure resources and partnerships to expand available support.

2.D Deliver train-the-trainer sessions for targeted service providers.

Local Level

2.E Review local MHSA Workforce Education and Training component assessments to identify elements relevant to suicide prevention efforts. To supplement information, survey suicide prevention training programs and needs and assess gaps. In conjunction with the state efforts, set local training targets for selected occupations, develop a plan with responsible parties to meet those targets and a process to measure progress.

2.F Disseminate and promote service standards and training guidelines. Design and implement an inclusive community process to adapt guidelines to better serve local needs as necessary.

Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

State Level

3.A In conjunction with any existing social marketing efforts, such as stigma and discrimination reduction activities, develop and implement an age-appropriate, multi-language education campaign and messages specifically designed and pilot-tested to positively influence attitudes about the preventability of suicide, to increase appropriate help-seeking behaviors, and to reduce suicidal behaviors.

3.B Obtain the necessary social marketing consultation to design, test, and promote the suicide prevention messages in ways that will benefit target populations at risk for suicide. Develop, test, and produce accompanying outreach and educational materials.

3.C Support local efforts to engage and educate the media by disseminating selected resources from national and other suicide prevention organizations.

3.D Identify a strategy for reducing access to lethal means in California.

3.E Identify and disseminate models that counties can use to implement suicide prevention gatekeeper education.

3.F Conduct regional training to build local capacity for peer support programs.

3.G Design, produce, and maintain a web page for the Office of Suicide Prevention that provides links to the many sources of reliable information. Identify and develop additional new information needed to appropriately address the needs of all Californians.

Local Level

3.H Coordinate local outreach, awareness, and education activities with other social marketing campaign efforts as a means to expand suicide prevention messages and information in multiple languages.

3.I Design and implement a strategy to better engage and educate the local media on the importance of appropriate and responsible reporting of suicide deaths and suicide prevention information.

3.J Design a community education plan that may include:

- Developing a community calendar of events and activities promoting suicide prevention awareness and education
- Identifying opportunities to integrate suicide prevention information into ongoing services in education, primary care, older adult, first responder, faith community, and other systems
- Localizing national and state suicide prevention events

3.K Reach out to community gatekeepers, including staff and volunteers providing home-based services, to increase their awareness and participation in suicide prevention efforts.

3.L Develop and widely disseminate a directory of local suicide prevention services and supports in multiple formats. Design a process to ensure that the directory is kept up-to-date.

3.M Foster the development of peer support programs, including support groups and networks.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

State Level

4.A Working collaboratively with other local, state, and national entities develop a California-specific research agenda, including surveillance and evaluation, on suicide attempts and deaths and suicide prevention to support more effective policies and programs. Design a process to identify priority activities from a comprehensive review of multiple data sources and an inclusive decision-making process.

4.B Work to improve the collection and reporting of data as well as the systems for surveillance for a better understanding of the suicide trends and rates, and the impact of protective and risk factors among California's diverse population groups that can lead to more appropriate policies and programs. Target research activities in key areas, such as policies and programs appropriate for specific ethnic, cultural, and age groups, that are gender-specific, that address trauma and other factors, and that have effective application in multiple settings.

4.C Develop an evaluation component to track and monitor the statewide effort, including a system for monitoring and tracking national, state, and local policy changes and system improvements leading to a reduction in suicidal behaviors and suicide deaths in California.

4.D Develop and disseminate data reports on special topics and specific target populations by age, sex, culture, race, ethnicity, and other factors to enhance programs and service delivery.

Local Level

4.E Assess local data sources and reporting processes pertinent for suicide prevention and develop and implement a strategy to enhance data collection across systems.

4.F Coordinate with the state Office of Suicide Prevention to build local capacity for program evaluation, including community participatory research methods.

4.G Complete an inventory of existing death review teams serving the county. In coordination with the local suicide prevention advisory council, build the capacity for conducting a suicide death review process in each county and provide for regular reporting on suicide deaths to the suicide prevention advisory council.

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Copies of The California Strategic Plan on Suicide Prevention and an Executive Summary of the Plan are available for download from the California Department of Mental Health web site at ***www.dmh.ca.gov***. Hard copies can be requested by contacting the Office of Suicide Prevention via postal mail, e-mail, or telephone.

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CALIFORNIA DEPARTMENT OF
Mental Health

MHSOAC

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

June 14, 2007

To the Members of the Mental Health Services Oversight and Accountability Commission:

Attached for your review is the report of the MHSA Stigma and Discrimination Advisory Committee.

As you know, this Advisory Committee met at your request over the last several months to formulate advice and recommendations. These were some of the most challenging meetings of the MHSA stakeholder process. Members struggled to identify common goals, strategies and approaches. One observer noted that issues of stigma and discrimination are so personally felt and so disempowering that work in this area by nature exposes our greatest vulnerabilities, both as individuals and as a system.

Our strategy to find meaning in these difficulties has been to listen. Advisory Committee members and the public had great deal to share: they spoke of painful experiences of stigma that have hurt them and limited their life opportunities. They spoke of systemic discrimination that has created barriers more formidable than the Berlin Wall. They detailed the ways that stigma and discrimination hurts adults and children, families and communities in almost every domain of life. It was a process filled with difficulty but it was also a very powerful process, going to the heart of the Mental Health Services Act itself.

This report is the first product of our work. It is not intended as a research paper of an academic nature; rather, it is an advocacy paper that is research-and-policy-informed. The problems, themes and often the voices and perspectives expressed are those of our stakeholders. After they articulated their views and concerns, we went to the literature in search of further evidence of the problems they raised. There we found validation of their experiences of stigma and discrimination and found that the problems they identified have been widely researched, written about and shared by others interested and involved with mental health.

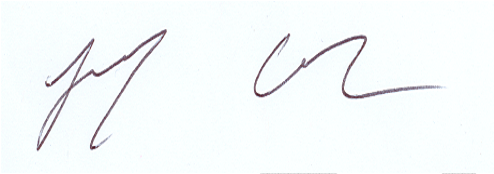
This process has not led to easy solutions. Mental health advocates are not well suited to "one-size-fits-all." Our stakeholders' views sometimes contradicted one another. We did not attempt to entirely smooth out those differences of opinion, but to represent them honestly and let them stand. The finished report reflects that approach.

There are also those who will notice that this initial effort is long on problems and short on solutions. However, the problems of stigma and discrimination against adults and children with mental health disabilities have existed throughout history. We cannot believe that we have solved them in a few short months.

What we have accomplished is to engage in an honest dialogue that has resulted in a detailed blueprint of the problem. SAMHSA's recommendation for developing a stigma reduction initiative is to first conduct a "Situational Analysis" – this document fulfills that purpose. This comprehensive Situational Analysis can serve as the foundation of our work on reducing stigma and discrimination. In addition, we have also developed strategies to be explored and developed further as we proceed, as well as fulfilling our main task of making initial recommendations to the Commission for making a sound investment of $80 million of initial resources.

There are many people whose contribution to this work has been invaluable, and they are acknowledged at the end of the report. Special thanks are in order to Laurel Mildred, MSW, who is responsible for the writing.

Respectfully Submitted,



Jennifer Clancy, MSW
Executive Director

MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

ELIMINATING STIGMA AND DISCRIMINATION AGAINST PERSONS WITH MENTAL HEALTH DISABILITIES

■ A Project of the California Mental Health Services Act ■

In today's world we are still considered disgraceful, diseased, abnormal, hysterical, even criminal in the minds of a society that, on the whole, seems to lack understanding and respect for us.

-Delphine Brody, Client Leader

Stigma is the most formidable obstacle to future progress in the arena of mental illness and health.

-United States Surgeon General

INTRODUCTION

According to the United States Surgeon General, "stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia. It reduces access to resources and opportunities (e.g. housing, jobs) and leads to low self-esteem, isolation and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its more overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society" (U.S. Department of Health and Human Services, 1999, p. 6).

Inclusion and integration can be achieved only if the law recognizes that people with mental disabilities are fundamentally like other people and hence entitled to equality as well as fairness.

(Levy and Rubenstein, 1996)

If stigma represents the feelings, reactions and stereotypes that people experience when they encounter mental illness and adults and children who face it,

discrimination is action taken to deprive people of their rights, based on those feelings and reactions. Stigma demonstrates a lack of understanding, compassion and knowledge of mental illness and the people it affects. Much discrimination, on the other hand, is illegal -- a fundamental abridgement of the civil rights of people who are fully entitled to the same rights as all other citizens of the United States.

The cumulative impacts on people that result from stigma and discrimination are the central concern of this work. When those who face the challenge of recovering from mental distress, crisis, trauma and illness are shunned, avoided, deprived of employment, housing, relationships and other life opportunities, the impacts can be devastating. Stigma can lead adults and children to feel ostracized, damaged, flawed, defective, and unwanted. It can lead those who need hope the most in order to face the world each day to isolation, depression and suicide.

These impacts are not an inherent part of mental illness. They are socially constructed, the result of oppression. And although the task of changing stigma and fighting discrimination are daunting, they are also amenable to change, because people can change. It is a matter of reaching both their hearts and their minds. For those facing mental illness, it is actually often a matter of life and death that we succeed in that endeavor.

Part I. FOUNDATION

A. BACKGROUND

Historically, stigma has been a key factor in why mental health problems are poorly funded (U.S. Department of Health and Human Services, 1999), and here in California, "mental health programs are the chronic losers in budget debates" (Little Hoover Commission, 2000, p. i). However, in November of 2004 California voters approved Proposition 63, entitled the Mental Health Services Act (MHSA), making California the first state in the country to levy a special tax to finance mental health services. The tax is 1% of personal incomes exceeding one million dollars, and will result in $2.53 billion dollars over the first three years, sustainable into the future, for mental health treatment, prevention activities, development of innovative programs, investment in a crumbling infrastructure of capital facilities and technology and providing training and recruitment for the critically understaffed mental health workforce.

It is not the funding alone that makes California's investment in the Mental Health Services Act a groundbreaking investment in mental health nationally. The funding represents about 12% of the statewide funding for mental health (California Mental Health Directors Association, 2007). It will not fully address the overwhelming need for mental health services in a state where less than 50% of children, adults and older adults who need and qualify for services receive them (California Mental Health Planning Council, 2003).

The greatest benefit of the MHSA lies in its underlying values and philosophy. The Act will not replicate old ways of doing business, but is designed to leverage funding to *transform* the old system to deliver client-driven, youth-and family-oriented services that reflect best and most effective practices and that clearly demonstrate outcomes and accountability. Clients, family members, ethnic communities, community-based agencies, providers and other stakeholders in the mental health system have become key partners in the decision-making process, meeting together to make essential decisions that were previously the domain of state and county mental health bureaucracies. This process of local decision-making is referred to as the "Stakeholder Process" and it has quickly become the first and most visible transformation accomplished by the MHSA.

> *The right to equality becomes the most critical right of all, subsuming all other rights. It means that people with mental disabilities must have the same right to liberty, autonomy, informed consent, due process as all other members of society and that qualified people with mental disabilities may not be discriminated against in housing, employment or the activities of civic life.*
>
> (Levy and Rubenstein, 1996)

The Act also established a new commission to oversee this sea change in the California mental health system. Intended to be used as a "bully pulpit" to promote mental health, to empower the voices of clients, family members and underserved populations in the process and to ensure accountability to stakeholders and to the public, the 16-member Mental Health Oversight and Accountability Commission was established in July, 2005. In keeping with their responsibilities for oversight and leadership in mental health policy, the Commission identified reducing stigma and discrimination as an essential goal of the MHSA, and approved an annual allocation of $20 million to this project, for a total initial investment of $80 million over the first four years. The Commission appointed an Advisory Committee of 26 key stakeholders and organized two public hearings to give feedback, provide guidance for the project, to draft this initial statement of the problems of stigma and discrimination and to make recommendations on strategies to employ.

B. THEORETICAL FRAMEWORK OF A TRANSFORMED MENTAL HEALTH SYSTEM

The work of the Mental Health Services Act, as described above, is diametrically different than older models of mental health service delivery. Guided by principles and methods based in a social justice and client-driven orientation, some of the key theoretical underpinnings of the transformed mental health system are critical to the reduction of stigma and discrimination.

The Ecological Systems Model is a general organizing theory – an umbrella theory – that provides a framework for understanding the new work of the MHSA. This theory asserts that each person is located within many environments, including the family, society, culture, and physical surroundings (Anderson and Carter, 1999). In this way, the person cannot be understood separately from his or her environment (so rather than simply considering only the mind, the whole person must be considered). This "whole person" approach is sometimes also described as a "bio-psycho-social-spiritual" (mind, body, relationship, spirit) approach.

Other theories and perspectives that respond to the whole person also operate under the general organizing principle of the Ecological Systems Model and are essential to the transformed mental health system. One of the most important of these is the Strengths Perspective, which de-emphasizes labels, diagnoses and deficits, focusing instead on strengths, resiliency and potential for recovery (Shriver, 2001). The Strengths Perspective emphasizes what is important and meaningful to the client for his or her life. It is often in direct conflict with the older "Medical Model," which focuses on diagnosing and treating a "disease," and this theoretical shift represents a major transformation in the way services are designed and delivered in the mental health system.

The Wellness Perspective is related to the Strengths Perspective and is also part of the new theoretical shift, but emphasizes some additional issues. Along with the mind-body connection, this perspective is respectful of the role of spirituality in healing and recovery, and it specifically calls for reducing barriers to living with a disability (Schriver, 2001); an important foundation for reducing stigma and discrimination.

Family Theory is also important to the transformed mental health system. This theory emphasizes interaction among members of families, respects the role that both biological families and affiliative families play in people's lives, and operates in ways that strengthen families as an essential asset to a person's well-being (Cocozzelli, 1987).

Culture Theory is based in the study of the diversity and similarities of different human cultures, and grounded in respect for the protective qualities of culture in good mental health (U.S. Department of Health and Human Services, 2001). Culture Theory provides a social justice framework that acknowledges that racism, poverty, exposure to violence and other adverse social conditions are risk factors associated with mental illness. It emphasizes reducing disparities among ethnic communities and other underserved groups, and on "cultural competence,"

providing services that are relevant, appropriate and informed by each person's cultural framework.

Finally, three related perspectives, the Empowerment Theory, the Recovery Model and the Resilience Model are at the heart of the work of the MHSA. Empowerment Theory advocates increasing political, social and economic strengths of people and communities by assisting them to develop confidence as well as control over their own lives (Lee, 2001). The Mental Health Recovery Model emphasizes that while people may not have full control over their symptoms, they can have full control over their lives by achieving stability, social rehabilitation and transcending limits to achieve their highest goals and aspirations (Mahler, Tavano, Gerard, Baber, 2001). The Resilience Model is well-adapted to the needs of children, taking into account developmental stages and focusing on cultivating factors that promote life success rather than trying to eliminate factors that promote failure (Garmezy, 1993).

Theories of course represent the ideal, and not the realities of practice. But taken together, these theories, perspectives and models represent the vision, values, hopes and dreams that we hold for California's mental health services and system, and are one of the major avenues toward reducing stigma and discrimination in our midst.

C. STIGMA AND DISCRIMINATION DEFINED

As noted above, *Stigma* refers to attitudes and beliefs that motivate individuals to fear, reject and avoid those who are labeled, diagnosed or perceived to have a serious mental illness – often anyone who is seen as "different."

Stigma also affects those who work with, advocate for or love people who are perceived as different. Family members are frequently stigmatized, especially by clinicians and the mental health system but also by society at large, judged responsible for a loved one's mental illness and treated with suspicion or disapproval. These views can be damaging to people who are already struggling under challenging circumstances, leading to isolation and a high risk of developing clinical depression themselves (Gray, 2003).

Those who work with persons perceived as different are also stigmatized. Mental health services are among the most underfunded, and mental health professionals in the public mental health system are among the most underpaid, of all the health professions (McRee et al, 2003). A severe shortage of a qualified mental health workforce is the result of these factors. Retaining qualified staff in the face of all this is equally a challenge, and the positive transformation of the mental health system is severely hampered by this dynamic.

