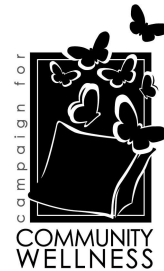


**Campaign Steering Committee Meeting
September 28, 2007
9-3pm**



Welcome:

Thank you for coming.

All notes and information can be found on the website:

www.campaignforcommunitywellness.org

Facilitator reviewed agenda and handouts on prevention and intervention best practices and an alert on a Medicaid policy happening at the state level.

Consumer Voice

Debbie You and member of our committee shared her personal story. Been in mental health since 1990, raised in a dysfunctional and abusive (physical) environment until 10. Had a rough childhood and developed emotional problems. Had a lot of trauma. Debbie was in a bad car accident, lost a lot of blood. Related to my Dad drinking, abusive babysitters, mom went to Europe for summer. When she returned I had a blank stare in my eyes. I blamed her and my Dad for my state. I was resentful and confused and didn't share what happened to me until my Dad passed away when I was 9. My Dad was a good person and so was my mom and I learned that from them, to be passionate. It's good to remember the positive. Then, we moved to Monterey after 9 . . .to my sister's house. Moved back to Simi Valley. I was blessed with good friends growing up. My mom and her friends were nice. It was called valium. My mom had her own addictions, caffeine, etc. I love the ocean, always loved the ocean. Then when we moved back to Simi Valley, I would go to school, babysit, had good friends. Was taught how to drive when I was 15. Gave me freedom. I could drive my mom around. Then I graduated. Always had problems learning in school and there was no special education. My mom did my homework and when I was tested I would get a D. I graduated and got my diploma and my mom kept it as she said she earned it!! My mom was a little controlling and said as I was youngest I had to take care of her. When I was 34 I was suicidal and had to go to mental health in Auburn. Penny Marshall suggested the EA program. Went to AA for 12 years. Both helped me tremendously to build my own self-esteem and take responsibility for my own actions. Quit blaming and resenting. I realize that my mom had her addictions. She was addicted to manipulating with guilt and shame. Took me until I was 40 to be independent of her. She kept trying to control me, and my son's life and find fault. It was very frustrating. My home family of origin was of this religion and they decided not to have anything to do with my son and I. But now I realize I am much better off, have a lot of

friends and go to support groups. They are great. All it takes is desire to seek this out. I am so grateful for the Welcome Center, their support groups, focus meetings, every first Monday 12-1:30, and I do the women's support group and my friends support me in this. It's a women's self-esteem group. Everyone's invited to participate in the art group too. We take turns at arts and crafts. Great program. People bring their own things and do their own art projects. I've had great case managers who have said you can do this. I have had dysfunctional neighbors, and am grateful to be aware, grateful to be grateful.

Thank you Debbie!

Public comment – 3 minutes a person, not a time for response, but reviewed quarterly by the Steering Committee.

Jerry Nevins: A reminder that tomorrow in Auburn, on the Auburn Rd., by the park, will be the Recovery Happens Event. It's the 7th event. I wrote it in the form of a poem.

For 7 years I have been reading poems at this event and it has been a good part of my recovery.

Deanne Thornton: Thank you and an observation. There is a reoccurring theme of trauma and abuse that I am hearing in the stories. And I think we need to keep that in mind as we are talking about prevention and early intervention.

Facilitator: We would like to bring Listening Well to this group somehow and are working on that.

Christina Nicholson: Yesterday in our SAMHSA strategic planning assessment, Anno Nakai suggested we talk about our community needs assessment.

Anno Nakai & Christina Nicholson: Introductions of themselves. They work together on the Substance Abuse Mental Services Health Administration. We call ourselves the Children's Campaign for Community Wellness. Part of that is making systems change that is culturally competent and formally driven focused. Focus is on Latino and Native American families. Part of the project is CAN.

About a year ago, we used a best practices tool that helps you look for stage readiness to engage in services and address mental health. We use that tool to look at HHS and how ready they are to increase cultural competency in their services. At another time we would like to share the data.

We want to share that we are now starting to focus at community readiness level. Identifying their primary needs, what directions we want to go on. The first set of outcomes has helped us with social marketing.

High commitment in Placer County, but from community perspective there is a lack of knowledge of resources and what County is doing.

Alisa Herrera is helping with Latino voice. I am working for Native American voice and Christina is helping too. And we would like to engage with CCW as to how we can both engage with Community.

One indicator on knowledge was: Denial and resistance. Feedback was that there is little knowledge of what County is doing for mental health.

Facilitator: We are doing our 2nd edition of the CCW newsletter and hope to make that our voice of all our different needs. Email me your articles.

Sharon Neal: October is mental health awareness month. But never hear anything about mental health awareness month. Would like to see something as strong as the Recovery Event about mental health awareness by next year, maybe an event.

Update on CSS

Maureen: Governor did eliminate AB2034 program in the state budget as of July 1, 2007. We received, as we've been planning for, \$881K of one-time.

