Prevention WORKS

A Convening of Southern California Counties

Successful Strategies, Stigma Reduction, Challenges and Solutions

June 2011

County of San Diego Behavioral Health Services Project
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Prevention and Early Intervention

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Acknowledgements

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Riverside County Department of Mental Health generously contributed to the Convening. With their support and vision outreach education materials were uniquely designed to carry the message that "prevention works" which was not only the theme for the convening but at the foundation for Prevention and Early Intervention efforts underway in southern counties and across California. Additionally, we would like to express our gratitude to Riverside County Department of Mental Health MHSA for making the reproduction of this publication possible.

We would also like to acknowledge the participants of the Prevention WORKS convening. They arrived ready to participate in a professional learning community. They brought with them successful strategies, challenges and solutions in implementing Prevention and Early Intervention programs. Participants of the convening provided the quotes and artwork that grace the pages of this report. Throughout the day participants contributed their thoughts and experiences in discussion groups and the conversation café. They wrote of challenges and solutions on cards provided, gave artistic expression to the values, beliefs, and conceptual foundations that guide our shared work.

Thank you.-

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Introduction

Prevention WORKS: A Southern Counties Convening

A Guide on Successful Strategies, Stigma Reduction, Challenges and Solutions

The County of San Diego Mental Health Services MHSA in partnership with Southern California Counties identified the need to increase awareness of prevention and early intervention efforts, and share successes and challenges across the southern region. Their vision was to create an opportunity where all PEI stakeholders including but not limited to, administrators, programs, educators, and community members could engage in a focused dialogue related to prevention and early intervention efforts across counties.

Background

Mental Health Services Act (MHSA)

In January 2005 the Mental Health Services Act (MHSA), originally Proposition 63 which imposes a 1% tax on personal income in excess of $ 1 million, was implemented. The Act provides counties with increased funding for new and expanded mental health services. It combines prevention strategies with treatment strategies as an innovative approach to improve the public mental health system and thus enhances the quality of life for individuals living with serious mental illness.

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI), a component of MHSA, focuses on programs and interventions for all individuals before a serious emotional or behavioral disorder or mental illness occurs. It brings mental health awareness into the lives of all members of the community through education, dialogue, activities, and short term interventions. It emphasizes the need for prevention efforts, giving special attention to children and youth, as well as multicultural and multilingual communities where it's evident there is health inequity. This inequality can be seen through the availability of mental health services, quality of received care, and outcomes of their mental health support and services.

Training, Technical Assistance and Capacity-Building (TTACB)

In 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved five PEI Statewide Projects including the Training, Technical Assistance and Capacity Building (TTACB) Project. The primary goal of the TTACB is to enhance the knowledge and skill set of local prevention & early intervention partners such as educators, law enforcement, and primary health care providers, who serve outside the mental health system.

The Prevention WORKS Convening

The County of San Diego Mental Health Services, utilized TTACB resources to host a one day Prevention WORKS Convening that not only brought together PEI partners from the Southern California Counties, but extended to Central and Northern California MHSA PEI partners, along with representatives from the California Department of Mental Health and California Institute of Mental Health.

These resources were further used to fund the development of this report in which Southern California Counties' leaders and programs shared successes and challenges, strategies on data collection and evaluation, and solutions, are presented.

In the summer of 2010, MHSA and PEI Coordinators representing Southern California Counties including Riverside, San Bernardino, Orange, Imperial, and San Diego formed a planning committee to ensure the convening topics addressed their county needs. On January 26, 2011 their vision came to fruition when over 120 people dedicated to improving the overall health and wellbeing of unserved/underserved populations came together at the ***Prevention WORKS Convening***.

The goals of the Prevention WORKS Convening were to:

- Provide an opportunity for Southern Counties' PEI stakeholders to come together
- Share challenges and successes
- Transfer learning opportunities
- Increase awareness of prevention in mental health

To reach these goals varied processes for eliciting input from event participants were integrated throughout the day. With these specific goals in mind, the day was organized to include presentations from county mental health leaders, data collection and evaluation experts, and representatives implementing a wide array of PEI programs whose emphasis range from stigma reduction to serving children and older adults. The agenda also included opportunities for focused breakout discussions and small group dialogues.