Finally and most importantly, the shame and blame of society's discomfort with the differentness of mental illness lands squarely upon those most vulnerable – those struggling to have meaningful lives while coping with the symptoms and effects of mental illness.

Discrimination is no less egregious than stigma, but may have impacts that are even more damaging. Discrimination occurs when people and societies *act* upon their feelings of rejection and discomfort with mental illness by depriving those associated with it the rights and life opportunities that are afforded to all other people. And many of its most common manifestations are illegal, for example, depriving people of housing, employment, education and opportunities for civic life.

Abuse is another form of discrimination which is illegal but which occurs all too frequently. Unnecessarily violent responses from police often lead to death and severe injury of people in mental distress. Children struggling with emotional disturbance are shunned by peers and taunted or beaten up by bullies in their schools and neighborhoods. People in crisis and admitted to involuntary "treatment" settings have been illegally strip searched or subjected to sexual abuse. They have been strapped into restraints and left for hours as punishment or as a strategy to manage staff shortages (Mildred, 2002). These are not examples from the dark ages. They are part of the very real dangers that people with mental illnesses face when they are stripped of power, choices and civil rights.

Most people do not face such experiences or dangers in the course of their everyday lives. Unfortunately, these most dangerous outcomes accrue to children and adults of all ages who are already burdened by mental illness, and vulnerable to harm and exploitation. Understanding the consequences of stigma and discrimination is the first step toward redressing these injustices and reducing the preventable harm they cause.

Part II: PEOPLE

A. A FIRST-PERSON PERSPECTIVE: LIVING WITH STIGMA AND DISCRIMINATION

It is important to note that while there is a substantial amount of research, theory and opinion about stigma and discrimination, people have personal experiences and actually live with it every day. They frequently report that the cumulative effects of isolation, alienation and denial of equal opportunities for life happiness can be more devastating than the illness itself.

Over a three-year period, the California Network of Mental Health Clients conducted twelve confidential focus groups in the Bay Area, surveying the experiences and opinions of 249 mental health clients on the topics of stigma and discrimination. The results reveal that frequently the

subjective experience of living with stigma and discrimination differed from the opinions of mental health professionals and other mental health stakeholders.

In particular, clients in this study noted that they felt that they experienced the greatest stigma and discrimination from the mental health system, as well as members of their families, followed by police officers (Brody, 2007). Many of the clients in this survey disagreed with often-cited anti-stigma messages, especially the notion that "Stigma is a problem in that it deters people from seeking treatment." They felt that this message promotes a notion of stigma based in the medical model, rather than a client empowerment model, and deflects attention away from environmental factors, traumatic experiences and the underfunding of essential voluntary services and supports. One client noted that anti-stigma messages of the "broken brain" school of thought may evoke pity, but do not promote client inclusion in society (p. 24).

> *I'm told that I've socially expired – I'm history. I've been given a social death sentence.*
> -Mental Health Client
> (Brody, 2007)

For these clients, the key effects of stigma and discrimination were "prejudice, labeling, intolerance, segregation, exclusion, the problematic concept of 'normal,' the harmful effects of the 'medical model' and the loss of personal freedom" (Brody, 2007, p. 33). The remedy, as one client stated simply: "Treat people equally" (p. 31).

B. CHILDREN AND ADULTS INTERNALIZE STIGMA

Children and adults with experience of mental illness are at high risk of internalizing stigma and suffering diminished self-esteem, feelings of confidence and mastery in their own abilities (Corrigan, 1998, Link, 1987). The low self-esteem that results from internalized stigma is often experienced as shame, and interferes with a person's life goals and quality of life (Corrigan, 2004). This low self-esteem and demoralization from constant reinforcement that one is shameful and devalued has been associated with failing to pursue work or independent living. In the view of one researcher, "It is undoubtedly threatening and personally disheartening to believe that one has developed an illness that others are afraid of" (Link et al, 2001, p. 1621).

Internalized stigma is also related to willingness to engage in treatment: "Consumer advocates have argued, and research seems to support the idea, that many psycho-social and medical treatments disempower people, and as a result, people in need decide not to fully participate in services" (Corrigan, 2004, p. 620). This research indicates that effective services that are defined useful by persons with mental illness and are also non-shaming can reduce stigma and internalized stigma, increasing the willingness of people to utilize and engage in those services.

This type of self-stigma can also exacerbate isolation. Fear of stigma and rejection can lead people to act less confidently, more defensively, or to avoid social contact altogether. It can lead to strained and uncomfortable social interactions with those perceived as potential stigmatizers. It can also lead to limited social supports, poor life satisfaction, unemployment or loss of income (Link et al, 2001).

The combined effects of societal stigma internalized by adults and children with mental illness can lead to substance abuse and suicide. According to the Surgeon General, as many as half of people with serious mental illnesses develop alcohol or other drug use problems at some point in their lives. Substance use exacerbates symptoms, hospitalization, depression, suicide, incarceration, family friction and costs of treatment. It also exposes people to negative life outcomes and to health risks such as violence and sexually transmitted diseases (U.S. Department of Health and Human Services, 1999). However, despite the high association of substance abuse and mental illness, substance abuse treatment for persons with mental illness is scarce. Exacerbated by separate delivery systems that are both underfunded, an estimated 500,000 mental health clients in California with co-occurring mental health and substance abuse disorders need substance abuse treatment to move forward in recovery, but do not receive it (Little Hoover Commission, 2000).

Suicide is most tragic outcome of mental illness and is integrally connected to internalized stigma. Societal messages that one is devalued, of little worth and has little opportunity to contribute, love, connect, experience success and feel happiness can become a vulnerable person's reality: suicide results from despair. According to the Little Hoover Commission, an estimated 3,430 Californians committed suicide in 1997 – the leading cause of preventable death. Thousands more struggle with suicidal feelings as an ever-present reality.

Research suggests that two of the most effective strategies to combat internalized stigma are empowerment and recovery. Empowerment includes peer support and self-help, advocacy, economic development projects, protest and participation in the system. Recovery is the individual journey of personal growth that supports better management of symptoms, healthy life choices and an improved quality of life. "Neither of these strategies make the world fairer, but they strengthen people's ability to withstand stigmatizing attitudes, to fight against discrimination and to stand up for their rights" (Everett, 2007).

C. PEOPLE FACING MULTIPLE OPPRESSIONS

Racial and ethnic minorities face multiple barriers involving stigma and discrimination that increase their risk of mental health problems, reduce their access to treatment, and make it less likely that treatment will be helpful to them.

In addition to the stigma experienced by all persons facing mental distress, racial and ethnic minorities also experience racism, poverty, language barriers, clinician bias and inappropriate services. These conditions have resulted in enormous disparities, leaving the populations who are at the highest risk of mental health problems the most underserved. These disparities operate in all health care, but are particularly severe in the mental health system.

The social conditions that put minorities at high risk for mental illnesses include racial discrimination in housing sales and rentals (Yinger, 1995) as well as hiring practices (Kirscheman and Neckerman, 1991). According to the General Social Survey of 1990, minorities experience higher financial stress as a result of racial bias. And recent studies link the experience of racism to poorer mental and physical health. Research has shown that major incidents of discrimination are associated with psychological distress and major depression, and the day-to-day grind of everyday incidents of discrimination is linked to generalized anxiety and depression. The Surgeon General concludes, "Racism and discrimination are clearly stressful events that adversely affect health and mental health and place persons of color at risk for mental disorders." (U.S. Department of Health and Human Services, 2001, p. 38).

WHITE PRIVILEDGE:

A term denoting a variety of advantages, for example, in housing, salaries, healthcare, employment, education, opportunity and life expectancy that white persons have come to expect but that are commonly unavailable to non-whites. These privileges are often "invisible" and taken for granted by those who benefit from them.

(Tatum, 1997, McIntosh, 1989)

The lack of appropriate language services is one of the major barriers to accessing the mental health system. The number of Californians age five and over who speak a language other than English was 12.1 million in 2000, with Spanish, Vietnamese, Cambodian, Laotian, Hmong, Armenian, Cantonese, Korean, Russian, Farsi, Mandarin and Tagalog among the major languages spoken. This snapshot does not capture the full complexity of the language barriers, however – just among the sub-group of Asians and Pacific Islanders, there are 43 subgroups and 100 languages. The fastest growing group of non-English speakers is the Latina/Latino population – in some counties such as Colusa, Imperial and Monterey, over 50% of Medi-Cal beneficiaries reported Spanish as their primary language (Bloom et al, 2005). Federal and state laws, including the Civil Rights Act of 1964, grant rights to equal access to services and require that language services be provided free of charge. But despite these protections, discrimination in access because of language barriers continues to be a significant roadblock to treatment in the mental health system.

Another significant barrier to mental health services for people of color is differential treatment and poor quality of care. While underserved in the voluntary community system of mental health care, minority groups, particularly African-Americans and Native Americans, are overrepresented in coercive services involving involuntary inpatient hospitalization (U.S. Department of Health and Human Services, 1999; Snowden & Cheung, 1990).

> *Legally sanctioned discrimination and exclusion of racial and ethnic minorities have been the rule, rather than the exception, for much of the history of this country.*
>
> -U.S. Surgeon General, 2001

In particular, African-Americans are disproportionately diagnosed with schizophrenia in many cases where a correct diagnosis is depression or bipolar disorder, resulting in incorrect treatment. Physicians are also less likely to prescribe the newer generation antidepressant or antipsychotic medications to African-Americans who need them (New Freedom Commission on Mental Health, 2003) and as a result they suffer from tardive dyskenesia, the irreversible movement disability caused by neuroleptic medications, at twice the rate of whites. People of color receive higher doses of high side-effect medications, are subject to more involuntary medications and are subjected to restraints at significantly higher rates than whites. Longstanding federal anti-discrimination laws prohibit this treatment, but they have rarely been used to challenge practices in the mental health system (Levy & Rubenstein, 1996).

> *A Latina woman in her 30's was referred to a clinic for mental health services. She requested a Spanish-speaking therapist but her request was dismissed and she was referred instead to an English-speaking therapist. After six months of clinical services in English, the therapist informed the client that she did not speak English well enough to continue, and suggested that the client improve her English before returning for mental health services.*

Stigma also presents such a barrier in some communities of color that people never receive services at all, suffering mental distress for a lifetime without any of the treatment that mental health services can offer. Asian Americans, for example, are only one-quarter as likely as whites to have sought outpatient treatment. In some Asian cultures mental illness is thought to reflect poorly on the entire family, and as such it diminishes the marriage and economic prospects for other family members (Sue & Morishima, 1982).

Culturally competent services are essential to reducing the burden of social oppression and mental illness for racial and ethnic minorities. According to the Surgeon General, "culturally competent" services incorporate respect and understanding of ethnic and racial groups as well as their

histories, traditions, beliefs and values systems (U.S. Department of Health and Human Services, 2001). Cultural competence is not a "program," but rather a systemic approach to changes that embeds integrated cultural approaches into all levels, reduces disparities, provides linguistic access and high quality of care. The five essential elements of cultural competence include valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity (Guerrero, 2006). This vision for a respectful, accessible and quality mental health system that reduces stigma and discrimination is central to the MHSA.

People who are lesbian, gay, bisexual, transgender or questioning their sexual orientation (LGBTQ) also experience multiple forms of oppression, frequently becoming the target of stigma and discrimination due to their sexual orientation. This puts them at high risk of mental health problems.

Homophobia is the fear of and prejudice against homosexuality and is rooted in the same historical and social processes as white supremacy, racism, patriarchy and sexism. "They are all systems of bigotry that classify and degrade human beings on the basis of presumed, internal, biological characteristics" (Platt, 2000, p. 2). "For most of the history of this country, homosexuals have been killed for their sexual orientation, had their children taken away, gone to jail, been forced into treatment, been hospitalized against their will, been hassled and beaten by the police, denounced in religious institutions and forced out of jobs" (Platt, 2000, p. 1).

LGBTQ teens are subject to harassment, threats and violence on a daily basis, hearing anti-gay slurs such as "homo," "faggot" and "sissy" about 26 times a day, or once every 14 minutes. Thirty-one percent of gay youth were threatened or injured at school in 2000.

(Bart, 1998, Chase, 2001)

Up until 1973, homosexuality was defined as a mental illness by the American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders (DSM). This regulated societal stigma and homophobia toward LGBTQ people by categorizing them as "mad, not bad." These efforts set up LGBTQ people for psychiatric "cures" for their homosexuality. The year 1951 was the last known example of the use of the lobotomy to "cure" homosexuality in the U.S., but hospitalization and other treatments such as aversion therapy remained common throughout the 1960s and beyond (Mind, 2007). Discrimination against LGBTQ people in the mental health system continues today. Research has shown that between 25 – 65% of LGBTQ people seek counseling at some stage of their lives, and up to 50% report discontent with their experience, noting their counselor's negative and prejudicial attitudes toward homosexuality (Rudolph, 1988). Research is emerging that emphasizes the importance of tailoring services to the special needs of gay, lesbian and bisexual mental health service users to improve the efficacy of services for LGBTQ clients (Cabaj & Stein, 1996).

LGBTQ people are also at high risk of becoming victims of violence. Along with African-Americans, gay men are subject to the greatest number of hate crimes (deGiere, 2004). Gay and lesbian youth are especially vulnerable to harassment and violence in school, often subjected to such intense bullying that they are unable to receive an adequate education, dropping out at a rate of 28%, three times the national average. These youth are frequently too embarrassed or ashamed to report the abuse, and feel that they have nowhere to turn for help.

The advocacy organization Mind notes that being gay is not in itself a mental health problem, but coping with the effects of discrimination can be highly detrimental to the mental health of LGBTQ people, reflected in high rates of depression, substance abuse and especially suicide. In 1989, the United States Department of Health and Human Services reported that "A majority of suicide attempts by homosexuals occur during their youth, and gay youth are 2 to 3 times more likely to attempt suicide than other young people." The report estimated that LGBTQ youth comprise up to 30 percent of the estimated 5,000 completed youth suicides annually (U.S. Department of Health and Human Services, 1989). Kevin Berrill, Director of the Anti-Violence Project of the National Gay and Lesbian Task Force at the time of the report, welcomed its release, stating, "The increased risk of suicide facing these youth is linked to growing up in a society that teaches them to hide and to hate themselves. We welcome this report and hope it will lead to action that will save lives" (Blumenfeld and Lindop, 1995).

D. FOSTER YOUTH

Children and youth in foster care and adolescents transitioning from foster care to independent living are another group heavily burdened by stigma and discrimination. Each year about 40,000 children in California are removed from their homes because of abuse or neglect (Little Hoover Commission, 2003). Being in the foster care system itself carries a heavy burden of shame and stigmatization; in addition, about 60% of children in foster care are estimated to have moderate to severe mental health problems, compounded by trauma of family separation and frequent and stressful relocation.

A University of California study found that 50% of these children with mental health problems are not receiving appropriate mental health services. Societal racism also intersects with stigma and discrimination in this population. Children of color face removal to foster care and longer stays in foster care than their white peers. Finally, an issue peculiar to the problems of mental illness occurs when loving parents are sometimes forced to relinquish custody of their children with serious mental illnesses because they cannot afford the expensive care that they require (Rita, 2002).

Foster care was originally intended to serve as a temporary haven for children who had been abused or neglected. However, it has evolved into a complex "system" that often exposes children to further trauma and abuse, uncertainty, instability and impermanence. For approximately one out of four California children who enter the system each year, foster care is not temporary, but a "heartless limbo -- childhoods squandered by an unaccountable bureaucracy" (Little Hoover Commission, 2003, p. 1) and children who are exposed to this system develop mental illnesses at high rates (Packard Foundation, 2004).