The first plan that this group approved was to expand Full Service Partnerships (FSPs) in areas of Adult, Homeless, and TAY, to account for AB2034 going away. What did happen is that the State Dept. of Environmental Health approved additional one-time dollars. We do not have exact data, but we think it is close to past funding for AB2034 (\$881k).

So I took your 2 recommendations and asked the state for both: one for the one-time monies and the other for expanded CSS funding.

Recommendation #1: One-time money will pay for the Full Service Partnership part of the recommendation, but not cover the voice element that you recommended.

But then, we can do what was our first priority for recommendation #2:
15% voice from families, consumers, Latinos, N. Americans
15% for our system transformation in the area of crisis triage
60% for FSP for adults
10% for Lake Tahoe

This was also submitted to the state.

Question: I got an email about 2 bills going through governor's office and I only printed out part, but seemed like important bills to support.

Maureen: Why don't we talk after and see what they are.

Edna: Would like to see how we can have the governor support this.

Maureen: Let's figure it out and get back to folks.

Consumer: Are we looking at Cal Endowment or government for housing?

Maureen: Perfect timing. I was going to update the other components, new monies coming down the pike. One is housing. It is expected with those dollars to match them wherever possible. Expected to be a developer in the community, a non-profit. These will be coming in the form of proposals as to how to increase housing in our community, which is critical. That part of housing is coming. We have some regulations and we will be having a planning process and meetings over next couple of months.

Early Prevention and Intervention – Now have final guidelines. The work we are doing today is the work we need to do, but we will get what the State wants us to do.

Workforce: We hired a workforce development supervisor, Amy Ellis, hired one-week ago. She will be developing a planning process. And we will work with you and families and consumers on this.

Facilities and Infrastructure: One time pot of money available for facilities providing services to folks in our community, to develop the capital, or purchase the facilities. It is likely that it will be County or non-profits that receive this. Infrastructure is our technology system. You rightfully want data on who we are serving, what we are doing, etc. So we will use these funds to improve the informational structural system at the county and with our partners.

We will come back and have further discussions on this. As it happens, it rolls out at the same time. We can't do everything at once, so we will present these to you as we go.

What we do not know about is innovative programs.

We need an integrated plan and we will work on this next year. It's a little confusing that these are rolled out separately. But the goal is to have an integrated plan with all the funding elements including the children's campaign. This will take us a couple of years. Each one has a process, etc.

Facilitator: Are you ready to stay here for another 7 years? (joke)

Consumers: Homelessness has a 10-year plan. We should do that too. Home again model. It is so good up in Oregon that they are using it in Sacramento

now. Jail program...are there any innovative programs in that area, for reentry into society, chronic homeless, in and out of jail? 10% of the population is using up 50% of resources, \$40k to keep someone in jail. Good article 9.20 issue in Sacramento.

Maureen: Innovative programs. There will be a pot of money to look at things like this. This is a possibility as well as others and we will take this to you.

Sharon: Explain the medi-caid handout.

Maureen: We have center for Medicaid and medi-care services (CMS), drafting new guidelines. Goal at federal level is to reduce amount of funds coming to states. I say that because they have identified savings as part of their budget package, so we expect fewer dollars.

The information you have is their draft regulations, comments by 10/12. We didn't feel like there was enough time to review it. We gave you Brazelton, and advocacy organization, and we will give you CASRA as well. In CA we have the Medicaid rehab option. We can provide mental health services in a community setting. I am going to really simplify this for time purposes. Regulations are trying to narrow our ability to provide services. Now we can partner, we can provide services in the community. Now if there are two services, only one will be allowed. Narrowing reimbursements for rehabilitation services. These restrictions are narrowing the federal reimbursement and the highlights show the areas they are going to reduce. The action they are trying to do at the federal level is to put a moratorium on these Medicaid reimbursements.

If individuals would like to write a letter we can do that. Not sure if Steering Committee wants to write a letter in this short period of time.

Committee agreed to do this individually and work with their organizations.

Brenda: What does this mean for services?

Maureen: We will have fewer resources to provide services if not reimbursed by Federal government.

Gordon: An idea for housing: sell house back, pay for original housing.

Maureen: There are all kinds of creative ideas for housing.

Facilitator: Today is not the time for housing, but we are recording this and we will review this.

Facilitator: Those were the updates. Focus of today is prevention and early intervention. We are going to review state guidelines, where we are at, and,

Lynne Marsenich from California Institute of Mental Health (CIMH) will give us a presentation on mental health.

Faciliator: We are in planning phase. We are focusing on making this a good plan and not rushing. Expect a plan early next year. Focusing on identifying community needs and mapping those needs to data and current assets.

[5 minute break]

Mike Lombardo introduces Lynne Marsenich. Lynn comes to us with a vast amount of knowledge that we haven't even tapped. She has been with them for 10 yrs., and has a lot of good things to bring to County and State.