Emerging Themes

Some of the key themes that emerged throughout the day were:

There is immense ***Stigma*** surrounding mental health and mental illness that prevents people from acknowledging they need help and from seeking help. There is also an overwhelming impact society has by placing judgment on people with mental health and/or mental illness. It's a problem of such great magnitude that the World Health Organization was cited by Dr. Chau as considering the stigma associated with mental health as a human rights issue that must be addressed through prevention and early intervention.

Barriers to Access, which in some cases stems from the fact that in many cultures and age groups the stigma associated with mental health needs is so great that people would rather suffer with their illnesses or challenges then to seek and accept assistance and support. In other situations mental health services are not readily available to certain communities.

Lack of knowledge and understanding of mental health issues and mental illness is another area that was commonly mentioned. There is a definite need for increased awareness and creating a sense of acceptance within cultures and across age groups from children and adolescents, to older and aging adults.

Prevention WORKS: How to Use this Guide

This report is divided into three parts. Mirroring the flow of the Convening, Section I highlights information reported on by presenters; Section II reflects information gathered through verbal and non-verbal approaches; and Section III includes checklists to enhance administration, programs, and community connectedness, followed by available resources.

Prevention WORKS: Section I

This section will highlight key areas presented on that we hope can provide new insights, guidance and recommendations for new strategies in the work being done to reach out to underserved and unserved populations in communities across California. Building upon the information presented from the keynote speakers and representatives implementing successful PEI programs, there are many avenues for applying this information to enhance prevention and early intervention efforts.

What Prevention Is

This event began with an overview of what prevention means in the field of mental health as described by keynote speaker, Dr. Clayton Chau, Associate Medical Director, Integrated Services and Recovery, Orange County Health Care Agency, Behavioral Health Services. Dr. Chau laid the foundation for the day by providing an in-depth understanding of prevention, and by discussing the impact societal attitude has toward those with mental illness and their families, to the extent that the World Health Organization recognizes the treatment by society toward individuals and their families as a human rights issue.

PEI…By the Numbers: How to Prove Prevention Works

Being responsible for measuring and monitoring the PEI outcomes for San Diego County, UCSD Health Services Research Center (HSRC) and Child and Adolescent Research Center (CASRC) were asked to present an overview of the system developed to track San Diego's PEI outcomes. Dr. Andrew Sarkin provided examples of PEI outcomes and data collection methods, including a General Outcomes Survey conducted by HSRC. Dr. Fawley discussed measurement challenges in PEI and provided a transferable step-by-step PEI evaluation process.

Prevention at Work in our Communities

A number of southern county PEI programs submitted presentation proposals of which five were selected. These programs reflect different populations from preschoolers to youth in the juvenile system to older adults across southern counties. They varied in strategies from outreaching to children, youth, families, and older adults to countywide efforts. This section expands upon the programs presented and offers an opportunity for readers to apply approaches that may be helpful to similar target populations or a completely different population. Maximize use of the information presented by exploring ways to modify examples presented to fit the needs of the population(s) you are working with.

Prevention WORKS: Section II

This section was derived from the wealth of information shared by participants at the Convening. Whether it was retrieved from chart paper, hand-written notes by facilitators, 3x5 index cards, or

casually drafted on butcher paper during the conversation café, the incredible insights, suggestions, and areas for growth that are provided shows that what the planning committee set out to accomplish was in fact achieved. The information reported on in this guide was drawn from participants during large and small group discussions, and by asking them to respond to pre-written 3x5 index cards at the beginning of the day.

View from the Field

"View from the Field" is a synthesis of input utilizing the information gathered from attendees in response to identifying challenges in implementing PEI and solutions to overcoming these challenges. This section provides examples of challenges confronted and recommended solutions to overcome them.

A Dialog on Improving Systems, Programs, and Communities

From the initial planning stages of the PEI Convening, committee members wanted to create an opportunity for participants to actively brainstorm in a focused dialogue in the following areas of their choice: Administration – related to policy and systems; Program – implementation and process; and Community – inclusion of community and stakeholders. Convening participants were enthusiastic and engaged one another to transfer learning using this process.

Conversation Café

The Conversation Cafés conducted at the PEI Convening entailed a unique process that allowed for a fast paced, high energy, engaging dialogue. MHSA PEI Coordinators and other stakeholders served as hosts and led structured conversations that resulted in fresh insights and innovative thinking.

Prevention WORKS: Section III

A set of checklists is provided, one for administrative policies and systems, another for prevention practice, and the last to guide community engagement, outreach and inclusion. Also provided is a "click and connect" guide to local, county and statewide MHSA Resources.