> *In high school, I didn't share my status as a foster youth with anyone. That was a secret kept in my family.*
>
> -Former Foster Youth
> (Sanchez, 2004)

In addition, the children of racial and ethnic minorities are disproportionately overrepresented in the foster care system. Children of color represent 33% of children under the age of 18 in the United States, but comprise 55% of the children in foster care. Studies have documented that "there are no differences in the incidence of child abuse and neglect according to racial group," (Packard Foundation, 2004, p. 79), but African American and Latina/Latino families are more likely than white families under similar circumstances to be reported for child abuse and neglect and to have children removed from the home. High poverty rates exacerbate this trend. African American children are most seriously affected, constituting about 45% of children in public foster care and more than half of all children waiting to be adopted. Native American children are in foster care at double their percentage rate in the general population (U.S. Department of Health and Human Services, 1999).

Research also indicates that children of color are treated differently inside the child welfare system, receiving fewer contacts with caseworkers, fewer written case plans, fewer developmental or psychological assessments and fewer family visits. They also tend to remain in foster care placement longer than their white peers. And although it has been found that a culturally sensitive environment can provide a nurturing and protective foundation that children can draw upon in times of distress, many children of color become disconnected from those benefits when they enter and remain in the foster care system.

In addition, federal Medicaid policies sometimes force loving parents to give up legal custody of their children because they cannot get mental health services for them in any other way. Protection and Advocacy reports that thousands of children who need mental health care cannot access it because their families do not qualify under Medi-Cal guidelines and cannot afford intensive treatment on their own (Rita, 2002). These children end up in foster care, group homes, hospitals, juvenile halls or the Youth Authority, where their care is paid for with state and local funds. This institutional out-of-home treatment is far more expensive than it would be to provide services to children in their own home, and is a disastrous outcome for children and their families.

The failures of the foster care system are paid for by youth when they turn 18, who age-out of the system with multiple burdens of stigma and discrimination. They are often dumped out of the system with no family or supports, and in addition must face the stigma and discrimination of mental illness. Approximately 1/3 of children aging out of foster care fail to complete high school, and few enter college. Twenty-five percent become homeless, and 50% experience unemployment (Little Hoover Commission, 2003). These children who grow up as the responsibility of the state face the stigma and discrimination of both the foster care system and the mental health system, and ultimately end up quite alone in trying to overcome these burdens.

> *As my life got bigger, my illness got smaller.*
>
> -Transition Age Youth
> (Clark, 2000)

E. FAMILY MEMBERS AND CAREGIVERS

Family members and caregivers of persons with mental illness are also frequently treated with stigma and discrimination. Known as "stigma by association," parents, partners and spouses, caregivers, siblings, and other relatives who care about a person with mental illness often face obstacles and barriers that are associated with the problems of mental illness, and the struggle to navigate a disconnected and poorly funded mental health system. The NAMI Family-to-Family peer support and education program introduces family members to the challenges of stigma and discrimination: "If someone has never been subjected to the systematic discrimination which occurs in mental illness, they cannot remotely imagine how terrible it feels, how it mitigates against the hope and optimism we need to take risks and move on with our lives . . . this is the bizarre aspect of recovering from mental illness. It requires us to endure public scorn while we try to heal" (NAMI, 1998, p. 11.1).

> *My teenage daughter was being released from the hospital after a mental health crisis. I fought for her to have services at home but I was told that the only option was for her to enter a group home, where I would not be able to contact her at all for the first three weeks.*
>
> *The social worker said to me, "You've done your job, now we'll clean up the mess."*
>
> -A Mother

The issues facing family members and caregivers date

back to the early origins of psychiatric theory. With little known about mental illness, early theorists promoted the concept that parents were to blame for mental illness in children. Not surprisingly, mothers came in for particular criticism: schizophrenia was thought to be caused by a "schizophrenogenic mother" who was cold and aloof (U.S. Department of Health and Human Services, 1999). These views reflected a lack of understanding of the biological basis of mental illness, as well as the unfair and inappropriate societal views of women and the superhuman expectations and responsibilities for which they are held accountable. Fighting such prejudices was one of the driving factors in the emergence of family member organizations in the mental health system. Despite many advances, these attitudes influence the way family members and caregivers are treated today by mental health professionals.

> *What other resources can you tap after you've already mortgaged your house? When you are too "rich" to qualify for Medi-Cal and too poor to cover the thousands of dollars for hospital fees, ambulance fees, doctor bills and medications for your family member?*
>
> -A Mother

Also a central concern of these organizations was the struggle to access care from disparate and uncoordinated public agencies (U.S. Department of Health and Human Services, 1999). In California, then-Governor Ronald Reagan began to de-institutionalize the state hospitals with a promise that the resources from the state hospital system would be re-directed to support people with mental health disabilities to live in the community. However, he subsequently vetoed the bills that followed-through with this funding. With no community system of care in place, family members watched their loved ones struggle in the community without adequate care, services or resources. Combating stigma and discrimination by advocating for system resources to provide services and prevent human suffering has been one of the major purposes of the family and caregiver movements.

The issues that affect family members and caregivers are not limited to advocacy, but often have a direct affect on their own health and well-being. Informal (unpaid) caregivers provide nearly two-thirds of all home-and-community-based care in the United States (Liu, Manton & Aragon, 2000). Despite this key role, caregivers struggle with stress, anxiety, and financial burdens that result in very high rates of depression themselves (Gray, 2003). Thirty to 59% of caregivers report depressive disorders or symptoms (Cohen et al, 1990, Family Caregiver Alliance, 2001). These high rates of depression put family members and caregivers at risk of the direct stigma and discrimination of mental illness, as well as to stigma by association. In addition, high rates of depression also put many caregivers at risk for chronic health conditions such as coronary heart disease, cancer and diabetes (Cannuscio et al, 2002). Focusing on their family member with mental illness, juggling caregiving with a job and other responsibilities, and financial stress often lead caregivers to neglect their own well-being and deplete their inner resources (Gray, 2003).

The physical and mental exhaustion faced by caregivers is often exacerbated by financial burdens. Family caregivers (of all kinds, not just for persons with mental illness) provide an estimated $257 billion dollars' worth of unpaid care in the United States, and this care helps to prevent expensive and inhumane institutionalization. Yet families rarely receive any payment for these services and are often in difficult financial circumstances as a result of their caregiving (Commonwealth Fund, 1999).

Programs that would support families, lighten financial burdens, support caregiver mental health and provide respite for stressed families and caregivers are practically non-existent in the underfunded mental health system. Programs that appropriately acknowledge the contribution of family members and caregivers are essential to reducing stigma, preventing discrimination and supporting the well-being of those with mental illness as well as their families and support systems.

> *If I came in to work today and said my child was hospitalized with a diabetic coma last night, people would bring casseroles. But because my child was "committed" to a psychiatric hospital, I cannot even mention what is happening with my family.*
>
> *It is a source of shame rather than an occasion for community support.*
>
> -A Parent

PART III: SYSTEMS

A. STIGMA AND DISCRIMINATION IN THE MENTAL HEALTH SYSTEM

Historically, people with mental disabilities have been subject to grave abuses in institutional settings: sometimes starved, tied to beds, beaten, and subject to inhumane practices such as lobotomies, electroconvulsive shock treatments, and immobilizing medications. In fact, California led the country in forced sterilizations between 1909 and 1950, responsible for about 80% of nationwide involuntary sterilizations that were performed under state auspices (Lombardo, 2003).

Today, despite the closure of many of the state hospitals, each year there are people who still remain in state hospitals for weeks, months and sometimes years. In addition, at least 100,000 Californians are involuntarily committed to acute psychiatric facilities in the community each

year (Mildred, 2002). "In this age of deinstitutionalization, a great many people find themselves institutionalized." (Levy and Rubenstein, 1996, p. 285.) These modern institutional settings remain controlled, restrictive and often excruciatingly boring, with severe sanctions for noncompliance, including being placed in restraints.

> *We want and deserve better treatment. We want people to know many of our friends are locked up and don't have equal rights.*
>
> -Mental Health Client
> (Brody, 2007)

Although the image of patients wearing straightjackets, locked in a tiny room or tied to a bed in four-point restraints are seen as the legacy of the distant past, institutional violence, abuse and injuries are "far more common than is reasonably acceptable" (Levy and Rubenstein, 1996, p. 285). According to the American Civil Liberties Union, "To the general public, [those images] are no more contemporary than the shootout at the OK Corral. Unfortunately, the public is wrong. Seclusion and physical restraint remain the wild west of institutional psychiatry" (p. 300).

In 1998, the Hartford Courant reported on wide-scale deaths from the use of seclusion and restraints. These reports found patients became comatose, suffered broken bones, were hit in the face, bruised, needed stitches or were bleeding as a result of being placed in seclusion and restraints. In the worst cases, patients died of causes that included asphyxiation, strangulation, cardiac arrest, fire or smoke inhalation, blunt trauma, drug overdoses or interactions, and choking (Mildred, 2002).

Protection and Advocacy reported in 2003 that California follows the national trend: despite extensive federal reforms, 22 deaths occurred between 1999 and 2003 to people who were in seclusion and restraints (California Senate Select Committee on Developmental Disabilities and Mental Health, 2003). A report by the California Senate Office of Research found California's oversight of these practices in facilities to be a "regulatory maze that impedes accountability and progress," stating that piecemeal standards have resulted in a condition where "the only meaningful measure of seclusion and restraints in California is when people die" (Mildred, 2002).

National leadership and statewide legislation have endeavored to reform institutional practices; however, between 2002 and 2005 the United States Department of Justice (DOJ) launched investigations into four California state hospitals. Under the authority of the Civil Rights of Institutionalized Persons Act of 1980, the U.S. DOJ found system-wide deficiencies in nearly every category of care, finding that standards in most areas were "well below professionally-accepted standards of professional care" and that staff at the hospitals used seclusion, restraints and medications in the absence of adequate treatment or as a punishment, violating the civil rights of state hospital patients.

PAI testified to the California Senate in 2005 that the DOJ reports validated their experience of problems in the state hospitals, including misdiagnosis, overmedication, lack of treatment planning, poly-pharmacy, aversive behavioral therapy, inappropriate use of seclusion and restraints, no discharge planning, and for children and youth, the failure to educate and prepare them for life in a non-institutional setting (California Senate Select Committee on Developmental Disabilities and Mental Health, 2005).

In May of 2006, the U.S. DOJ and the state of California reached a settlement concerning civil rights violations at the four hospitals, and agreed to a 5-year Consent Judgment that requires extensive reforms (California Department of Mental Health, 2007). The agreement includes provisions for the department to make quarterly reports to the Legislature on implementation of the reforms.

> *Stigma is not only a barrier to treatment; it is part of treatment as well.*
>
> -Mental Health Client
> (Brody, 2007)

Although the U.S. Department of Justice investigations were focused on state hospitals, persons with mental illness are subject to stigmatizing and discriminatory treatment practices in the community as well. Seclusion and restraints, forced medication and other institutional abuses are also utilized in psychiatric hospitals, group homes and skilled nursing facilities. In addition, persons labeled as mentally ill are sometimes subjected to bias and discrimination by mental health providers whose role is to help people to achieve recovery.

Studies have shown that many health care professionals harbor unconscious negative feelings about their clients (Tate, 1991). Although under the recovery philosophy the client-physician relationship is more appropriately conceptualized as a partnership, stigmatizing attitudes, including devaluing statements, are sometimes endorsed by mental health professionals (Perlick et al, 2001). Psychiatrists sometimes perpetuate biased and stigmatizing attitudes, and the way that psychiatry is structured tends to reinforce the status quo (Fink and Tasman, 1992). Research has shown that the impact of perceived stigma may be even more powerful in non-mental health settings that provide treatment for depression, such as primary care (Sirey et al, 2001). One general practitioner summarized his views: "[Mental health clients] take up far too much of our time and energy – people complaining, miserable, depressed, neurotically whining about how unhappy they are, pouring out all their problems in the [office] and dumping them on my doorstep. It would be really unbearable if I was actually listening to them." (Farrell, 1999, from Byrne, 2000, p. 66). When people encounter stigmatizing attitudes from helping professionals, it has a negative impact on their willingness to seek and continue treatment. Together, fear of the abuses of the mental health system and negative responses from healthcare professionals are two of the most frequently cited reasons that people reject mental health treatment and seek to "go it alone," feeling that the cure is worse than the disease.

The mental health system has paid scant attention to the central experience of physical and sexual abuse in women's lives. In one recent study 45 percent of women in an outpatient clinic for people with mental illness had been sexually abused, 51 percent had been physically abused and 22 percent had experienced childhood neglect.

Women who have experienced abuse report that clinicians either ignore their history of abuse or ascribe a woman's emotional problems to an entirely different cause.

-Levy and Rubenstein, 1996

B. IMPACTS OF STIGMA AND DISCRIMINATION ON ACCESS TO MENTAL HEALTH AND HEALTH SERVICES

Peter Byrne has written that negative attitudes toward people with mental illness start at playschool and endure into adulthood (2000). These attitudes often discourage people from seeking help for mental health problems or continuing mental health treatment they have begun (U.S. Department of Health and Human Services, 1999). Although the Surgeon General has estimated that about one in five Americans experience a mental disorder in the course of a year, a large-scale epidemiological study shows that less than 30% of people with psychiatric disorders seek treatment (Regier et al, 1993). "Public identification as 'mentally ill' can yield significant harm" concludes one researcher (Corrigan, 2004, p. 616), and many people reject or drop out of services to distance themselves from being labeled and devalued as "mentally ill" (Sirey et al, 2001, Perlick, 2001, Corrigan, 2004). Concerns with labeling apply to children and adolescents as well as adults – research shows that adolescents who are more likely to endorse the stigma of mental illness are less likely to seek care when it is needed (Corrigan et al, 2000). The effects of being labeled with mental illness have been shown to be much more severe than the labeling of people with other health conditions (Corrigan et al, 2000), making the instinct to avoid treatment understandable.

Stigma has become a marker for adverse experiences – first among these is a sense of shame. Mental illness is perceived as an indulgence, a sign of weakness.

-Byrne, 2000

Stigma also interferes with recovery when people do receive treatment. To be devalued and discriminated against can impede the restoration of self-esteem, a sense of purpose and a better quality of life (Perlick, 2001). At its best, mental health recovery is a journey of healing and transformation that enables a person with a mental health problem to live a meaningful life in a

community of his or her choice while striving to achieve his or her full potential (SAMHSA, 2006). Stigma and discrimination subvert these aims, interfere with treatment and recovery and add an unnecessary burden to those who can ill-afford to bear it.

Another barrier to treatment access is the range of discriminatory insurance policies that do not adequately cover mental health treatment. Private sector insurance coverage for mental health care lags significantly behind coverage for physical health conditions. Despite California's "parity" law, intended to ensure equal physical and mental health benefits, significant disparities in insurance coverage of mental health treatment persist. Attempts at the federal level to pass a parity law have failed thus far, despite research supporting its' cost-effectiveness.

Ironically, both private insurance and federal Medicaid programs provide better access to high-cost institutional services than to more effective, recovery-oriented community services, which are severely rationed. As an example, institutionalization rates for children skyrocketed during the 1980's because of these perverse trends – nationally, the average daily census of children in psychiatric hospitals and residential treatment centers increased 60% between 1983 and 1986 (Levy & Rubenstein, 1996). This "institutional bias" of funding affects all age groups, and results in ignoring opportunities to support recovery in the community and offering services only on the far end of the spectrum when people decompensate into acute crisis. These public and private insurance practices run counter to the U.S. Supreme Court's landmark 1999 decision *Olmstead vs. L.C.*, which decreed that people must be treated in the least restrictive setting possible, in the community instead of institutional settings whenever feasible. Private sector insurance coverage as well as federal Medicaid policies must be aligned with the *Olmstead* decision in order to provide access to cost-effective, recovery-oriented community services that are both more effective and greatly preferred by people with mental health needs.

Accessing physical health care is another barrier for people who are labeled with mental illness. They experience significant disparities in physical health care, receiving fewer medical services than those without that label (Desai et al, 2002). This is especially concerning because medications used in mental health treatment frequently cause side effects that endanger a person's health, such as obesity. This often leaves people with mental illness at high risk of diabetes, hypertension, heart disease, cancer and other life-threatening physical health conditions, but with very little access to physical healthcare to address these illnesses.