Lynne: Let me begin with a little bit about myself and CIMH; a LCSW (licensed social worker), but what drew me is my background in an ethnic, immigrant, and poor community, high levels of violence. I lived in a multigenerational family, my grandmother with schizophrenia and my extended family. And there were no services. No Medicaid, no medical.

I lived in a mining community. Young males without limbs, injured, etc. It is my touch point from where I come. It is my strength, lots of adversity and lots of strength. Use that in my work for CIMH.

CIMH is Sacramento-based, private non-profit. Our primary constituents are mental health community in CA and mental health partners. I work in children's division (4 people). We work with child welfare, schools, etc. We provide technical assistance, program development and evaluation, and large scale research efforts to improve services.

Review of PEI guidelines

What are State Guidelines? So Placer can map back to this.

In transformation effort, lots of folks have lots of good ideas and many do not fall into state guidelines, so it is important to realize this up front.

Thrust is to help specific populations in communities so that mental health disorders don't emerge and when they do, to provide best early intervention programs so that the mental health disorders are less severe.

Key Strategies:

Improve quality: Disparity in access to services. Why does disparity exist? Some we might not be able to do anything about. Some of this has to do with who's insured. The biggest disparity is lack of access to some kind of insurance. That accounts for about 75% of difficulty in getting services.

Psycho-social impact of trauma - victim of violence or child abuse to communities who have experienced this (City of New Orleans). What is the outcome of these events?

At-risk children, youth and young adults - let's be clear about at-risk and we will talk about this.

Stigma and discrimination: There is stigma that any individual experiencing a mental health disorder has. If you are an African American gay male with mental health disorder you have another layer of stigma and discrimination.

Suicide risk: Who is most at risk?

Target Populations:

All ages groups – 51% 0-25 yrs.

- When you are looking to prevent, you are really looking at childhood: what is going on in school, at home, with families.

Underserved cultures: Most underserved Latino and Native Americans (in County and State).

- Asian Americans use services greater than anyone else. African Americans utilize services at high rates if they have insurance.
Disentangling cultures

Individuals w/ early onset of mental illness:

- First episode of mental illness – how you intervene is key, it sets a course for deterioration or not. Very sensitive. Medication, supportive interventions, therapy. Course looks different if you approach it. This is a critical age for young people struggling with onset of mental health disorder.

Trauma exposed:

This is a broad category. Right now biggest groups are young men and women returning in Iraq, highest suicide rate of our troops since Civil War, high posttraumatic stress disorder.

Children/Youth:

(refer to PowerPoint)

Partners:

Schools- Story on school-based intervention. Can't do unless medicare or Medicaid site. Got a list of regulations (building needs to be certified). It was a boost when certification changed to a person and not facility.

Schools - From my own experience it is a place to provide services without stigma. I was a "teacher" in the school to help the kid do better and everyone accepted it. Schools are a great way to give services and see what is going on in the classroom and you have an understanding how to intervene more successfully.

Primary Care- Another place where my colleagues and I think we should have better mental health services. Most people go here for mental health care. Depression is single biggest mental health problem in our society. First place people go to is their doctor and they continue to go to their doctor even when the doctor isn't always the most knowledgeable about the care they need.

Primary Care is also a place where you can cut stigma and discrimination. You are going to see your doctor, not a psychiatrist or an institution, a wonderful place to go to provide and increase expertise on mental health.

Faith based – Great place to go. Some people are nervous about this. The church was a great place to go in my community growing up. No services, and church coordinated the social service needs. Church is accepting of all people. Faith based orgs often have a handle on the needs in the community.

Traditional healers- Sometimes in traditional Asian communities, my sister and brothers both married Native Americans. Interesting on how they use traditional and other practices when there is a difficulty. Very often used.

Early childhood education-

Mental Health consultation, great place for early identification. Families come not because of a problem, but to get information, HeadStart as an example. Center for Child Poverty in Columbia looked at effects of mental health consultations (not programs). It has reduced level of child poverty, as families are eligible for income supports for insurance, skill building and other supports that they don't know they are eligible for. Way of accessing services that decrease child poverty.

Youth at risk programs-

Harder to identify where these exists, Boys and Girls Clubs often are good, after school programs in low income housing facilities. Five days a week after school, tutoring, recreation and meal programs.

Long Term Outcomes:

Reduce school failure – critically important. School success. Reading at grade level and competent in mathematics is best predictor of good life outcomes that we have. If we look at those having difficult early on, you can see what that creates, school exclusion, etc. Highest rates of drop out are kids in foster care (50% drop out). Latino and Latinas dropping out in 9th grade another issue.

Homeless/Long-term suffering:

Effective early intervention; if you have 1 bout of depression you are at 50% risk of a 2nd, you have a 2nd, and your risk is 80% of another, third even higher. So we want to intervene at first bout of depression.