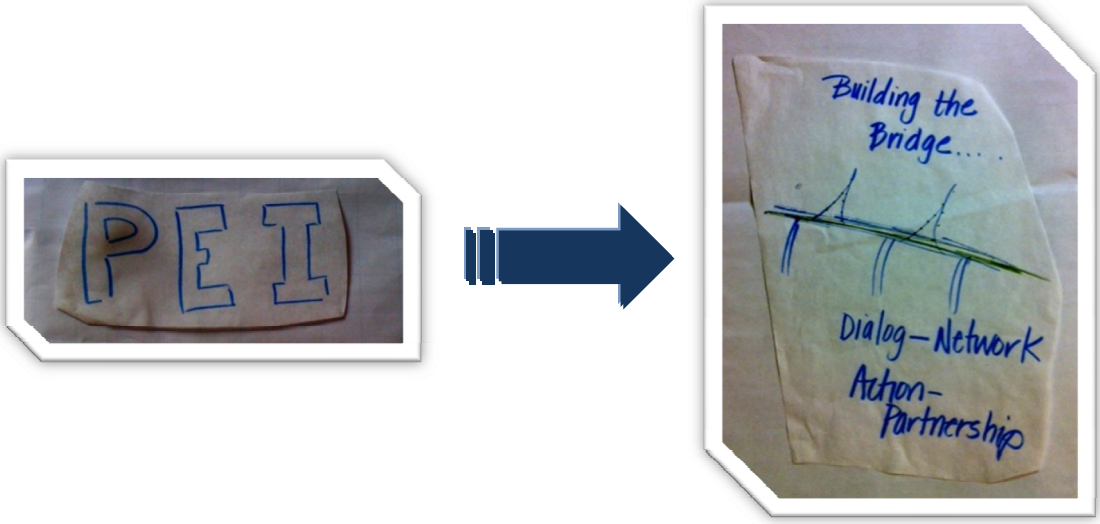
Spotlight on PEI Successes

Successes desired and achieved by participants are highlighted throughout this document. Attendees were asked to write down their *greatest* success with PEI programs. A sampling of their responses reflecting PEI successes that they proudly shared is listed below.

PEI Successes

- Having support groups for family members with loved ones with mental illness - San Diego County
- Parenting programs have made a positive impact – Orange County
- Programs working closely to ensure consumers are linked with all services needed –Tulare County

- Reaching underserved/unserved communities – Solano County
- Families attending our program, benefiting from it and watching then change – Orange County
- Becoming a "house hold" name in just over a year of starting our programs. Doing what we say and saying what we do – San Diego County
- Incorporating Prevention efforts into Middle and High Schools and empowering young people to embrace the issues and provide peer to peer services supported by adults –San Luis Obispo County
- Seeing hundreds of children become successful adults – Riverside County
- Departments, agencies, and staff willing to come to the table in collaborative efforts and working towards more effective PEI – San Diego County
- Working collaboratively with other agencies and department units – Los Angeles County
- Seeing people's lives change for the better because of the services of the PEI programs – San Diego County
- The expertise, resources and willingness to expand outreach in Riverside County, No shortage on passion and knowledge for those in the field – Riverside County
- Helping different systems communicate and work better together, resulting in more satisfied clients and communities – Orange County
- Working with providers to develop high culturally competent and culturally relevant PEI services for the Native American Community
- To have been able to successfully implement "12" PEI programs in 18 months – San Bernardino County
- Linking mental health to overall health – San Diego County
- Patients seeking information – Imperial County
- Launching community wide network of traditional prevention providers and new mental health wellness providers. Our "SLO the Stigma" documentation and media campaign – San Luis Obispo County



Section 1

All About Prevention and Early Intervention (PEI)

Prevention Works: What Prevention Is

The term "prevention" has been used in a variety of ways to refer to a wide array of activities, as Dr. Clayton Chau explained during the delivery of his keynote address. Although the concept of prevention has been discussed for over 100 years, its application to the mental health field is relatively recent. Many mental health professionals and partners are new to prevention, therefore it is important to clarify the meaning of prevention, and more specifically its meaning as related to prevention in the mental health field. When Dr. Chau asked to see a show of hands of those who knew what the definition of prevention means, only a small percentage of over 100 attendees raised their hands. With one of MHSA key elements being PEI it is clear that national and state leaders believe in the important role prevention plays within mental health.