Problems of access to services are especially acute for racial and ethnic minorities. According to the Surgeon General, "the U.S. mental health system is not well-equipped to meet the needs of racial and ethnic minority populations" (U.S. Department of Health and Human Services, 2001). As these groups grow, the lack of access to mental health services for people of color is tantamount to a public health crisis.

In 2003, the President's New Freedom Commission on Mental Health gave serious attention to the problems of lack of access to mental health services for people of color. This high-profile

commission noted that among many barriers, societal stigma is a key factor. The lack of culturally competent services, as discussed previously, was reported as a contributing factor, including language competency and respect and understanding of the histories, traditions, beliefs and values of minority groups. For example, in many traditional societies, mental health problems can be viewed as spiritual concerns and as occasions to renew one's commitment to a religious or spiritual system of belief (U.S. Department of Health and Human Services, 1999). Mental health services that do not respect and understand these issues as part of the client's cultural framework are ineffective and provide a significant barrier to access.

Steven, 28, has bipolar disorder. He maintains a family and a job as a landscaper. He had never had problems with the law or any history of violent behavior, until one night while he was driving the police signaled him to pull over. He heard voices telling him to keep going. He did, and was apprehended, shot in the hand, bitten by police dogs and arrested. He spent four months in jail without the medication that had kept him stable. Eventually, he was found "not guilty by reason of insanity" and was hospitalized. The charges were dismissed.

-The Bazelon Center for Mental Health Law, 2007

The New Freedom Commission also cited the significant underrepresentation of minority populations in the mental health workforce as a barrier to access, as well as mistrust and fear of treatment, different cultural ideas about illnesses and health, differences in help-seeking behaviors, language, communication, racism, varying rates of being uninsured, and discrimination by individuals and institutions. In addition, we know that problems with the mental health system are even more pronounced for recent immigrants (Sue et al, 1994).

The Commission stated that as a result of these factors, Native Americans, African Americans, Asian Americans and Pacific Islanders, Latinos and other racial and ethnic minorities bear a disproportionately high burden of disability from mental illness – not because of a higher prevalence or severity of illness in these populations, but from receiving less care and poorer quality of care. The Commission reported that misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems (New Freedom Commission, 2003).

Stigma is a significant factor in this intersection between mental illness and the criminal justice system. The criminalization of adults and youth with mental illness occurs when police, rather than the mental health system, respond to mental health crises (Watson, Ottati et al, 2004), and it is among the worst outcomes of the lack of access to appropriate mental health services. According to the Little Hoover Commission, "The criminal justice system is too often the only resource – the only safety net – available to mental health clients and their families in time of

crisis" (Little Hoover Commission, 2000, p. xii). People exhibiting symptoms and signs of serious mental illness are more likely than others to be arrested by the police (Teplin, 1984), and people with mental illness tend to spend more time incarcerated than those without mental illness (Steadman et al, 1989). Of the 30,000 seriously mentally ill people in California jails and prisons, the majority are thought to be nonviolent, low-level offenders who landed in the criminal justice system in part because they did not receive adequate community treatment (Little Hoover Commission, 2000, p. xiii). Once people are in the criminal justice system, their mental health needs are usually unmet (The Bazelon Center for Mental Health Law, 2007), and they are likely to recycle through the mental health, substance abuse and criminal justice systems over and over again (New Freedom Commission, 2003).

According to the President's workgroup, these problems are equally pressing for youth: "Recent research shows a high prevalence of mental disorders in children within the juvenile justice system. A large scale, four-year, Chicago-based study found that 66% of boys and nearly 75% of girls in juvenile detention have at least one psychiatric disorder. About 50% of these youth had substance abuse issues" (New Freedom Commission, 2003, p. 32). According to the Little Hoover Commission, 50 – 90 % of the children in the juvenile justice system in California need mental health care, and a great many do not receive any services (2001). Studies also show that as youth progress further into the formal juvenile justice system, rates of mental disorders increase (The Bazelon Center for Mental Health Law, 2007). The New Freedom Commission called for appropriate treatment and diversion to be provided in juvenile justice settings, followed by routine and periodic screening.

For youth as well as adults, the Commission noted that too often the criminal justice system becomes the primary source of mental health care due to lack of access to appropriate services, and that the added stigma of a criminal record is an additional hardship for many people with mental illness. Cost studies suggest that taxpayers can save money by increasing access to mental health programs instead of placing them in jails and prisons (New Freedom Commission, 2003). Better access to mental health services on the front end, and appropriate diversion and re-entry strategies once people with mental illness become involved with the criminal justice system, are essential to avoid the criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illness.

C. EDUCATIONAL SYSTEMS

Discrimination in access to a public education is one of the fundamental abridgements of civil rights, and the struggle for educational access for children with disabilities has followed a similar path to the groundbreaking struggle of ethnic minorities to establish their rights to a free and public education.

The importance of education to life success is well understood. In *Brown v. Board of Education*, the U.S. Supreme Court wrote:

> [*Education] is a principal instrument awakening the child to cultural values, in preparing him for later training, and in helping him to adjust normally to his environment. It is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education.*

Achieving the benefits of a free and public education for children with disabilities has been a long struggle. Prior to 1975, at least one million children with disabilities, including those with mental and emotional disabilities, were denied access to public education. Four million others were segregated from mainstream schools and students (Disability Rights Education & Defense Fund, 2007). To remedy these inequalities, Congress passed the Individuals with Disabilities Education Act (IDEA) in 1975. The IDEA reformed educational access and practices for children with disabilities, guaranteeing them a free and appropriate education in the least restrictive environment. Under the IDEA, children in special education are entitled to mental health services that are required in order to allow them to benefit from a special education program. The IDEA utilizes Individualized Educational Programs tailored to each child's need, along with special educational and supportive services, to provide children with disabilities with educational rights.

However, despite these protections, children with emotional disorders face many barriers to receiving an education. According to a report sponsored by the California Endowment and conducted by the Disability Rights Education & Defense Fund (DREDF), "California has failed to effectively monitor the delivery of mental health services to children" (DREDF, 2001, p. 1). As a result, the state lacks an effective service delivery system to provide mental health services required by state and federal law to thousands of children with disabilities. This leaves some of California's most vulnerable children at risk for dropping out of school, unemployment and incarceration.

The Surgeon General has reported that half of the children in the United States who require mental health services receive them, if at all, through the public school system (U.S. Department of Health and Human Services, 1999). In California, it was estimated in 2001 that up to 864,000 children diagnosed with emotional disorders do not receive the services that they need. Parents of children who need these services report that they are rarely informed of their children's rights to special educational services, that lack of coordination between schools and mental health agencies creates the "run-around" instead of allowing access to services, and that these barriers are so severe that hiring an attorney is often the only way to gain access to the educational rights to which their children are entitled by law (DREDF, 2001). Responding to these barriers, DREDF itself has given great emphasis to assisting parents of children with disabilities to become capable self-advocates, in order to obtain the special education and supportive services their children require.

DREDF's broader recommendations for remedy of educational discrimination against children with emotional disorders include better state monitoring of children's mental health services, greatly improved interagency collaboration, preventing schools from "passing the buck," and maximizing available funding. The central strategy to ensure educational access to children is the Children's System of Care, a successful model of integrated care delivery for children that the state of California developed and implemented for over 20 years, but which it gradually de-funded and eventually eliminated completely in 2004 due to state budget pressures.

The Children's System of Care (CSOC) provided funding for counties to provide coordination, integration and individualized treatment planning for children with mental health needs. It recognized that children and youth with emotional disturbances will be more likely to have problems at home, in school and in the community at large (Hendrickson, 1995). The CSOC model views parents as partners in treatment, rather than adversaries or the cause of the child's problems, operates from a strengths-based model, acknowledges the need for culturally competent services and views institutionalization of children as the exception rather than the rule (DREDF, 2001). The Children's System of Care provided a bridge between different agencies with responsibility for children's mental health care (such as mental health agencies, schools and the juvenile justice system) in order to maximize collaboration and resources, coordinate care and develop effective, comprehensive treatment and follow-through.

The Children's System of Care was a foundational model for the Mental Health Services Act and was designated as the key approach for developing children's mental health strategies. However, state actions and regulatory interpretations have prevented it from being funded through the MHSA after the state eliminated all general fund support for the program. These dilemmas have prevented the funding of this successful model program since 2004, negatively impacting educational access for children as well as their access to other necessary services and supports.

Transition-age youth and adults also experience barriers to educational access because of stigma and discrimination. According to a 2006 report conducted by the University of California, university students are presenting mental health issues with greater frequency and complexity. These issues have been reported to be equally urgent for the California State University System and for students attending California Community Colleges. However, system-wide, diminished funding has resulted in longer student wait-times, difficulty retaining staff, huge student-to-counselor ratios and decreased services and supports. These factors have resulted in a dearth of appropriate support for students who are faced with significant developmental challenges, emotional stressors and mental health risks. They put students at high risk of suicide and mental health issues and they are another example of system problems that leave those who are at great risk to cope without preventive supports until they are in crisis (University of California Student Mental Health Committee, 2006).

Students have unique mental health needs that are growing in scope and complexity. Nationally, nearly half of all college students report feeling so depressed at some point in time that they have

trouble functioning (Kadison & DiGeronimo, 2004). In addition, late adolescence and young adulthood are periods of high risk for "first break" episodes of psychosis as well as the onset of eating disorders and substance abuse issues, and most concerning, suicide. The UC system has seen rises in student suicide, as well as significant rises in suicide attempts. Suicidal behaviors at UC San Diego have doubled over the past four years. A large survey in 2000 found that over 9 % of students had seriously considered suicide. Only 20% of those students were receiving mental health services – *80 % of students who were thinking of suicide received no mental health services at all* (University of California Student Mental Health Committee, 2006).

Racial and ethnic minority students, gay and lesbian students and graduate students are at particularly high risk because of the multiple challenges they face. Scarce resources have diminished the ability of higher education to provide assistance to those students and to others who are not so acute but who are also dealing with concerns of a more "traditional" nature such as homesickness, questions of identity, relationship issues and concerns over career choice.

The lack of resources for mental health services in higher educational institutions in California leaves young adults and adults on college and university campuses vulnerable to suicide, substance abuse, poor educational outcomes and other mental health risks.

PART IV: COMMUNITY

A. VIOLENCE: MYTHS AND FACTS

According to the Surgeon General, stigma and discrimination against persons with mental illnesses persists and is stronger than it has been in the past in large part because of the perception that people with mental illness are dangerous (U.S. Department of Health and Human Services, 1999). Research debunks these stereotypes. The MacArthur Community Violence Study demonstrated that there is no significant correlation between mental illness and violence in the absence of substance abuse (substance abuse affects rates of violence in the general population as well as among those defined as having a mental illness) (Steadman et al, 1998). In fact, "the overall contribution of mental disorders to the total level of violence in society is exceptionally small" (Swanson, 1994 from U.S. Department of Health and Human Services, 1999, p. 7).

There is a significant body of research which concludes that people with mental disabilities are actually much more likely to be victims of crime. According to an extensive assessment conducted by the University of California, people with disabilities are targeted as victims of violent crime at much higher rates than the general population, and that these crimes are dramatically underreported. The research suggests that people with disabilities are often

victimized because of stigma and discrimination -- because they engender fear and hostility, guilt, or have visible traits that are different than others (deGiere, 2004).

This vulnerability to violent crime is most evident among those who are homeless. According to a California Department of Justice Report in 2002, 66 percent of homeless people surveyed said that they were victimized in the previous year, "suggesting an estimate of over 66,0000 homeless persons victimized in California in 2001" (Mallory, 2002, p. v-vi). Of these, 72 percent said they were victimized on multiple occasions, and 75 percent stated that the crime was assault -- 23 percent of the assaults were rapes. In 2004 the National Coalition for the Homeless reported that between 1999 and 2003 there was an alarming increase in reports of homeless men, women and children being killed, beaten or harassed. In California, the Coalition documented 39 of these incidents, resulting in 17 deaths over the five year period (deGiere, 2004).

> *We need to support fundamental change that will ultimately transform our image of people living with mental illness from community liabilities into an accurate reflection of those individuals as our neighbors, family members and loved ones.*
>
> -Toby Ewing
> (Little Hoover Commission, 2000)

Children are also subject to violence and bullying at school because of stigma and discrimination. Children diagnosed with Serious Emotional Disorders (SED), as children's mental illnesses are referred to, face much greater risks of violence at school than their peers. Thirty-three percent of special needs children who attend mainstream schools are targets of bullying, compared to 8 percent of their classmates (Garrity and Barris, 1996). Bullying behavior is an ongoing, pattern of physical or psychological aggression that is threatening, coercive, relentless and leaves the victim feeling powerless (Goodman, 2000). Effective interventions to protect these children need to be comprehensive, focusing on the child who bullies, on the victim, and on the peer culture as well as home and school environments (Garrity, et al, 1996). However, the programs that exist to prevent bullying tend to overlook the special risks, vulnerabilities and needs of children with serious emotional disorders.

Older adults with mental illnesses are also vulnerable to violence and abuse. A 2003 report by the Public Law Research Institute reports that elder abuse is a serious and growing problem in California, and it is a "crime that often accelerates a senior's death" (Hydorn, 2003, p. 3). In a 13-year longitudinal study, only 9% of abuse victims survived, compared with 40% of elders who were not abused – the mortality rate for elders who were abused was three times higher (Beers and Berkow, 2000). Mental health issues make older adults very vulnerable to physical, sexual, and financial abuse, especially when combined with physical frailty. Exacerbating these vulnerabilities is the low rate of mental health services this population receives -- only 15% who need services receive them (California Mental Health Planning Council, 2003).

People in mental distress are also at high risk for dangerous or deadly confrontations with police. In November, 1999 the Los Angeles Times reported that from 1994 – 1999 the Los Angeles Police Department had shot and killed 25 people who were exhibiting mental or emotional distress, using "questionable tactics and the use of deadly force." The Times reported that based on standards agreed upon by nationally recognized authorities on policing and mental illness, officers took actions that helped push confrontations to fatal conclusions (Senate Health and Human Services Committee, 2000).

In May, 2000 the federally-mandated organization Protection and Advocacy, Inc. (PAI) addressed police violence against persons with mental illness, investigating the shooting deaths of Charles Vaughn of Monterey County and Marvin Noble of Mendocino County. PAI found that neither man presented a threat of danger that would call for law enforcement intervention, let alone the use of deadly force, and found that inadequate training, policies and procedures led to the deaths (Duryea and Hughes, 2000).

Amnesty International has also singled California out for concern about deaths related to the use of deadly force by police. Danny Dunn, a "mentally disturbed" man, died in the Kern County Jail after being physically restrained by three deputies who knelt on him, pepper-sprayed him and placed him in a choke hold, according the Rights for All Campaign, which reported on numerous cases of concern. The autopsy report established the cause of death as a torn liver due to compression trauma to the abdomen. Sacramento County was also singled out for the use of a four-point restraint chair in the local jail, after it was implicated in egregious abuses (Amnesty International, 1999).

These high profile cases did garner the attention of policymakers, and the California Legislature passed AB 1718 (Hertzberg), Chapter 200 of 2000, requiring the Commission on Peace Officer Standards and Training to establish a continuing education course on law enforcement interaction with persons with mental and developmental disabilities, designed to avoid such preventable tragedies. However, the course is completely voluntary and optional; the only required training of law enforcement in how to interact with persons with mental health disabilities is six- hours of basic instruction in police academy curriculum.

Los Angeles County instituted a major reform project that is thought to have yielded some improvements (Senate Health and Human Services Committee, 2000) and a number of counties around California have adopted the Memphis, Tennessee model of Crisis Intervention Teams, which are seen as a promising collaborative model of training. However, newspaper stories persist around the state of incidents of dangerous restraint procedures, stun devices and pepper spray and shootings that result from a relatively innocuous incident or a person who is suicidal. These urgent and preventable tragedies indicate the need for consistent tracking, reporting and investigation of these incidents and mandatory rather than voluntary training requirements.