Same with schizophrenia – intervene early and it changes a life trajectory.

Unemployment: High unemployment of those with mental health disorders.

Incarceration:

Removal from home:

- Sometimes child is relinquished to get mental health services

Suicide: Clearly we are trying to prevent this.

Short Term Goals/Evaluation & Accountability

Need to have them, 5-8% on evaluation. Are you spending the \$ you intended to and getting the outcomes you expected. If not, figure out why.

Question: Where is the 5-8% of funds coming from?

Maureen: New state guidelines now, we will look at it. We do not have an administrative budget like the state so we need to look at that. We are going to do an evaluation and we will figure out where funds are going to come from.

Definitions – adopted by state dept. of mental health. We need shared understanding as what is meant by this.

Institute of medicine (work done in mid 90's) looked at 3 levels of preventive interventions.

Universal preventive intervention: Target to whole population (refer to PowerPoint)

Example: mass media campaign. Everyone smoked in my childhood. Then in early 60's surgeon general noted health risk. Started campaign. Targeted our entire society: Nobody should smoke. We have low rates of cigarette usage in

our country relative to the world. Part of it is due to these public health campaigns.

Drug and Alcohol programs in schools are also universal preventive intervention programs. Everyone in elementary school got DARE program in my area.

Selective preventive interventions:(refer to PowerPoint)

Risk imminent or lifetime risk? We know given your experiences you are about to experience depression in the next year. Or, you will experience it sometime in your lifetime.

Elderly have highest rates of depression in our society and highest rate of suicide completions. It is targeted. Solution? Screen everyone in senior centers – selecting out seniors.

Mentoring programs are a selective intervention example too.

Indicated preventive interventions: (refer to PowerPoint)

Lots of short-term trauma interventions done during Katrina incident. Many would not have met criteria of the state criteria, but were at very high risk. Also, children and adults who witness community violence, kids in our mental health clinics that didn't meet diagnostic criteria, but were living in highly violent communities...we can serve those kids using this criteria.

Question: It seems Katrina victims are more selected rather than indicated preventive, so why do you have them under indicated?

Answer: These definitions are often not clear-cut. You can have one segment span some of them. As a public health approach, Katrina victims are subclinical, so we are going to treat it as an indicated preventive.

Question: I'm thinking of kids who grow up in foster care who have lost their family. Are they selective or indicative?

Answer: Could be either. Depends on where you are coming from. They overlap. Kids in that group are at high risk of post-traumatic stress, juvenile justice involvement, etc.

Framework of Risk and Protective Factors (refer to PowerPoint)

Useful for making decisions on who you are going to serve and analyze.

All prevention programs begin with this framework of risk and protective factors.

The first risk and protective work came out of substance abuse field.

Now you see it in health fields (who is at most risk to getting cancer, diabetes).

(What is protective to lower your risk of getting cancer, diabetes, or alzheimers).

Risk factors: In my community: Poverty, violence, no social services programs, no health care.

It's the interplay between risk and protective factors.

Risk and Protective Factors

(refer to PowerPoint)

6 life domains:

Individual: (refer to PowerPoint)

These are categories of risk factors:

- Biological/psychological dispositions–
 - Kids, temperament can be risk or preventive, tend to be that way through life
 - Born with serious health problem or developmental disability
- Attitudes
- Values – you can steal from corporate but not our local grocery store. If you are taught this, it creates a risk factor.

Peer:

Norms – Both risk and protective

- When you have kids getting in trouble, that are likely to be in or are in juvenile justice system, and they are in a peer group that steals, lies, etc. We look for interventions that don't put those kids together.

Activities:

- Adults- heavy drinkers...if you are a group you will not get pressure not to drink that 3rd drink. But if you are in a group of non-drinkers, they may question your 3rd drink.

Bonds:

If you are in a group that is not good for you and you are bonded. This is a huge risk factor.

Family:

If there is a lot of negative it is a risk factor.

If there is a lot of positive that is a protective factor.

Warm and nurturing family relationships are protective against substance abuse, suicide, depression and other areas.

Housing neighborhoods where there is lots of violence and disruption is a risk.

School/Workplace:

Lots of research on school bonding

- Kids who get c's and d's but like to go to school, positive, activities, bonded to school, that is good.
- Other schools, metal detectors to get in, no lockers, not comfortable place to be, Police on premises.. Doesn't create a good environment.
- Low performing schools vs. high performing schools.
- Policies

Workplace:

Stress - many of us experience stress at the workplace. Police, child protective service workers, probation; they are known for high stress. What protective factors are built in?

- Alienation from work – in or out of group
- Climate – predictor for mental health outcomes. “I have an idea,” ...no one says bad idea. “I disagree with you”, “OK, let’s look at it”... openly. Other environments you can only talk in parking lot; fear of losing job.
- Culture - similar to climate - welcoming, be different, and encourage change or not.