Keynote Address
Clayton Chau, MD, PhD

Associate Medical Director, Integrated Services and Recovery
Orange County Health Care Agency, Behavioral Health Services

The keynote address was built upon a fairly recent global report by the World Health Organization on the Prevention of Mental Disorders, and a national report by the U.S. Department of Health and Human Services, Office of Disease Prevention & Health Promotion, titled Healthy People 2020: The Road Ahead. Dr. Chau's presentation laid the foundation for the Prevention WORKS Convening.

Prevention can be defined as "measures taken to prevent diseases, (or injuries) rather than curing them or treating their symptoms". This is a contrast to traditional health and mental health models, but is aligned with public health methods.

There are three distinct categories or tiers of prevention:

- **Universal** – efforts that address an entire population such as a state, city, school district, school and aim to prevent or delay an illness or problem. Everyone is equally provided with information and the necessary skills to prevent the problem.
- **Selective** – focuses on groups whose risk of developing a condition or problem is above average, as evidenced by biological, psychological or social risk factors.
- **Indicated** – involves a screening process and targets high risk people who are identified as having signs or symptoms that foreshadow mental disorder.

Dr. Chau also explained that there are multiple levels of prevention ranging from primary to quaternary. To better understand what is meant these levels were explained as follows:

- **Primary prevention** – Strategies intend to avoid the development of disease. Most population-based health promotion activities are primary preventive measures
- **Secondary prevention** – Strategies attempt to diagnose and treat an existing disease in its early stages before it results in significant morbidity
- **Tertiary prevention** – Aim to reduce the negative impact of established disease by restoring function and reducing disease-related complications
- **Quaternary prevention** – Set of health activities that mitigate or avoid the consequences of unnecessary or excessive interventions in the health system

Prevention Works and is Cost Effective

Traditionally, prevention efforts have been at the mercy of philanthropists and government agencies for funding support. Moving forward, the vision for prevention is as a shared responsibility. This means that mental health partners must move away from over-reliance on vendor-contractor relationships with government agencies. Globally, the question of who should pay for prevention, meaning whose responsibility it is (as opposed to perceived responsibility) is an ongoing debate.

Determining which partners should pay for prevention, and how much each should contribute, is an ongoing debate. At the same time the cost of health care is increasing statewide, there is increasing competition for shrinking resources. The reality of diminishing resources and support can put prevention, which usually is a long-term outcome, at a disadvantage. When there has been competition for limited funding in the recent past, intervention and treatment efforts are much more successful in securing funding support mostly because it brings more tangible near-term benefits. Economic interests are generally more prominent in the treatment domain than in prevention, resulting in limited investments for prevention activities. Health care providers often do not see prevention as their primary responsibility, especially for interventions that are normally implemented by partners in sectors other than health. Public health authorities and health professionals will need to take a strong leadership role here, even if they cannot find the necessary financial resources within the health sector to implement programs.

Fortunately, in 2004, California's leaders recognized the need to identify and secure resources for prevention and early intervention programs in mental health and millions of dollars were allocated by imposing a 1% income tax on incomes over $1 million. Much of the funding is distributed to county mental health programs upon approval of their plans for each component of the MHSA.

The reality of cost savings from prevention and early intervention are evidenced by examples of major companies that have implemented award-winning prevention programs that are characterized by their cost-savings, health promotion, and disease prevention programs.

Examples of Cost Saving Prevention Programs:

- Motorola's wellness program saved the company $3.93 for every $1 invested
- Northeast Utilities' WellAware Program reduced lifestyle and behavioral claims by $1,400,000 in its first 24 months of operation
- Caterpillar's Healthy Balance program is on track to result in long term savings of $700 million by 2015
- Johnson & Johnson's Health and Wellness Program has produced average annual health care savings of $224.66 per employee

Vision for PEI Aligned with Healthy People 2020

The U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion has articulated a population vision: A society in which all people live long, healthy lives. As it is being planned and implemented in California, Prevention and Early Intervention (PEI) has largely retained, but made slight adaptations to Healthy People goals and objectives.

Objectives of PEI are:

- Increase the proportion of persons with serious mental illness (SMI) who are employed
- Increase the proportion of adults with mental disorders who receive treatment
- Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders

Prevention is a Social and Human Rights Issue

Mental disorders are inarguably a social and human rights issue in that individuals who have mental disorders suffer from intense and pervasive stigma, discrimination, and human rights violations. The very limitation of human rights may in itself be a powerful determinant of mental disorders. It follows that effective prevention measures are designed to promote social equity, equal opportunity and care of the most vulnerable individuals in society.