Finally, family violence is sometimes an issue associated with mental illness, as it is in society in general. Even among those who labor together in this effort of implementing the Mental Health Services Act, the topic of family violence is painful and difficult to discuss. Family members advocating for access and care for their loved ones have shared that there have been times when their loved one's behavior has been violent or abusive in the home, sometimes prompting the necessity of police intervention. And client advocates who have struggled to become empowered and find their voice in recovery have shared many experiences of violence and abusive treatment by their families of origin.

As leaders together in this effort, we can only strive to honor the courage of those who struggle to speak their truth under difficult circumstances, to be kind to one another, and to hope that our efforts to address these issues will help to prevent painful experiences of family violence for others.

B. DISCRIMINATION IN HOUSING

Homelessness may be one of the most visible outcomes of mental illness, and it was an important motivation for passing the MHSA. Homelessness is considered one of the major consequences of the state's de-institutionalization efforts; an estimated 57% of homeless adults have a mental illness (Little Hoover Commission, 2000). Homelessness is also a result of the poverty that is caused by having a mental illness (Dohrenwend et al, 1992).

> *[Living in a Board and Care] was such a horrible experience. We were only allowed to shower twice a week . . . the food was atrocious. We ate lots of Spam, no fresh fruit ever, no vegetables ever, lots of spaghetti, rice, hot dogs. Lunch would routinely be two stale pieces of bread with a thin layer of peanut butter. I lost a whole lot of weight there. I was always hungry . . . we were not allowed in the kitchen.*
>
> -Charles, Age 54
> (Hosseini, 2004)

In addition to those forced to live on the streets, thousands of people with mental illness are warehoused in loosely regulated Board and Care homes. A 2004 report examining Board and Care homes by the California Network of Mental Health Clients related experiences of verbal, physical and sexual abuse, over-medication, lack of privacy and respect and nowhere to turn to report abuses without retaliation. They frequently reported a lack of adequate food and poor quality of food (Hosseini, 2004). People who live in Board and Care facilities are not considered as "institutionalized" because technically they are living in the community, and they are largely forgotten by society and even within a mental health system that

largely responds to people in crisis.

Still others with mental illness live under precarious circumstances, "languishing in the back bedroom" or "couch surfing" in the home of relatives or friends because they have no other options. Taken together, an estimated 75,000 people with mental illness needed housing in California in 2000 (Little Hoover Commission, 2000). In addition, people who do have housing but who go through a mental health crisis are at extremely high risk of losing both their job and their housing in the first year afterward, increasing the need for additional housing each year.

In addition, families of children with serious emotional disturbances are housed under precarious circumstances as children's behaviors, which are frequently symptoms of their disorders, threaten to result in the family's eviction from settings where neighbors do not want them around and landlords are not inclined to assist them. Eviction is also a possibility when parents' ability to pay for housing is compromised by their inability to work regularly because of the extensive needs of their SED children.

The responses to people with mental disabilities who seek to rent an apartment or move as a group into a neighborhood have become virtual mantras of discrimination:

- *Sorry, we don't rent to "handicapped" people.*
- *You've been in a psychiatric hospital – we just can't take a chance on leasing you an apartment.*
- *Is this area of town really safe for you?*

(Levy and Rubenstein, 1996)

Adequate and affordable housing is essential to solving these problems and providing the basic foundation of a safe home for persons with mental illness. However, stigma and discrimination create serious barriers to safe, quality housing. Landlords frequently discriminate by refusing to rent to individuals and families because of a perceived mental illness. In addition, neighborhoods and communities routinely band together to kill housing projects for people with mental illness. These community exercises of discrimination, called NIMBYism (Not in My Back Yard) are especially destructive, increasing the cost and difficulty of building desperately-needed housing.

Both individual and community discrimination are prohibited under the federal Fair Housing Act Amendments of 1988. The Fair Housing Act protects those with physical or mental disabilities from discrimination on the basis of disability when buying or obtaining financing for a house, a cooperative or a condominium or when renting an apartment. It prohibits conditional leases. It also protects families and caregivers with a minor child who has a serious emotional disorder from discrimination in housing.

The Fair Housing Act also covers the actions of zoning boards and other land-use regulators who are the most frequent enforcers of local NIMBY efforts. It protects against discriminatory

zoning or other land use decisions, and prohibits special licensing, health or safety restrictions are not required for other housing. These provisions have been found by the courts to rule out many common forms of discrimination:

- It does not allow special distance requirements, such as a rule that requires special housing project from being located a certain distance from one another.
- It prohibits occupancy limits, or rules that allow only four, five or six unrelated people to live in a home.
- It prohibits special procedural requirements such as conditional use permits.
- It does not allow onerous health and fire safety rules that do not apply to other housing.
- It does not allow rules that require the operator of a residence for people with disabilities to provide advance notice to neighbors about the project.
- It prohibits restrictive covenants in deeds.
- It prohibits decisions about housing projects that are based on neighborhood opposition.

However, "Localities, often at the behest of neighborhood associations, continue to discriminate against people with mental disabilities through land-use powers. Only concerted advocacy, together with information about rights, can overcome it" (Levy and Rubenstein, 1996, p. 188).

C. DISCRIMINATION IN EMPLOYMENT

The Americans with Disabilities Act (ADA) has been called "the most comprehensive civil rights law in a generation," and affects every aspect of civil life (Levy and Rubenstein, 1996, p. 154). It outlaws discrimination in public services, transportation, communications technology and public accommodations. It also prohibits discrimination in public and private employment.

People with serious mental illness experience unemployment at rates of 80 – 90 % although a majority of them wish to work (Little Hoover Commission, 2000). Existing research as well as accounts of personal experiences suggests that stigma and discrimination in employment are pervasive and contribute significantly to the extremely high rate of unemployment among persons with mental illness. Research indicates that stigma and bias in employment against people with psychiatric disabilities is greater than against any other disability group (Levy and Rubenstein, 1996).

Adults who are parents of children with serious emotional disturbance also encounter difficulty obtaining and retaining employment. Employers are reluctant to hire a worker with a family member who may compete for the worker's time and energy. Many employers are also reluctant to accommodate a parent who needs to miss work to attend treatment sessions and other meetings designed to address the special needs of his or her family.

Working is a successful strategy for reducing stigma and discrimination, highly valued for its potential to generate financial independence, social status, to reduce isolation and increase opportunities for personal achievement and contribution to the community In addition, paid employment has been found to reduce the symptoms of mental illness (U.S. Department of Health and Human Services, 1999).

> *Mental health professionals should convey that recovery is possible and that working at every level is possible. They should re-examine the predominant belief that people with severe mental illness are best suited for low-wage, unchallenging jobs.*
>
> (Russinova and Ellison, 2000)

The ADA defines a "qualified person with a disability" as one who is able to perform the essential functions of job, either with or without a reasonable accommodation. The accommodations requested most by persons with mental health disabilities are training of supervisors, onsite support and flexible work schedules, which are generally inexpensive to accommodate (U.S. Department of Health and Human Services, 1999).

However, practical difficulties arise in accessing these rights. The law protects prospective employees from disclosing a disability to help protect them from the potential effects of discrimination. But disclosure is required in order to get a "reasonable accommodation." The practical contradiction this creates is left to the person with a disability to navigate. The skill to negotiate a "reasonable accommodation" to receive needed support is uncharted territory in which a person with a mental health disability must frequently depend on the "good will" of the employer, because practical methods of accessing this right are undeveloped. Knowledge, training and practical tools to ask for and receive an appropriate "reasonable accommodation" are areas that require serious attention if persons with mental health disabilities are to be successful in joining the workforce.

Another barrier to employment is the counterproductive policy of the Social Security Disability system, which punishes people for trying to move off of Social Security and into competitive employment. These rules are especially unworkable for persons with mental illness, whose symptoms are cyclical and may come and go. If a person receiving Social Security Disability benefits tries to go to work, he or she risks losing essential health benefits that cover treatment and medications. If people are well now and go to work but become symptomatic at a later time, they experience a long delay in re-gaining benefits. And if their initial attempts to work aren't successful immediately, they have lost their benefits and must suffer destitution while they await a long delay for their benefits to resume.

However, despite such difficult barriers and persistently high rates of unemployment, research shows that people with mental illness can be successful in employment and in fact are employed at all levels. A 2000 research study by the Center for Psychiatric Rehabilitation of Boston documented persons with mental illness holding high-level, demanding jobs. A non-

representative sample of 501 people showed people employed at all levels, including lawyers, managers, engineers, physicians, nurses and other professionals. Seventy-eight percent of participants had been hospitalized for mental illness, 25% in the past three years. Study participants came from all major psychiatric diagnoses – 11.5% had been diagnosed with schizophrenia or schizoaffective disorder, 43.5 percent with bipolar disorder, 29 percent with major depression, 16 percent with PTSD and other disorders (Russinova and Ellison, 2000).

There are a number of successful strategies for assisting people to enter the workforce, including client-run and client-owned vocational programs and independent businesses which have begun to flourish, supported employment models which utilize ongoing support to work in competitive employment, and employing persons with mental illness to work in the mental health system.

Consumer employment in the mental health system is an important strategy in California as the MHSA expands services and places an unprecedented value on the healing potential of personal experiences as a unique expertise when shared on a peer-to-peer basis. Employment of consumers in both administrative and direct service positions infuses the public mental health system with a viable workforce, while at the same time providing consumers with an opportunity to live outside of poverty or dependence upon public supports. It is also effective to reduce stigma in the workplace through thoughtful design and implementation of services that create a supportive workplace for people with mental illness, for those who experience mental illness in their family, or those who choose to keep their experience secret out of fear of being isolated in the workplace.

Currently, consumer and family member employment is clustered among a few counties in the state and within the adult system of care (California Mental Health Planning Council, 2003). There are few entry-level educational pathways for consumers to utilize opportunities and no financial incentives designed to attract them into the workplace. Addressing these issues is one of the essential tasks of the MHSA, and is critical to supporting consumers in employment and independence.

Research indicates that the greatest factor in reducing discrimination in the workplace is a track record of hiring and working with people with mental illness; such personal contact contradicts stereotypes and promotes understanding and acceptance of mental illness and increases willingness to continue to engage in non-discriminatory hiring practices (U.S. Department of Health and Human Services, 1999). Opening up employment opportunities is a time-honored civil rights strategy, and it is central to breaking down the barriers of stigma and discrimination that face those who live with the challenges associated with mental illness.

D. STIGMATIZING MESSSAGES IN THE MEDIA

Portrayals of mental illness in newspapers, radio, television, novels and the movies have an enormous impact on stigma and discrimination in the public consciousness. A 1990 survey conducted by the Robert Wood Johnson Foundation found the primary source of information about mental illness for survey respondents was the mass media (SAMHSA, 2006). However, media representations of mental illness are widely inaccurate and distorted. The University of Pennsylvania's Annenberg School for Communication studied network television dramas over a 25-year period and found that "mentally ill" characters were portrayed as the single most violent group on TV (Schraiber, 1995). Seventy percent of characters in prime-time drama are portrayed as violent, and more than one in five are shown as killers (SAMHSA, 2006). Only two out of 10 of the characters identified as mentally ill were considered good characters, while about six out of 10 of the "normal characters" were depicted as good (Schraiber, 1995).

> *The relentless framing of mental illness in the context of violence and criminality is amplifying, sustaining and legitimizing a largely false picture of mental health . . . We should be honest enough to acknowledge that in doing so, we are helping to perpetuate deep-rooted and largely unjustified public attitudes which make the lives of the vast majority of peaceable, de-institutionalized mentally ill people more difficult than they already are.*
>
> -Patrick Smellie
> Bazelon Center for Mental Health Law, 1999

At the other end of the spectrum, movies and television utilize mental illness as comedy, usually laughing at rather than laughing with the characters, or portray people with mental illness as victims, pathetic characters or the "deserving mad" (Byrne, 1997).

Newspaper reporting is also a potent source of stigma, displaying bias toward reporting crimes by persons with mental illness. According to Otto Wahl, a professor of psychology at George Mason University in Virginia, "Crimes connected to mental illness are more likely to lead the news or be on the front page, and there is more multiple, ongoing coverage of crimes involving mentally ill people – arrest, trial, verdict and sentencing." In Wahl's opinion, "the media teach people to fear, devalue, and distrust people with mental illness. So people who need understanding are met with rejection and isolation, as well as discrimination" (Levin, 2001, p. 10).

In addition to conditioning the public to mistrust persons with mental illness, these messages have a powerful affect on those personally affected by mental illnesses. Media messages are an ever-present reinforcement of social rejection that can lead people to internalize stigma, feeling loneliness, alienation, hopelessness, anger and despair.

Because of the influence of the media and the pervasiveness of the stigmatizing messages it delivers, media reporting and portrayal of mental illness present a powerful opportunity for change. The Substance Abuse and Mental Health Services Administration's Eliminating Barriers Initiative (EBI), launched in 2003, is a national stigma campaign that focused attention on stigma reduction efforts in general, and on working with media gatekeepers to eliminate stigma. The EBI offered advice on successful strategies, including understanding reporters' needs, developing relationships with them, showing respect for them and for their role, exercising patience, developing opinion pieces, tailoring materials to suit unique situations, developing quotable sound bites, publicizing events, and establishing partnerships (U.S. Department of Health and Human Services, 2006). Patrick Smellie of the Bazelon Center for Mental Illness also emphasizes the importance of the first-person experience in developing accuracy and balance in reporting: "Reporters should be exposed to the notion that people with a history of mental illness are capable of being reliable sources" (Bazelon Center for Mental Health Law, 1999, p. 9).

The Entertainment Industries Council, Inc., works along similar lines to influence movies, radio, television and novels – trying to impact those involved in the entertainment industry to use their powerful creative medium to educate, develop empathy, and to eradicate negative, stereotypical portrayals of mental illness. In 2005, SAMHSA launched the Voice Awards in Los Angeles, intended to acknowledge successes in this key arena. The high-profile awards ceremony recognized film, television and radio writers and producers whose work has given a voice to people with mental illnesses by incorporating dignified, respectful and accurate portrayals into their work (SAMHSA, 2006). Among the works honored in the first year were "The Aviator," "ER," "Huff," "Larry King Live," and "Monk." The Voice Awards continue as an annual event that set the standard for success in reducing stigma in the entertainment industry.

PART V: STRATEGIES AND RECOMMENDATIONS

A. FRAMEWORK

The ACLU publication The Rights of People with Mental Disabilities outlines eight strategies for combating stigma and discrimination. They include negotiation, education, consciousness raising, publicity, demonstrations, organization, lobbying and persuasion, and legal action (Levy & Rubenstein, 1996). All of these strategies may be utilized in addressing the problems of stigma and discrimination, leveraging existing opportunities and materials to avoid reinvention wherever possible.

While the initial efforts of the Advisory Committee did not encompass comprehensive strategic planning, this blueprint of the problems and issues that has been developed constitutes a

"Situational Analysis," a detailed assessment of the problem. Developing a Situational Analysis is recommended by SAMHSA as a first step in developing a stigma and discrimination campaign (SAMHSA, 2006). Future planning efforts should build upon the framework of identified issues developed in this Situational Analysis.

FRAMEWORK OF IDENTIFIED ISSUES:

1. PEOPLE
    - 1A. Internalized Stigma in Children and Adults
    - 1B. People Facing Multiple Oppressions
    - 1C. Foster Children
    - 1D. Family Members and Caregivers
2. SYSTEMS
    - 2A. The Mental Health System
    - 2B. Access to Health and Mental Health Services
    - 2C. Educational Systems
3. COMMUNITY
    - 3A. Violence Myths & Abuse Prevention
    - 3B. Housing
    - 3C. Employment
    - 3D. Media

B. STRATEGIC PLANNING

In the process of assessing the problem and making initial funding recommendations, many valuable ideas and approaches for addressing stigma and discrimination were encountered in the academic literature, discussed in the Advisory Committee and public hearings, and explored in a meeting held to solicit the advice of a grassroots communications expert. The work of ensuring that the list of strategies is comprehensive and of subjecting them to critical analysis, the Logic Model, integrating them into existing MHSA activities, and defining focus and priority was beyond the scope of this initial report, and has not yet been undertaken. Those activities will be central to developing a comprehensive ten-year strategic plan (see Recommendation 2, page 42, below). However, it is worthwhile to capture the initial thinking of the group on strategies to address the issue areas they previously identified. This repository of potential strategies can serve as a basis for the work of strategic planning, and is attached to this report as Appendix A.