Community:

Defined in # of ways, all of you here are different members of different communities:

- Neighborhood
- Church
- Consumer Groups
- Professional Associations

Are these places you want to be, are these sources of support?

Is the norm to support a high level of drug sales/use?

Resources:

Incredibly important, this comes with economics often.

- Community parks (my community has 10 parks with 35,000 people)
 - o Roller skate park, day care center, soccer
 - o Cut down on crime, (soccer lights on until 10pm)
- Health Clinics
- Grocery Stores (some neighborhoods don’t have them – get on a bus and it takes a whole day!)

Awareness/Mobilization:

What is going on in our community with kids? Are you paying attention?

Society:

Again, similar to above.

I went to Norway/Finland last year and what was striking about norms is that folks in those countries have a different view of gov’t.

Norm is government is good and needs to support all people, provide health care, education, etc.

Policies:

Can promote or impinge change,
Universal health care – protective.

Biggest predictor to mental illness is having no insurance (access to services).

Gordon: health promotion activities. Right now there is something on HIV and needle exchange programs. These are things we need to promote.

Lynne: In Norway they have a needle exchange program, no stigma. You go there, get a meal. Not a big deal.

Gordon: We have welcome center in Auburn, would be nice to have one in Roseville.

Risk and Protective factors (refer to PowerPoint)

Sometimes risk and protective change (not static)

An OK kid goes to college – starts drugs and alcohol – factors have now changed.

Be thoughtful when you target your risk factors and build protective factors.

Using a risk and protective factor framework

Ex. Suicide:

Trying to change rate of society.

First look at risk factors...what are they?

Add risk factors from side

The more risk factors you have, the more at risk you are of mental illness (gay, Latino, poverty → high risk)

Ex. Native Americans have trauma: Native lands were taken. Genocide was the norm. People lived on reservations, ongoing experience with discrimination, and high rates of post-traumatic stress disorder.

Ex. People with multiple sclerosis, cancer, brittle diabetics: At risk for depression and mental illness.

Ex. Gay and lesbian youth - The highest suicide attempters among young people are gay and lesbian and Native American youth (triple the average). The highest completers are Native American youth.

Ex. Girls and young women - Depression is a gender disease. Starts in early adolescence, girls have 5 times the rate of depression of boys, and stays true to age 25. Stays true til you move to older age.

Other risk factors (refer to PowerPoint)

Ex. Boys use most lethal means: Guns and automobiles. Boys succeed more frequently as they use lethal means. In Native Americans, both genders have access to lethal means so the completion rate is even higher.

Ex. Clusters of suicides: 9 suicides in a school over 2 months, very contagious.

Ex. Discrimination: Is perhaps the single best predictor of developing a mental health disorder and is a huge factor of suicide.

Protective Factors

(refer to PowerPoint)

The more protective factors you have built up the better.

Consumer: Latino and Asians sometimes have kids with mental illness and keep them in their homes and do not have them access services.

Lynne: That could be protective and risk. Because we know this, how do we deliver services to those families differently? Preserve the protective factors of the families and decrease the risk of getting services.

Consumer: These same groups define mental illness as a physical problem, not a mental problem, Lyme's disease as example.

Lynne: Great comments particularly as they relate to cultural competency. Asians and Latinos somatize (culturally determine), in terms of training and screening, you need to know this and be sensitized to this. Stomachache persistence could be an expression of depression. This is critically important in training of how things are expressed.

Gordon: Medications like Prozac often trigger suicide. Often given for depression but yet cause suicides. I come from a family of suicides and am a brittle diabetic. My sister committed suicide and my cousin as well. Medications in fact sometimes cause the suicide. The last suicide was a veteran who couldn't access services (waiting list) and he committed suicide. Have a center where people can go to it. Develop a regular place to go. Welcome Center in Auburn is good. Again, think another welcome center in Roseville. Wondering if we should work with United Auburn Indian Community (UAIC) and reach out.

Lynne: What we know about medication and this is evolving, and how it may be a precipitant. I've never experienced a bout of major depression but have seen it in my family. Medication may be effective and your spirits rise and you get engaged. But now you have more psychological energy about thinking about suicide. That is where the risk is. Effective medication should be paired with a plan. Seeing someone frequently at first, for example, when you first start medication.

Gordon: Peer counseling, mentorship, these are good things.

Lynne: If your mood is elevating and someone asks you what you are thinking about and you have a relationship with that person, then you can catch this.

Mike L.: In designing our plan we need to be careful not to decrease risk factors so you do not eliminate protective factors.

Katherine Smith: When you talked about underserved groups I have to say they are all underserved. People at my church (Bayside Church), are an affluent group. They are all underserved. None of those kids get follow up care. Doesn't matter how much money you have, or your insurance, the follow up care is not there.