Cross-System Collaboration and Leadership is Important

In order to create momentum and realize the full potential of vision for prevention and early intervention programs, collaboration between mental health, public health and other sectors is complex, but essential. One potential starting point for this level of collaboration is the dissemination of key messages regarding the evidence of the effectiveness of PEI efforts. (Key messages must be scientifically accurate, but still easy to understand and practical enough to act upon.)

Leaders who are championing PEI need to make it clear that prevention of mental disorders is a public health priority. They must help others to understand that because mental disorders have multiple

determinants, prevention needs to be a multipronged effort reflecting a variety of approaches and points of entry. Effective prevention can reduce the risk of mental disorders, the implementation of which should be guided by available evidence. PEI leaders are encouraged to do more to increase awareness of successful programs and policies, along with knowledge of the evidence-base supporting them.

Since schools have become one of the most important settings for health promotion and preventive interventions among children and youth, leaders from the education sector are critical. There is ample evidence that school-based programs in elementary, middle and high schools can influence positive mental health, reduce risk factors and emotional and behavioral problems through social–emotional learning and ecological interventions (see review by Domitrovitch et al., 2005).

Cultural proficiency in PEI is another front ripe for leadership and collaboration. Prevention needs to be sensitive to culture and to resources available across neighborhoods and communities. Protecting human rights, a major strategy to prevent mental disorders, is a universal goal across cultures.

Summary / Conclusion

Views related to how prevention and early intervention in mental health are addressed are shared by local, state, national, and international experts who draw upon similar conclusions and recommendations.

During Dr. Chau's closing remarks he emphasized the following:

- **Prevention does work!**
- The stigma associated with mental health and mental illness is so significant that it is recognized by the World Health Organization as a social and human rights issue
- Interdisciplinary approaches in prevention and early intervention of mental health is essential
- New capacity, along with fiscal and policy support, is required

PEI by the Numbers: How to Prove Prevention Works

How do we know if what we are doing matters? Systematic evaluation of outcomes provides the data that helps determine the impact of prevention and early intervention programs. Evaluating outcomes allows one to decide what to measure, how to apply what is learned from what is measured, what is important and whether the program is serving the purpose for which it has been put into place. Program evaluation provides accountability and thereby can generate support for future funding by demonstrating a given program's effectiveness.

Dr. Sarkin and Dr. Fawley shine the light on what PEI means…by the numbers. Dr. Sarkin spoke about the importance of program evaluation and described a General Outcomes Survey that is broadly applicable to diverse PEI programs. Dr. Fawley went on to lay out a step by step evaluation process for PEI.

The County of San Diego Department of Mental Health has contracted with UCSD Health Services Research Center (HSRC) to evaluate the Prevention and Early Intervention program and the Child and Adolescent Research Center (CASRC) who evaluates the PEI programs serving children and adolescents. They were selected to speak at the Convening to share (use San Diego's work as an example) their data collection strategies, program evaluations, measurement tools, and pertinent areas they've identified in evaluating complex and multifaceted countywide PEI efforts.

The Contribution of Program Evaluation to Prevention Efforts

Andrew Sarkin, PhD
UCSD Health Services Research Center

Dr. Andrew Sarkin enlightened participants about the importance of program evaluation, and provided examples of statewide outcomes along with methods for measuring them. He also provided information on how to conduct a general outcomes survey and ended his talk on a partnership note, encouraging the cultivation and nurturing of cross-sector relationships.

Importance of Program Evaluation

Program Evaluation is necessary to meet the goals of prevention and early intervention and is of clinical, organizational and social importance. It is one important step in focusing our attention on improving the quality of life for unserved/underserved individuals by creating, refining, and disseminating evidence-based practices on a large scale.

Clinically, evaluation feedback loops lead to continuous quality improvement and help us to implement programs and services with fidelity to the intervention plan, especially with regard to evidence-based practice. Further, evaluation of outcomes captures both intended and unintended impacts, whether planned or not.

Program Evaluation is also important ***organizationally*** in that it demonstrates accountability, fiscal responsibility, and shows whether a particular program or service is cost-effective. Quality and accountability both support future funding opportunities, making it feasible to continue or expand prevention efforts.