C. DETAIL AND JUSTIFICATION FOR SPECIFIC FUNDING RECOMMENDATIONS

Through a process of agreement between the Mental Health Services Oversight and Accountability Commission, the California Mental Health Directors Association and the state Department of Mental Health, funding in the amount of $20 Million annually for a total of $80 Million over the first four years has been designated for activities to reduce stigma and discrimination associated with mental illness in California.

These are the recommendations for initial funding:

1) Anti-Stigma and Discrimination Activities Targeting Children and Youth

Efforts in these areas would be addressed within K-12 and higher education, and blended and combined with other funding resources to support the MHSA Student Mental Health Initiative, described separately. These are the stigma and discrimination activities that the Student Mental Health Initiative will provide. (Please see Student Mental Health Initiative for full details of that proposal.)

K-12 Violence and Bullying Prevention

These activities would focus on education campaigns and training for school-age children to develop empathy and create norms around appropriate, accepting and respectful behavior that would act as a preventive measure against school violence and bullying.

$2.5 Million Annually
$10 Million Total

Peer-to-Peer Support on Higher Education Campuses

This project would be part of a multi-pronged matching grant program for California Community Colleges, California State University and University of California campuses. The activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. It would address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.

$2.5 Million Annually
$10 Million Total

2) Empowerment Strategies Targeted To Adults

Intended to address the problems of internalized stigma, these strategies "do not make the world fairer, but they strengthen people's ability to withstand stigmatizing attitudes, to fight against discrimination and to stand up for their rights" (Everett, 2007).

Consumer Empowerment and Personal Contact Strategies

This project has two prongs. First, it would fund existing and new peer self-help and self-advocacy organizations to provide client empowerment through training, mutual support and advocacy. The activities would focus on promoting acceptance of cultural diversity, disability and the reduction of internalized stigma associated with mental illness.

Second, based on the "Stamp Out Stigma" model developed in Belmont, California, these peer-run programs would be funded to develop consumer-driven advocacy and educational outreach programs designed to make positive changes in the public perception of mental illness and to inform the community about the personal, social, economic and political challenges faced by people living with mental illness through personal contact strategies. Consumers would be trained to participate in interactive panels to share personal stories at conferences, workshops, Boards of Supervisors, in television and radio, schools, colleges and professional schools, police and fire departments, and with physicians, hospital administrators and mental health professionals. These "personal contact strategies" would compliment the work of the External Influence Campaign.

$5 Million Annually
$20 Million Total

3) External Influence Strategies

Stigma and discrimination are consistently identified as major barriers to improved use of mental health programs and recovery by people with mental health problems, their families, friends and mental health providers. These barriers tend to be more pronounced in ethnic, historically underserved communities. A public education campaign can improve the public's awareness of unmet needs and reduce the harmful effects of stigma and discrimination. Successful campaigns will require enormous collaboration with community based organizations, community leaders, and the media industry. Outreach, engagement and grassroots support of ethnic, underserved communities should be a key component of public education campaigns.

Campaigns challenge the harmful stereotypes about people with serious mental illness and promote accurate portrayal of individuals experiencing mental illnesses. Since negative views are held by many people—teachers, landlords, providers, religious leaders, etc—a strategic communications campaign can change the stereotypes held by diverse stakeholders and significantly improve the quality of life of people with mental illness. The accurate reporting of and portrayal of people with mental illness must be culturally and linguistically sensitive to diverse audiences. Given the diversity of California's population, public education materials should be developed in languages other than English and those materials should be developed by ethnic media representatives who come from ethnic communities themselves. Messages that are designed for the general public should be culturally and linguistically tailored for ethnic communities and to the level of health literacy of historically underserved populations.

An efficacious campaign needs community member participation and input. Community members, especially from underserved communities, are key in determining the most pervasive and harmful stereotypes of people with mental illness, as well as the language/messages/images that need to be tailored in order to change such views in their particular population. This campaign would be targeted toward specific areas identified as particularly relevant to stigma and discrimination, where a potentially significant change could be effected through a strategic communications strategy.

The campaign would be developed and implemented through a contract with an expert professional communications firm, who would be expected to sub-contract for appropriate message development, strategies and input with ethnic community communications experts and ethnic media outlets who are members of ethnic communities themselves. Activities would include planning, conducting focus groups, developing high impact messages and strategic approaches, polling, media testing, grassroots organizing, conducting a press strategy and buying advertising tailored to diverse audiences, as called for.

Five key issue areas are suggested for this communications strategy, with potential strategic outcomes. Based on advice we will garner from the communications experts, we would expect only one of these topic areas to involve an initial large public media campaign. In the other four issue areas we would expect to utilize much more focused communications techniques to reach specialized decision makers to impact system change through making an impact on key leaders.

EXAMPLE:

FIVE SAMPLE THEMES FOR EXTERNAL INFLUENCE CAMPAIGN

**** 1. Employing People with Mental Health Disabilities**

Potential issue for a public media campaign – a possible outcome would be public support for legislation supporting the employment of people with mental health disabilities in the workplace.

2. Accessing Quality Mental Health Care through Primary Care

Potential strategies may include disseminating quality of care and anti-stigma and discrimination materials to primary care doctors, as well as communicating with potential patients through creative means, such as educational videos in doctors' waiting rooms.

3. Education

Potential strategies may include communicating on a regular and ongoing basis with school principals on relevant mental health issues.

4. Law Enforcement

Potential strategies may include talking to key informants in law enforcement on strategies for collaboration, training, communication, education and violence prevention in encounters between people in mental distress and law enforcement officers.

5. Media

Potential strategies may include developing information, relationships, strategies and rapid responses to influence media reporting on mental illness to be more accurate, fair and less biased towards persons with mental illness.

Total Proposed Budget for External Influence Campaign
$10 M Annually
$40 M Total

D. SPECIFIC RECOMMENDATIONS FOR COMMISSION CONSIDERATION

These specific measures are recommended as the initial activities to launch the MHSA Stigma and Discrimination Campaign:

RECOMMENDATION 1

The Commission should generate a special report on the impacts of stigma and discrimination on racial and ethnic communities, modeled on the Surgeon General's 2001 break-out report on Culture, Race and Ethnicity.

RECOMMENDATION 2

The Commission should develop a comprehensive ten-year Strategic Plan to guide MHSA activities to reduce stigma and discrimination (see Appendix A).

RECOMMENDATION 3

The Commission should develop a public policy agenda that addresses stigma and discrimination through legislative and regulatory policies (see Appendix B).

RECOMMENDATION 4

The Commission should take ongoing steps to ensure that messages utilized in MHSA stigma and discrimination campaigns do not increase stigma and discrimination.

RECOMMENDATION 5

The Commission should fund K-12 Violence and Bullying Prevention Strategies at $2.5 million annually over the first four years of the MHSA.

RECOMMENDATION 6

The Commission should fund Peer-to-Peer Support on Higher Education Campuses at $2.5 million annually over the first four years of the MHSA.

RECOMMENDATION 7

The Commission should fund Consumer Empowerment and Personal Contact Strategies at $5 million annually over the first four years of the MHSA.

RECOMMENDATION 8

The Commission should fund and oversee a contract with an expert communications firm for a Strategic Communications Campaign to develop and

manage external influence strategies at $10 million annually over the first four years of the MHSA.

RECOMMENDATION 9

The Commission should be guided by stakeholder input to finalize a list of 5 focus areas for the Strategic Communications Campaign, selected from the eleven core issues identified by the Stigma and Discrimination Advisory Committee:

1. **PEOPLE**
   - **1A. Internalized Stigma in Children and Adults**
   - **1B. People Facing Multiple Oppressions**
   - **1C. Foster Children**
   - **1D. Family Members and Caregivers**
2. **SYSTEMS**
   - **2A. The Mental Health System**
   - **2B. Access to Health and Mental Health Services**
   - **2C. Educational Systems**
3. **COMMUNITY**
   - **3A. Violence Myths**
   - **3B. Housing**
   - **3C. Employment**
   - **3D. Media**

YOU AND ME

If you're overly excited
You're happy
If I am overly excited
I am manic.
If you imagine the phone ringing
You're stressed out
If I imagine the phone ringing
I'm psychotic.
If you're crying and sleeping all day
You're sad and need time out
If I am crying and sleeping all day
I'm depressed and need to get up.
If you're afraid to leave the house at night
You're cautious
If I am afraid to leave my house at night
I'm paranoid
If you speak your mind and express your opinions
You're assertive
If I speak my mind and express my opinions
I'm aggressive.
If you don't like something and mention it
You're being honest
If I don't like something and mention it
I am being difficult.
If you get angry
You're considered upset
If I get angry
I am considered dangerous.
If you over-react to something
You're sensitive
If I over-react to something
I'm out of control.
If you don't want to be around other people
You're taking care of yourself and relaxing
If I don't want to be around other people
I'm isolating myself and avoiding.
If you talk to strangers
You are friendly
If I talk to strangers
I'm being inappropriate.
For all the above you're not told to take
A pill or are hospitalized, but I am.
--Debbie Sesula

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APPENDIX A

IDEAS TO BE CONSIDERED IN STRATEGIC PLANNING

1. PEOPLE

1A. Strategies for Addressing Internalized Stigma in Children and Adults

- Fund client empowerment strategies through existing peer self-help and peer self-advocacy organizations.
- Employ strategies to reduce isolation and alienation among children and adults with mental illness.
- Focus on improved service delivery, client-led training and contact strategies for mental health professionals to reduce negative attitudes that tend increase internalized stigma.
- Create "contact" programs in the community at large that take the person who has experienced or is experiencing mental ill health out of the "other" category (such as the Stamp Out Stigma program based in Belmont, California).
- Promote suicide prevention, including awareness of the California Youth Suicide Prevention Plan -- **http://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp**.
- Work with youth groups like the YMCA and Boys and Girls clubs to provide mental health awareness campaigns.
- Foster mutual support programs and societal acceptance for the issues facing family members of persons with mental illness.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.

1B. Strategies for Addressing Stigma and Discrimination Associated with Multiple Oppressions

- Modeled on the work of the Surgeon General, consider developing a report to supplement this general overview, focused on a more detailed analysis of stigma and discrimination in racial and ethnic communities and its impacts on mental health outcomes for those populations.
- Create interaction between agencies that work with racial and ethnic communities and high school counseling services.
- Foster mutual support programs and societal acceptance for the issues facing family members of persons with mental illness.
- Create linkages between suicide prevention and stigma reduction efforts for LGBTQ youth.

- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Employ ethnic and racial minority consultants, media outlets, and firms to assist in the development of stigma and discrimination campaigns.
- Make assertive efforts to outreach and include underserved populations into all aspects of the MHSA stakeholder process.
- Promote understanding of the multiple barriers faced by ethnic and racial communities in accessing mental health care, tailored to each community's needs, and design methods for reducing the barriers through culturally appropriate services.

1C. Strategies for Foster Children

- Assist foster children aging out of the system in dealing with employment and housing in preparation to exit the foster care system.
- Collaborate with the child welfare system to reduce the inappropriate removal of children of color from their homes by promoting cultural understanding.
- Work to increase access to mental health services for foster youth and their families as well as youth and families at risk of child welfare interventions.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.

1D. Strategies for Family Members and Caregivers

- Foster mutual support programs and societal acceptance for the issues facing family members of persons with mental illness.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.

2. SYSTEMS

2A. Strategies for the Mental Health System

- Promote strategies to shift involuntary services to services that are voluntary in nature.
- Provide training and education to empower consumers to understand what quality mental health services involve and what they may expect from mental health care.
- Monitor abuses in institutional settings and develop collaborations to protect mental health clients from abuses, including seclusion and restraints.
- Monitor the state's compliance with the federal CRIPA Consent Judgment regarding abuse and discrimination in state hospitals.
- Design interventions to ensure that when a person is hospitalized s/he does not lose his or her home, children, employment or belongings.
- Inform people who are homeless of their right to keep their belongings if they are hospitalized, using a Possessions Advanced Directive to prevent hospital staff from throwing away a person's belongings.
- Provide training to providers in the public mental health system as well as the primary care system about provider bias and reducing stigma and discrimination in treatment settings.
- Make assertive efforts to outreach and include underserved populations into all aspects of the MHSA stakeholder process.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Promote understanding of the multiple barriers faced by ethnic and racial communities in accessing mental health care, tailored to each community's needs, and design methods for reducing the barriers through culturally appropriate services.

2B. Strategies for Creating Access to Health and Mental Health Services

- Provide training and education to empower consumers to understand what quality mental health services involve and what they may expect from mental health care.
- Provide client-led trainings for mental health professionals and service providers.
- Design interventions to ensure that when a person is hospitalized s/he does not lose his or her home, children, employment or belongings
- Inform people who are homeless of their right to keep their belongings if they are hospitalized, using a Possessions Advanced Directive to prevent hospital staff from throwing away a person's belongings.
- Provide training to primary care providers to improve their diagnosis, responses and treatment of mental health problems.

- Make assertive efforts to outreach and include underserved populations into all aspects of the MHSA stakeholder process.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Promote understanding of the multiple barriers faced by ethnic and racial communities in accessing mental health care, tailored to each community's needs, and design methods for reducing the barriers through culturally appropriate services.

2C. Strategies for Educational Systems

- Partner with advocates for special education to promote appropriate access to a free and public education for all children with disabilities.
- Provide teachers with in-service training and materials about mental health education.
- Reduce bullying of emotionally disturbed students at school through collaboration with the California Dept. of Education's "Health Education Content Standards for California Public Schools."
- Provide teachers and administrators with pertinent information and guidelines about bullying.
- Create a kindergarten through grade twelve curriculum in conjunction with the California Department of Education's new "Health Education Content Standards for California Public Schools" for the content area "Mental, Emotional and Social Health."
- Create interaction between agencies that work with racial and ethnic communities and high school counseling services.
- Create client "contact programs" for graduate education schools in the areas of primary care, mental health care and alternative care.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Discourage educational institutions from expelling students with a mental health issue.

3. COMMUNITY

3A. Strategies for Addressing Myths About Violence and Preventing Abuse

- Reduce bullying of mentally afflicted students at school through collaboration with the California Dept. of Education's "Health Education Content Standards for California Public Schools."
- Provide teachers and administrators with pertinent information and guidelines about bullying.
- Create "contact" programs that take the person who has experienced or is experiencing mental ill health out of the "other" category (such as the Stamp Out Stigma program based in Belmont, California).
- Partner with older adult advocacy organizations to prevent elder abuse.
- Develop collaborations with other civil rights and disability organizations to address areas of mutual concern (such as police violence).
- Ensure that all law enforcement agencies have training in dealing with crisis situations, either using the CIT or similar models.
- Raise awareness of violence toward persons with mental disabilities, including the homeless, LGBTQ persons and other high-risk populations. Develop and support a violence prevention agenda.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Develop collaboration with law enforcement agencies.
- Provide media guidelines on reporting/portraying mental illness, using advice similar to that of the American Foundation for Suicide Prevention (AFSP) or the World Health Organization (WHO).
- Provide course instruction for college training programs of future media professionals.

3B. Strategies for Addressing Discrimination in Housing

- Develop strategies to reduce discrimination in permanent housing, including efforts targeting private landlords, housing authorities, nonprofit supportive housing managers and master tenants in shared rentals.
- Develop strategies to reduce discrimination in emergency shelters for adults and families and transitional housing programs, including domestic violence shelters and "safe houses" for runaway youth.

- Target efforts at decreasing community opposition to siting of housing for persons with mental illness.
- Develop collaborations with other civil rights and disability organizations to address discrimination in housing.
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.