Lynne: Retrenchment of therapy in our system. Has to do with lack of money. Has also to do with erroneous treatments. Evidence is that for some things you would want to try talk therapy before medication. Other times, medication does help in combination with talk therapy. There is a tension with our biological treatments. Medications have improved dramatically. We see students in college now that couldn't be there 15 years ago. But it is not the panacea. Need to support meds with the consultative.

Christina: Someone who lives in an environment and is removed for child protective services. Want to keep as many supports as possible. In the past, you would have removed the person and not asked about their supports and now we do. Want to make sure you reduce the risk and keep the support.

Sharon: MHSA is not tied with hiring of staff. If staff is constantly frozen we are so limited in our abilities. How do we tie it together?

Lynne: You are absolutely right. One of the challenges we are facing now is that the MHSA comes as a great hope. I think that what folks don't understand is that our "other mental health system" has been defunded year after year after year. Programs are continuously being cut. It is an issue that could be dealt with by workforce development. Wish I had a better answer.

Protective Factors (refer to PowerPoint)

Enculturation – Particular to Native American and other communities. Positive ethnic identity is very protective, figure out their ethnic identity. Participation in cultural practices ties to this, kids that go to pow-wows, songs, storytelling, and camps for Native Americans. These are great for ethnic identity.

Brenda: Kids take pills for suicide. Easy access.

Lynne: Often they do not succeed here. Think about the kinds of things they have access to.

Protective Factors (cultural and religious)

Lowest rate of suicide is among African Americans. There is a cultural perception against it. We have been faced with a lot and we do not kill ourselves. Part of the belief system, very powerful protective factor.

Suicide:

If you were to look at a suicide prevention activity and you look at target populations. It is not a good idea to do a shotgun approach. You get little outcome that way. There is money here, but it is not huge and will not meet the whole need in the community.

So, who are you going to target?? Who is most at-risk in your community?

Here are perhaps a few areas where you might want to focus on:

Elderly

Girls and young women – We know they have high rates of depression and within that there are girls and young women that have been sexually abused. You can narrow within this group or not.

Gay and Lesbian

Adults with serious mental disorders – but trying to prevent

Native American Youth

These are overlapping categories. Really think of target population.

2nd question: What is the level of intervention?

Universal

Ex. 9th grade suicide prevention program (kids know who is suicidal, make it safe to talk about it)

Depression screening at senior centers

In conjunction with county-wide public health campaign.

Selected

Care management program for elderly, done out of primary health care.

Surprising that routine health care does not look at this.

We miss depression among elderly a lot.

Aging is about loss, which increases depression, which increases risk to suicide.

Could be social support, someone to talk to, going to dr.'s appointments.

Stephanie: For Health Kids survey in Tahoe we asked how many kids would like information on suicide and prevention and 100% said yes. And for elderly, the majority who had committed suicide had seen a doctor within last few months. So there is some targeted intervention that we could be doing.

Sharon: Girls are more attempters and boys are more completers?

Lynne: Rates of depression are very high for girls 11-25. In terms of a target population, they carry a risk by virtue of their gender. A boy may carry a risk due to other factors and will complete suicide more often due to access to lethal means.

Now you have:

Our target population

Type of programs (universal, selective, indicated)

So, where are you going to do it (locus of intervention)?

Primary care clinics are a great place to do it. (Screens, assessments)

Gordon: You have everything on there but homeless. Do you have data on that?

Lynne: Homelessness, when you are looking at risk factors it is mental health disorder and substance abuse. The risk itself is not homelessness. The risk factors of mental health disorder and substance abuse and loss of employment lead to homelessness.

Domestic violence and divorce put women at risk of homelessness. It is an outcome.

Steering Committee member: Stanford recently did a study. Homeless population was 85% more likely to develop mental health issues and substance abuse after they were homeless.

Gordon: My friend, lost 2 friends to suicide last week, both were homeless.

Lynne: Again, look at risk factors. Hard to target homeless as risk factor with PEI money, with MHSA there are places to target homeless. PEI is preventive. Interfere BEFORE homelessness.

Gordon: TAY in foster care and then homeless? What's up with that?

Lynne: What you would want to target in terms of prevention is TAY risk factors and protective factors before they become homeless. We know that kids that age out of foster care are at risk of homelessness. What are you doing to prevent this?

Mike L.: Talk about the Training for Pro Social Skills program?

Lynne: Targeted to young people, in juvenile justice or on their way, or with drug and alcohol programs. This is an intervention. This would be hard to fund. Even though you are trying to prevent kids going to juvenile justice or more serious

drug and alcohol use. But it is an example of an intervention not prevention. This is complicated. In an integrated mental health system you want to see a continuum.

Gordon: I left home at 14 and was automatically homeless. I was convicted. I've been OK for 30 years. I had mentors, people in prison who helped me. I was on student council, worked at a radio station. I had someone who paid attention to me. From 14 until I went to prison I was homeless. My kid turned 14, moved out. Now not going to school anymore and won't access the services. When you are homeless you can't get to services. Too worried about where you are going to sleep. Not as symptomatic as drug abuse. Once you are out of the house at a young age you are out alone.