System-wide PEI Outcomes

The overall system-wide goals or outcomes of PEI are:

- **Stigma reduction:** *People feeling comfortable seeking help for mental health issues.*
- **Increase in knowledge:** *Individuals in our target communities know more about how to recognize and get help for mental health problems*
- **Increase in access to services:** *Those in need can gain access to the effective and appropriate services they need*
- **Suicide reduction** (especially among the most vulnerable populations): *Prevention of self-inflicted injury or death*

Measurement Challenges

It is difficult to attribute these outcomes to any single program, as other simultaneously occurring activities can impact outcomes. There are multiple PEI programs throughout each county, which sometimes have overlapping activities contributing to accomplishing the same goals. The availability of multiple programs is desirable for their collective impact and reach. However, outcomes also must be measured against environmental changes such as, media campaigns, the economy, and publicized mental health concerns. All of the above variables can cause certain data to be changed or skewed.

Maximize Use of Available Data

Evaluation data is available to help us better understand the long-term trends in the target outcomes. For example, the UCSD Health Services Research Center (HSRC) has had success in tracking ***stigma reduction***, and accompanying increase in consumer knowledge and access to services through use of a community survey. Although ***suicide attempts*** are difficult to track, data from the medical examiner on lethal suicides can provide insight on the issue of reduction.

Data Collection Methods

Using a wide variety of data collection methods allows each individual program to be evaluated on the effectiveness of the program and benefits for the community. Some of the measurement methods for prevention and early intervention programs to consider include:

- **Key Stakeholder Interviews:** Participants, Staff, Community, Stakeholders, Funders, Experts in the field (individually or in focus group settings)
- **Surveys:** Phone, Paper, Computer
- **Objective Data:** Specific data, utilization of services, numbers of referrals, missed days of work due to mental illness
- **System Indicators:** Suicide reduction, Homelessness, Housing
- **Active Investigation:** Random public survey, shown information on topic, then surveyed again to see if response has changed

General Outcomes Survey

Considering the broad variety of prevention and early intervention programs, a common "currency" of measures is needed. For this reason, the HSRC developed a General Outcomes Survey which could be used by a wide variety of programs to evaluate and report on their impact. Developers of the General Outcomes Survey reviewed retrospective data and solicited input from county administration and stakeholders. As a result, they were able to agree on four items that vastly different stakeholders and policymakers could agree are important to unique and different interventions and prevention programs.

The following data points with corresponding questions were agreed upon:

- **Satisfaction:** Was the participant satisfied with the service they received, whether as an intensive 10-week program or a one-session lecture?
- **Access:** Did participants increase perceived access to appropriate services that they are comfortable using?
- **Coping:** Are participants able to cope better because of the PEI service they received?
- **Knowledge:** Did participants increase their knowledge about mental health issues, their mental health literacy?

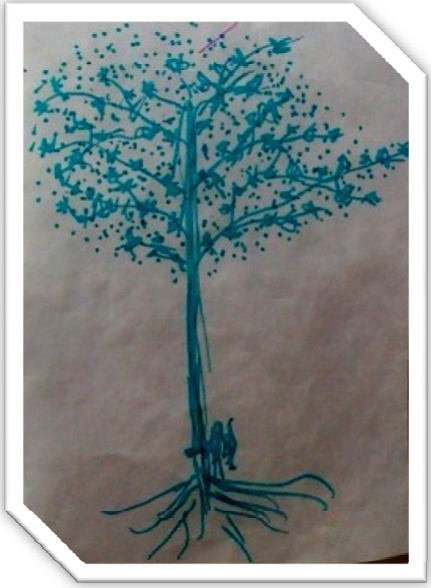
To assist with the collection of data, a centralized data collection and reporting system should be set up. By creating a central secure database with demographic information from the programs, as well as the data from the surveys, a report can be generated to show the positive effects of PEI across the whole county or for individual programs.

Building Relationships

Because the work of PEI is challenging, partners are needed. No single individual or discipline can attain the goals of PEI working alone. Professional networking and the building of relationships is crucial for the sustainability and growth of successful and effective programs. When healthy relationships are built within the community, programs are more likely to have support and reach positive outcomes.

Key PEI partners include:

- All other PEI Programs
- County Administration
- Other Mental Health Programs
- Medical Examiner
- Law Enforcement
- Hospitals and Health Clinics
- Alcohol and Drug Programs
- Child and Adolescent Services Research Center



Outcome Evaluation Process for San Diego's PEI Programs

Kya Fawley, Ph.D and Nancy Calderon, B.A.
Child and Adolescent Services Research Center

Dr. Fawley also made the case for the importance of partnerships in program evaluation, and presented a step-by-step approach to evaluation that is broadly applicable.