3C. Strategies for Addressing Discrimination in Employment

- Provide training for mental health clients in techniques to pursue competitive employment, to secure a "reasonable accommodation" for their disability, and to thrive in the workplace.
- Provide pre-employment training, ongoing training and supports for clients to enter the mental health workforce.
- Provide training for county mental health departments on hiring and retaining clients in their workforce.
- Establish strategies to educate officials and work to change county personnel policies that are not supportive of consumer employment.
- Create incentives for counties to hire clients for the mental health workforce.
- Create "contact" programs aimed at employers that take the person who has experienced or is experiencing mental ill health out of the "other" category (such as the Stamp Out Stigma program based in Belmont, California).
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Provide a training program for businesses to be given through local chambers of commerce associations utilizing the Open Minds/ Open Doors employer literature -- **http://www.openmindsopendoors.com/upload/EmployerGuide.pdf**.
- Create an awards program that recognizes California state businesses that have the best record in hiring and/or retaining people who have experienced or are experiencing mental health problems.

3D. Strategies for Addressing Stigma in the Media

- Promote suicide prevention, including awareness of the California Youth Suicide Prevention Plan -- **http://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp**.

- Create "contact" programs aimed at the media that take the person who has experienced or is experiencing mental ill health out of the "other" category (such as the Stamp Out Stigma program based in Belmont, California).
- Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
- Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
- Employ ethnic and racial minority consultants, media outlets, and firms to assist in the development of stigma and discrimination campaigns.
- Provide media guidelines on reporting/portraying mental illness, using advice similar to that of the American Foundation for Suicide Prevention (AFSP) or the World Health Organization (WHO).
- Provide course instruction for college training programs of future media professionals.
- Develop and disseminate materials depicting people with mental health issues from a positive, strengths-based perspective.

APPENDIX B
DEVELOPING A PUBLIC POLICY AND ADVOCACY AGENDA

A powerful method for addressing structural stigma and discrimination is to develop a public policy agenda in order to promote systemic changes. As the MHSA moves from the initial start-up phase and the Mental Health Oversight and Accountability Commission develops capacity, it may wish to adopt a public policy agenda. The Advisory Committee identified these initial public policy issues to reduce stigma and discrimination at the systemic level:

Public Policy Initiatives:

- Promote compliance with and enforcement of existing laws, including Americans with Disabilities Act, the Supreme Court's *Olmstead* decision, the Fair Housing Act, and the Civil Rights Act among others.
- Educate policymakers on the association between stigma and discrimination and the under-resourcing of the mental health system, and work toward appropriate funding of the system.
- Support pending legislation on mental health parity, including California's AB 423 and the pending federal mental health parity act (HR 1367 and S 558 being considered in the current Congress).
- Explore options for changing the "double bind" regulatory decisions that have prohibited the funding of the Children's System of Care with MHSA funds.
- Explore legislation that supports hiring and retention of persons with mental health disabilities.
- Advocate for increased oversight and higher standards in community board and care facilities.
- Support statewide legislation to reduce the effects of NIMBYism.
- Advocate to improve mental health and supportive services to children in the foster care system.
- Develop a federal policy agenda to reduce discrimination, including challenging the institutional bias of Medi-Cal and Social Security Disability system rules that discourage employment.

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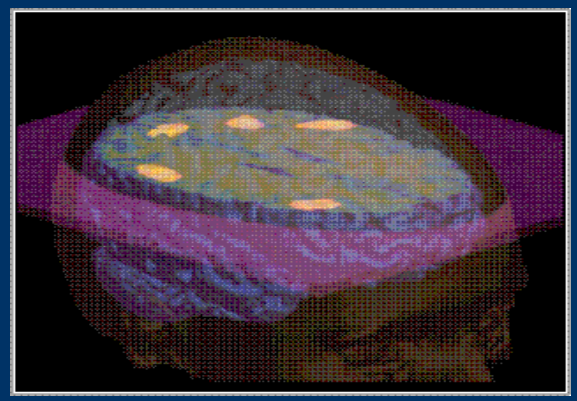
Early Intervention for Transitional Age Populations



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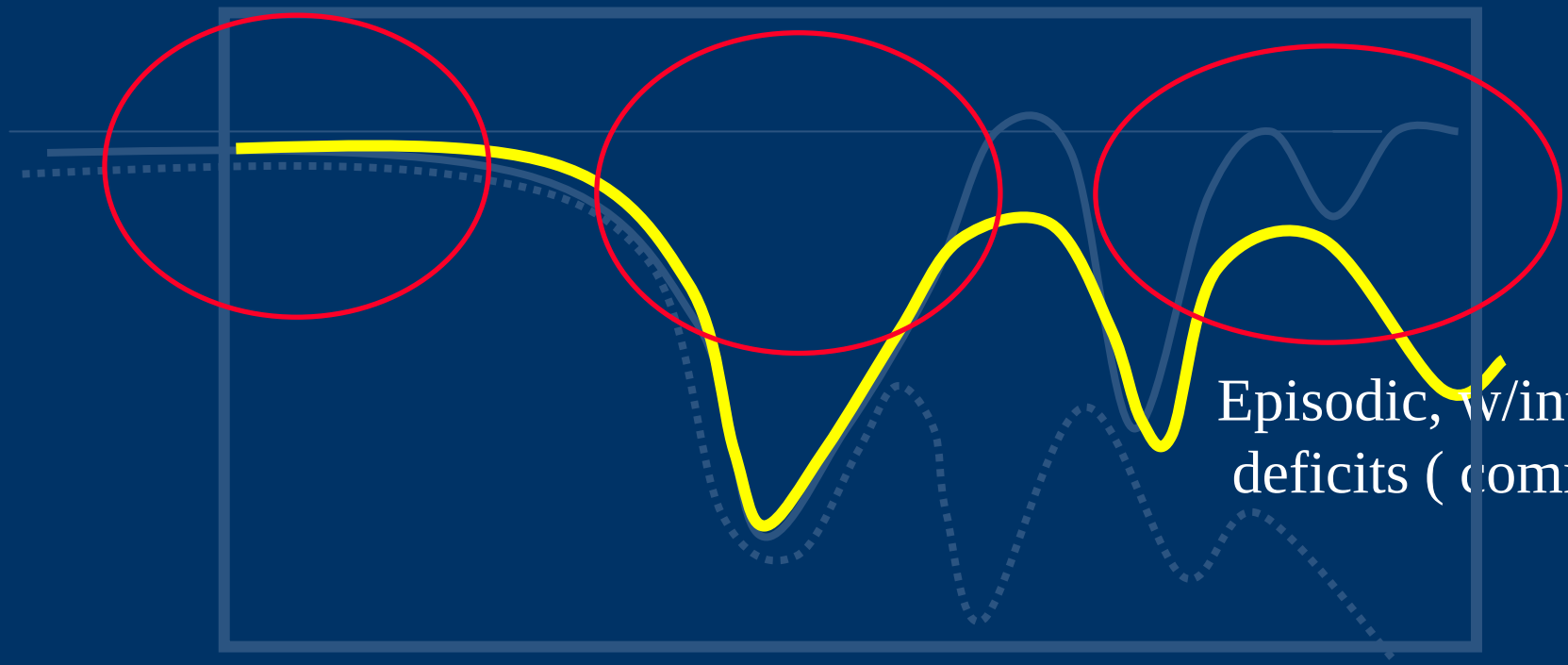
Serious mental disorders in youth

- Schizophrenia, bipolar disorder and serious depressive disorders affect up to 3% of the population
- Typical onset 12-25 years (TAY)
- Hospitalization, suicide attempt, school failure, substance abuse, disability and unemployment, criminalization and incarceration frequent complications
- We can significantly improve outcome and prevent these complications with an early intervention approach

The course of schizophrenia



Broad therapeutic window for Prevention/Early intervention

What is Prevention?

- From the PEI Guidelines:
  - “Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.”
  - “Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills and increasing support.”

What is Prevention? (continued)

- "The Prevention element of the MHSA PEI component includes programs and services defined by the Institute of Medicine (IOM) as Universal and Selective, both occurring prior to a diagnosis for a mental illness."
  - Universal: target the general public or a whole population group that has not been identified on the basis of individual risk.
  - Selective: target individuals or a subgroup whose risk of developing mental illness is significantly higher than average.

What is Early Intervention?

- "For individuals participating in PEI programs, the Early Intervention element:
  - Addresses a condition early in its manifestation
  - Is of relatively low intensity
  - Is of relatively short duration (usually less than one year)
  - Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
  - May include individual screening for confirmation of potential mental health needs"

Exception to Limit on Funding for Early Intervention

- There is an exception to this limit on the use of PEI funds for Early Intervention:
  - "The standards of low intensity and short duration do not apply to services for individuals experiencing ARMS [at risk mental state] or first onset of a serious psychiatric illness with psychotic features"
  - "At risk mental state (ARMS), usually a period of one to two years, describes the condition of individuals who are at risk for developing a psychotic illness and are experiencing signs or symptoms that are indicative of a high risk for psychotic illness."
  - "First Onset is defined as the first time an individual meets full DSM-IV [diagnostic] criteria for a psychotic illness."

Prevention and Early Intervention in Mental Health

- Prevention a fundamental approach in many areas of medicine e.g. cardiovascular health, cancer
- More recent idea in psychiatry, history of poor outcomes, stigma working against us
- Idea that's time has come

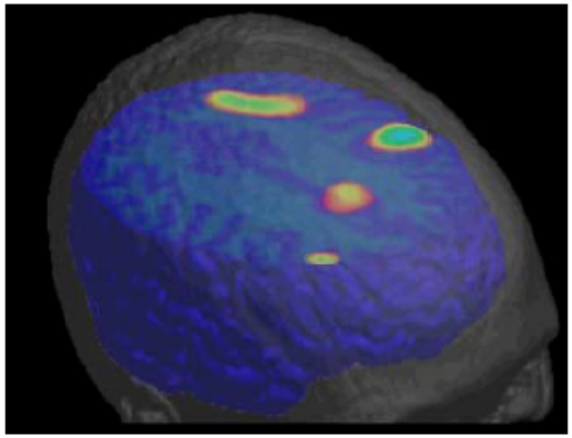
Risk Factors in Early Psychosis

- Impaired cognition: threatens academic performance, decision making
- Anxiety, suspiciousness: impairs social function, increased risk for substance abuse, hostility and aggression
- Loss of interest, motivation: negative impact on social functioning

Protective factors

- Relatively low symptom levels, ready response to treatment
- Intact Family support
- Relatively intact developmental trajectory (school, work, social)
- Preserved insight

Questions?



The EDAPT Clinic

Early Diagnosis And Preventative Treatment
of
Psychotic Illness

University of California, Davis Medical Center

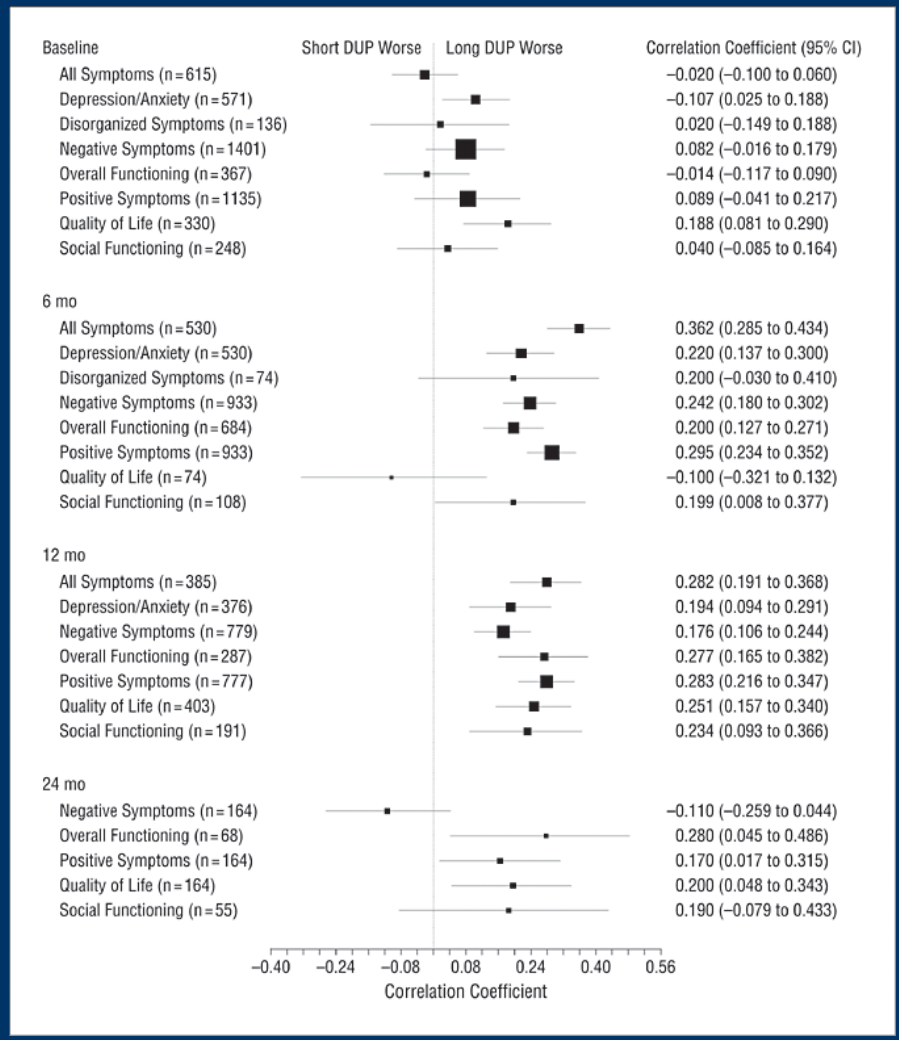
http://earlypsychosis.ucdavis.edu

EDAPT Clinic: Rationale

- Duration of untreated psychosis is associated with poor outcome
- Early in illness treatment response is robust
- Loss of function and treatment resistance follow repeated relapses
- Early intervention can improve functional outcome
- Tailored treatment pathways and therapies for early treatment and rehabilitation

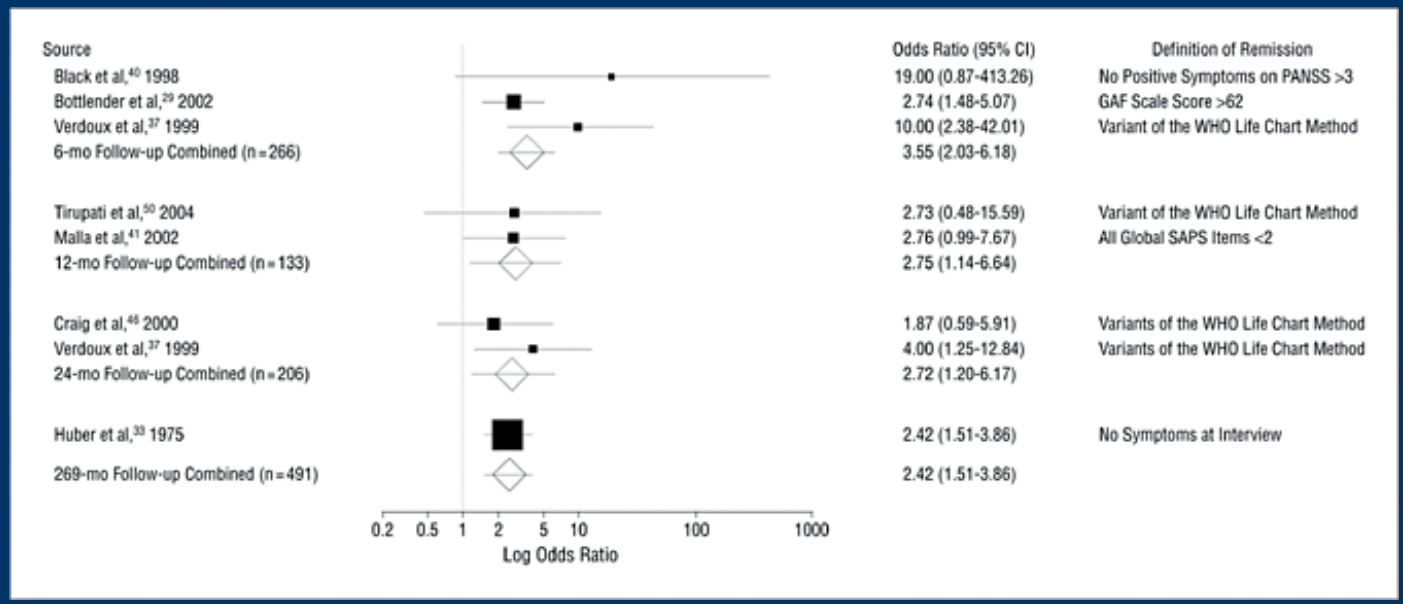
What's the evidence?