Lynne: You described something as a continuum. Let's take your son's example. I'm assuming there is something going on in the home that is not healthy. What prevention would do would start at the home. As you move along the intervention continuum there are other things you can do.

Gordon: Kids misdiagnosed...on ritalin. Stigma and seeking mental health services at an early age is hard. I was diagnosed in 3rd grade. I had my father a PHD and mom as a librarian. My boy's mom left home at 14. It's a cycle.

Lynne: I'm going to push back to "I don't disagree with you around traditional mental health services." PEI is not about that. If you are in 3rd grade and you are having difficulties in school. If there is a program that you are in in 3rd grade that says "all of you" in 3rd grade are going to be in this cool program, that's a Prevention program. If we did that to you, perhaps you might have had a different experience.

Jerrey: Gordon is a lot now like he was in 3rd grade.

Lynne: Returning to locus of intervention
ER rooms – a lot of times it is a suicide attempt, lots of accidents.

Stephanie: Is pregnancy a risk or protective factor?

Lynne: It depends, but it doesn't really show up. It's other risk factors or protective factors that go along with it.

Question: When we are talking about locus of intervention, are those for suicide or PEI in general?

Lynne: PEI in general.

Question: Because my interest is in those kids in foster care that are scattered now, where do I go?

Lynne: Schools. None of us want to be stigmatized. You wouldn't want a program for just "foster care kids", might want to be universal to reduce stigma. Selected might be all kids with x experience.

Gordon: One of the first places it pops up is juvenile hall. There is a generational cycle of juvenile hall to jail. If you give them mentorship...

Lynne: Kids already in juvenile justice system might be dicey. Might want to look at kids before they end up in detention. In Placer County you have (functional family therapy, teaching pro social skills) that are prevention and intervention.

Gordon: I'm saying start with juvenile hall.

Lynne: You would have to figure out how it matches with PEI guidelines.

School: There is legislation AB490 that makes it so that we keep these kids in their home school.

Comment: I want to address what was said about a PEI program. There are primary, secondary and tertiary programs. Again, don't know how terminology works, going into juvenile hall and providing prevention services is prevention in the secondary realm.

Lynne: What are you providing in juvenile hall? Does it meet the guidelines? The goal is to prevent kids from ever stepping into the hall.

[LUNCH BREAK]

Evidence-Based Practices

Lynne continues the meeting with a discussion on Evidence-Based Practices

What is an evidence-based practice? First emerged in medicine, now used in mental health.

Definition: "the integration of the best research evidence with clinical expertise and patient (consumer) values" (Based on the definition used in "Crossing the Quality Chasm: A New Health System for the 21st Century" (2001), by the Institute of Medicine)

Ex. We know in treating depression we have medicine treatments and strong talk therapy (interpersonal psychotherapy and cognitive behavioral therapy). My obligation as a therapist is to tell you my experience in what is effective, but what works for you? Match with the values of the consumer. I want meds, I don't want meds, I want to talk, I don't want to talk.

Brenda: Instead of giving a pill for depression, can you tell how depression happens in the mind? There is a video on how the brain works and how depression happens. Somebody suffering from depression wants to know why is it happening to me? And people don't understand. And many of us don't want a pill.

Lynne: That's what I mean about consumer values. What do we know that is effective and what works for you?

Evidence-Based Practices clinician expertise (refer to PowerPoint)

Take all these things into consideration

Levels of Science = Evidence

Because Evidence-Based Practice is required or mandated, more people talk about their programs being EBP based.

Effective/Efficacious- you get the outcomes you are looking for that come from controlled rigorous research. What caused the change? This is what you are looking for. Flip a coin, this group gets this, this group gets that, and this group did better. And, this group did better because . . .

Gordon: Placer's best evidence-based practice is a new program called, "go to jail, read a book".

Lynne: Not effective. This is very important. Want to find out if a practice is not effective or negative. One area we know...putting juvenile justices kids in boot camp or CYA, they get worse. You are grouping them together. Kids with lower level behavior problems begin to look like kids with higher behavioral programs.

Another example: Adults with psychophrenic adults ...keep them away from the psychi mother. The thought problem was because of mom. We found it did more harm to the relationship (protective). We saw mom being protective and the kid getting reactive and worsening situation.

Promising: Some positive research evidence, quasi-experimental, of success and/or expert consensus

Emerging practice: Recognizable as a distinct practice with "face" validity or *common sense test*

Unknown – Not clearly articulated nor evaluated

Evidence-Based Practices (EBP)

This is not a panacea. You want to go through a thoughtful decision-making process when you look at a program.

Ex. Functional family therapy specific to delinquent and substance abuse kids.

Outcomes: A decrease in juvenile justice recidivism, a decrease use of drug and alcohol use.

Evidence-Based Practices do not work 100% of the time for 100% of the people. Don't oversell it. Appreciate that there might be other alternatives for certain people. Evidence-Based Practices is just the beginning!

Parent Child Interaction Therapy – It's an Intervention for 3-7 year olds and it is meant to prevent too. What about kids who don't fit into the program, what about parents who don't like this type of therapy?

Gail Johnson Vaughan: If you are building on an Evidence-Based Practice, and it is no longer Evidence-Based Practice what do you do?

Lynne: You evaluate it. I believe we have an obligation to always reevaluate our practices. We have done harm in certain instances. If you are changing an Evidence-Based Practice or doing something that is not Evidence-Based Practiced evaluate it.

Mike L.: It's really a continuum of different services. Don't put all your eggs in one basket.

Evidence-Based Practices – Lots of reasons not to do EBP, lots of reasons why (refer to PowerPoint):

Increase hope

Increase choice

Increase individualized care- It is really about this, what works for you?

Improves achievement of outcomes

Reduces adverse consequences of inappropriate care (which leads to hopelessness)

Ex. You need to convince me why someone should be put in a group home for a positive reason.

Achieve outcomes sooner

Outcomes last longer

Ethical – Particularly for involuntary clients (child welfare, juvenile, public schools)

Cost effective

Selecting an Evidence-Based Practices program (refer to PowerPoint)

Ex. of outcome: Every kid reading at grade level by 6th grade??

Gordon: Dept of Justice 64% in juvenile justice have mental illness. Since you have a captive audience, why not do some EBP practices on them while they are in there.

Consider lower levels of science when no alternative at higher level:

Ex. Cambodian refugees that have been through Kamir Rouge as immigrants had high levels of PTS; PTS interventions tend to be based on cognitive behavioral principles. That intervention was used, but didn't work. Had to look at culture ... the trauma rested in (somatic – symptoms occurring as physical)...and evaluated it and tailored the practice to the cultural aspect of the trauma.

Promoted heavily before research:

Ex. The DARE program – widely used in our country and widely promoted, has a lot of support. And evidence shows it is not effective. But widely promoted as effective and lots of money gets spent and there is no difference.

Facilitator: Any questions?

Gordon: Drug and alcohol and crime and say that it is not a crime problem but a health program. How would you use drug and alcohol issues as health problems rather than incarceration programs (criminal justice) with respect to funding—access to MHSA.

Lynne: In healthcare field, drug and alcohol gets treated as a health problem. Increasing as we destigmatize this, there is a movement there. I would also tell you that large amounts of money for drug and alcohol does not come from criminal justices, but from drug and alcohol orgs. Look at how commonly drug and alcohol occurs in our culture and where to provide services along the continuum. I am a Kaiser member and there is low-level drug and alcohol services at low level that are not stigma related.

Facilitator: We are now going to get into small groups (randomly determined) Who is most at risk at Placer County?
What are they most at risk for?

First: Individually answer the questions

Second: Share with your group

Third: Get consensus or agreement around 4 top answers for each question.

DeAnne: I think this was the process we were trying to avoid? I thought we were going to get into data?

Answer: The reason we are not getting into the data today is that we found that, as we were sorting through data, it became very subjective. We want the Steering Committee to drive the needs and we will map data to what you come up with today.

Lynne: You need to ask about your data sources. There could be a huge need with no data. You can then begin to include folks in your data set based on a perceived need.

Committee member: Who is at risk and for what?

Lynne: Each of you have a sense of an at risk population. Then, you think to yourself, at risk to what? School drop out (which is in the guidelines), serious drug and alcohol abuse, having your children removed. These are mental health overlay. From where you sit in the community, you have a “sense” of who you think is at-risk?

Lynne Tarrant: Would it be helpful to look at the outcomes from the state: juvenile justice, homelessness, etc.?

Lynn: You could...to make it easier. Or another way is to not constrain yourself that way, depending on how you write, you may be able to serve in a different way. My fear is that you will be too constrained.

Sharon: When you are going into cards. Can I ask you to prioritize what is most important of 4 cards (We will capture what areas pop up)?

We have a huge MHDAB, I want to see them give us a proposal for substance abuse. They have been dealing with it for years.

Committee Member: Why are we diluting ourselves across the room?

Facilitator: We like to mix things up and have people sit next to people in their area. You have a richer discussion that way.

Facilitator went through process slide: (refer to PowerPoint)

Christina: Last year, there was lots of focus on substance abuse and drug and alcohol. A lot of data showed that it was due to access in their own homes. So, they developed a plan and it was a recommendation and I don't know what happened to that. What data are you looking at?

Facilitator: We looked at: CA Healthy Kids Survey, Community Collaborative of Tahoe Truckee report card, Technical Assistance Coalition needs assessment, Placer County demographic data and Placer County Health and Human Services data.

Comment: Will our ideas get lost?

Facilitator: We will capture all ideas and put up those ideas (4) where there is general consensus for who is at most risk and for what.