Summary correlations between duration of untreated psychosis (DUP) and outcomes by follow-up point



Marshall, M. et al. Arch Gen Psychiatry 2005;62:975-983.

Odds of no remission in the long vs short duration of untreated psychosis (DUP) groups



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EDAPT Clinic: 2 "Target" Populations

- Early psychosis "first episode" patients
- Ultra high risk

EDAPT Clinic First Episode Cohort

- 12-45 years of age
- Onset within the previous 12 months
- Goal is to engage patient (and family/support system) in sustained treatment
- Stabilize, and support recovery of function and developmental trajectory

Key elements of EDAPT treatment model

- Family focused
- Multidisciplinary treatment team
- Rapid response, extensive medical and psychiatric assessment
- Setting, may be better outside of CMH setting
- Medication management
- Individual and group therapy (psychoed, motivational, supportive)
- Advocacy (school, vocational, insurance and disability etc)
- Multifamily support group

Some key first episode treatment issues

- Diagnostic uncertainty, symptom based treatment, side effects
- Denial of illness, non compliance
- Depression, suicidality
- Family support
- “re-entry”, socialization, stress, advocacy
- Individualized pathways to recovery, value of peer groups

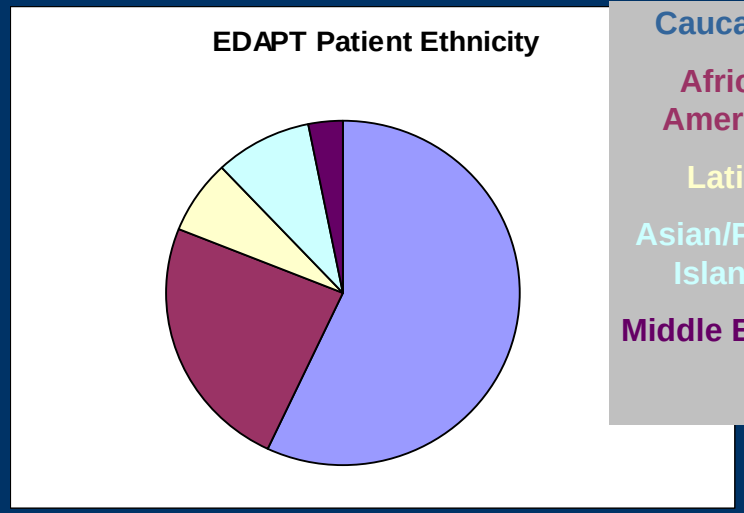
The EDAPT Clinic

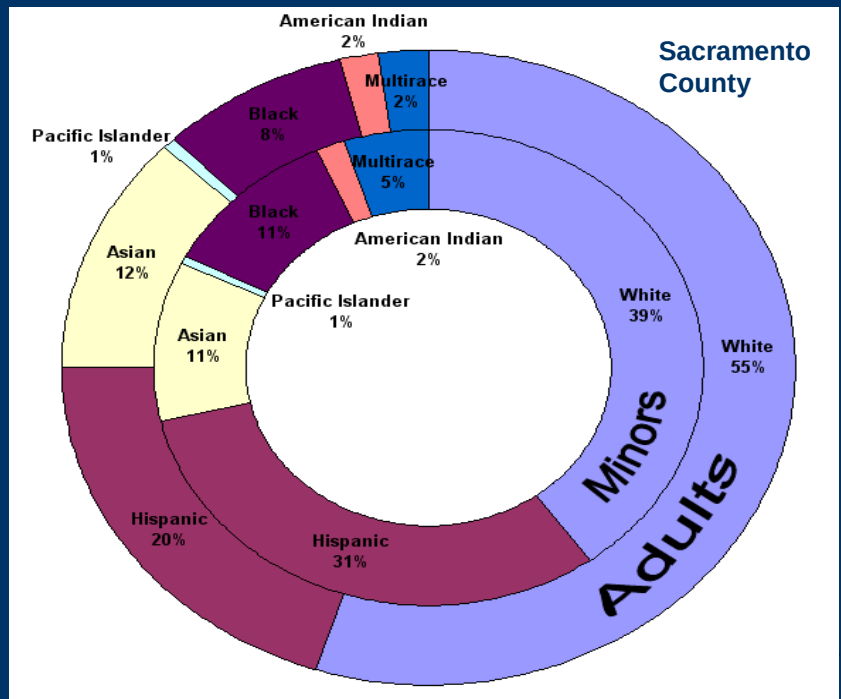
Clinic Demographics

Screened (07/05 - 08/07)	**493**
Accepted into Clinic	**104**
Total Number Enrolled	**70**
First Episode Patients	**49**
'Ultra High Risk' Patients	**21**
Age Range of Patients	**11-34**
Average Age	**19**
Under 18	**46%**
Working or in School	**91%**
Number hospitalized	**10**

Ethnic Makeup of Clinic

Caucasian	57%
African American	24
Latino	7
Asian/Pacific Islander	9
Middle Eastern	3





Questions

Very Early Intervention: Ultra High Risk Cohort

- Can we delay the onset of psychosis and prevent functional decline?
- “Ultra High Risk” strategy: genetic risk factors, subthreshold psychosis and functional decline predict 20-40% conversion rate

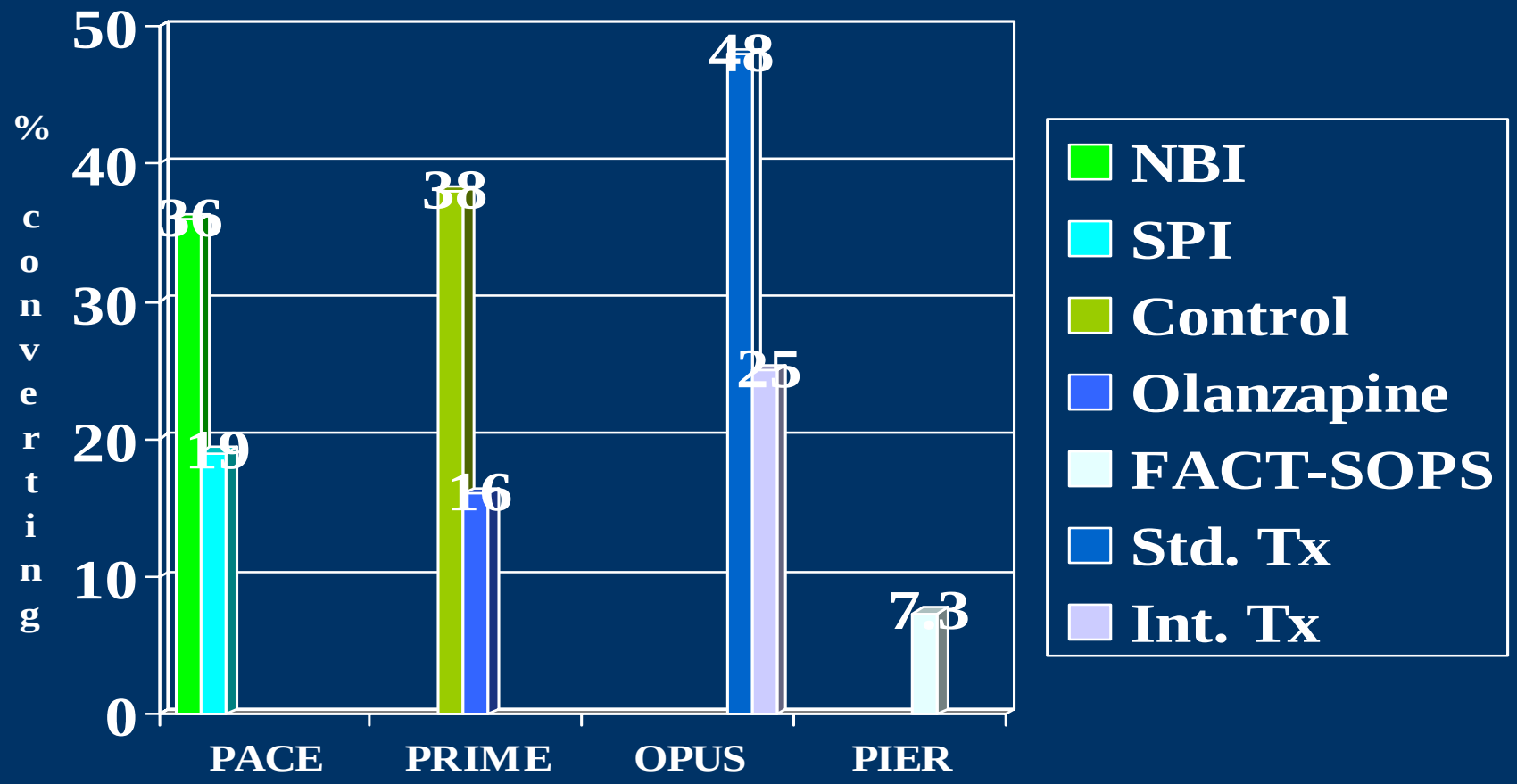
Three Prodromal Risk State Categories

- Attenuated Positive Symptom State
  - Onset or worsening in the past year of (a) paranoid, grandiose, or referential ideas but without full conviction, (b) perceptual disturbances but without certainty of an external source, or (c) vague, circumstantial or tangential communication that is coherent and structured under redirection
- Brief Intermittent Psychotic Symptom State
  - Onset in the last month of transient hallucinations, delusions, and/or thought disorder, lasting less than one hour per day
- Genetic Risk and Deterioration State
  - A decline of 30% or more on the Global Assessment of Functioning in the past 12 months, AND patient either (a) has a first-degree relative with schizophrenia or (b) meets criteria for schizotypal PD

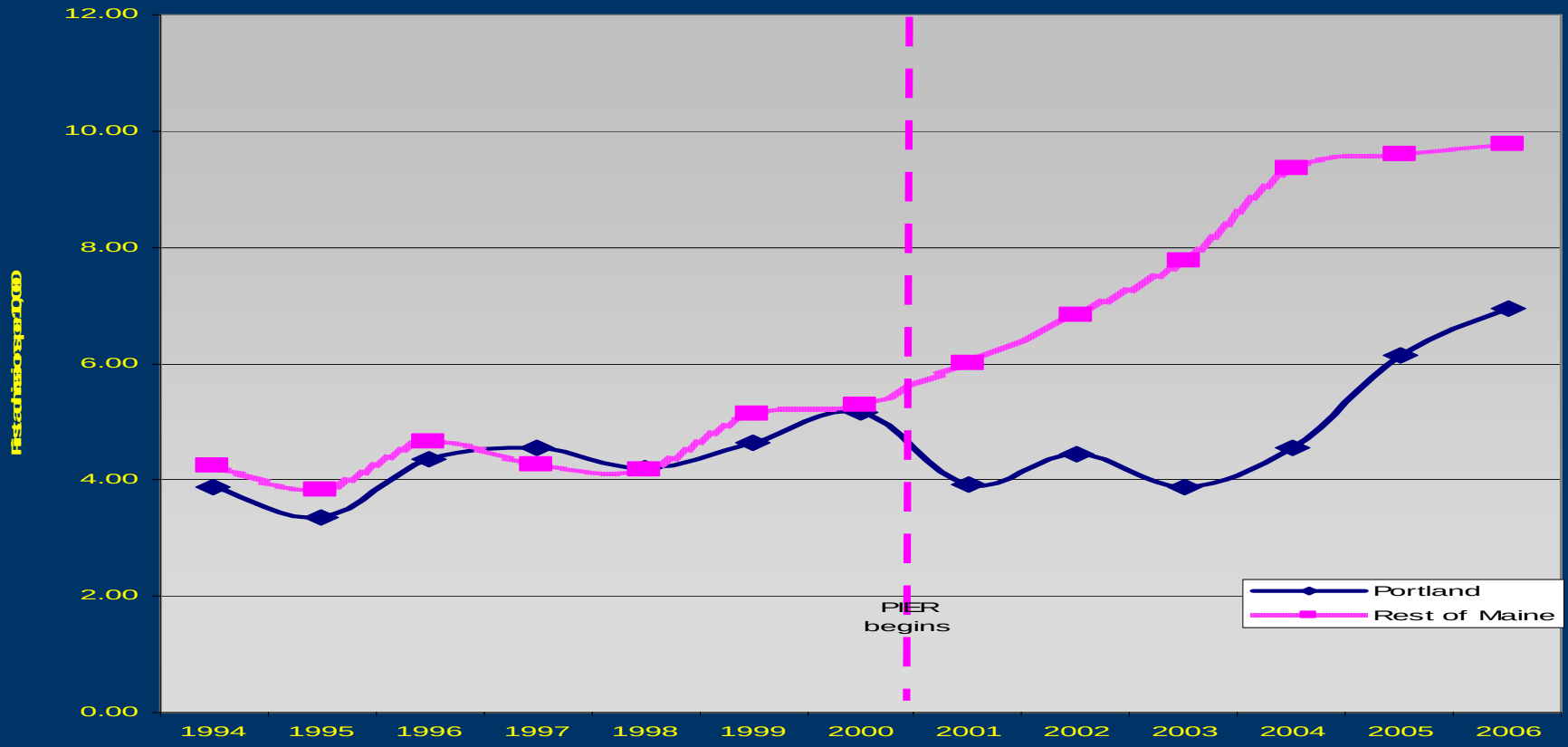
Very Early Intervention

What is the evidence?

PACE, PRIME, OPUS and PIER
12 month outcome



First hospitalizations for psychosis
Greater Portland vs. rest of Maine



PREVENT MENTAL ILLNESS WITH EARLY DETECTION

The PIER Program
"an ounce of prevention"

Improved Outcomes from Very Early Intervention

- Results suggestive from Australian, Danish and U.S. studies BUT
- Definitive results will be needed to change public policy in the U.S.

Earlier Intervention: EDIPP

- Funded by a $2 million grant from the Robert Wood Johnson Foundation
- 5 sites across the nation
- Sacramento City, favored due to diversity, UCDMC favored for its strong community partnerships
- Seeks to make history, change public policy
- Enriched early intervention approach

Earlier Intervention: EDIPP

- Careful diagnostic assessment, SIPS (Structured Interview for Prodromal States) interview, plus active diagnoses and co-morbidities
- TARGETED pharmacological therapies
- PIER model multifamily Psycho education and support groups
- supportive therapy, family support and therapy, supported education and employment and advocacy
- Epidemiological catchment area control plus needs based treatment assignment and regression discontinuity analysis to evaluate effectiveness of early intervention
- Research for enhanced risk prediction

Role of Communities in Early Detection & Intervention

- Communities set the context for development of early detection outreach and education programs
- Communities identify belief systems for stigma reduction
- Community involvement is crucial to recruitment and retention of diverse groups' participation in research
- The community is where the full impact of culturally competent intervention will be realized
- Successful community engagement builds skills and capacity within the community, which are fundamental factors for optimal health

Addressing diversity in EDIPP

- **Role of community partners in outreach, education, development of materials and MFG design**
- **UCDMC medical interpreting services, for outreach, SIPS and individual patient evaluations and care**
- **Development of culturally tailored Multifamily Group, partnering with therapists from African American, Latino and Hmong communities**
- **Success would provide strong evidence for the value of the early intervention approach in an increasingly diverse American population**

Key Elements

- Outreach and Stigma Reduction: culturally competent, to schools, primary medicine, and mental health community
- Family focused intervention
- Rapid response (FACT)
- Increased intensity
- Psycho education and support (individual and family) and case management
- Substance abuse and symptom management interventions
- Targeted medication management
- Supported education and employment
- Family based intervention (various models), other specialized treatments as needed (e.g. CBT)

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