Measurement Challenges

One of the biggest challenges of measurement is designing the process in such a way as to ensure programs can find the answer they are looking for. The challenges may be compounded by the multiple types of respondents when collecting data and measuring outcomes. Programs provide services for divergent populations, including youth, parents, elders, military, and others. Evaluation questions that apply to one population may not apply to another. Questions that apply to adults may not apply to children. For example: "Have you ever served in the military?"

It is important for questions to be phrased in a way that each participant can understand and respond accordingly. Measurements need to be designed to give the answers/information/knowledge you are looking for and to make certain data is properly collected.

PEI as the Focus of Evaluation

The complexity of evaluation is heightened when considering the need to measure something that didn't happen, or that happened less than it could have, for example prevention and early intervention. Nevertheless, recent advances have occurred that allow us to use valid and reliable measure to further build the evidence base for PEI.

Evaluation Process

In order to ensure a program is successful and is reaching its goals, a formal evaluation process must take place. The evaluation must be rigorous enough to demonstrate the value of a PEI program by both showing that it works, while at the same time improving the way it works. Although evaluation is useful to document impact and demonstrate accountability, it should also lead to new learning. The goal of PEI evaluation is to enhance the capacity of staff, programs, and agencies. Evaluation is a useful program tool, not an end all by itself. When done optimally, it is conducted as a participatory process that allows for flexibility.

Any effective PEI evaluation process will utilize some or all of the following steps:

PEI Evaluation Process

1. **Meet with Programs**
   - Ensure partnerships are in place *before* evaluation to help in accessing needed records (partners can also provide valuable information on existing data)
   - Meetings should be held in person
   - Statement of work should be reviewed
     - Is the program plan still the same?
     - Were the goals clear and measurable?
     - Rephrase goal if needed
2. **Choosing appropriate assessments**
   - Reliability- same person, same conditions
   - Validity- is it really measuring what you are asking
   - Length
   - Cost
3. **Feedback on assessments**
   - Phrasing of the question is understandable and objective
   - Number of response options

- Length of measurement
- Size of measurement

4. **Translating assessments**
   - Appropriate language used/written
   - Large print
   - Culturally sensitive
5. **Timing of data collection**
   - How often and when should be collected
   - Depending on program goals
   - Feasibility of collecting data
6. **Follow-up**
   - Any issues with data collection
   - Any new components of the program
   - Any challenges with measurements

Prevention at Work in Our Communities

Dozens of successful PEI programs were enthusiastic in responding to our call for papers to present on how their PEI programs are being implemented in Southern California Counties. From those submissions, five programs were selected for showcasing at the convening. Selection criteria included a cross-population focus and diversity among counties, to ensure that participants would hear about unique strategies serving different populations across southern counties.

Five successful PEI programs were selected to present at Prevention Works to share *how* prevention is working in communities and schools, on the ground. Three of the five programs cover PEI across the lifespan with one program, San Bernardino's *(0-5) Preschool Program* aimed at children 0 – 5 years old, Orange County's *Stop the Cycle* targets young adolescents, and San Diego's *Positive Solutions Program* is tailored to meet the needs of older adults. The final two programs, Riverside's *Dare to be Aware* and San Diego's *It's Up to Us* are more universal in scope and speak to increasing awareness while reducing the stigma associated with mental illness in the community. Taken together the following successful PEI programs speak either to implementation with a specific population (micro perspective), or to a broader-based audience (macro).

It is our hope that the information provided by these programs will allow for a transfer of knowledge to be utilized when serving unserved and underserved populations. Please use the PEI program information provided to improve outcomes for your own similar populations and/or utilize their strategies, modifying or adapting as appropriate for your demographic.

(0-5) Preschool Program, San Bernardino County

The program selected to represent the 0-5 population was the Preschool Services Department Program from San Bernardino County. The information below was provided by program manager, Joe Prologo, who shared at the convening the early successes, challenges, and lessons learned throughout their program.

Each year San Bernardino County's Preschool Services Department (PSD) serves approximately 5,900 children 0-5 years of age, pregnant women, and families living in the County of San Bernardino. It operates *Early Head Start*, *Head Start*, *State Preschool* and other programs funded by *First 5*. PSD hold oversight for over 40 center-based sites throughout the county.

In San Bernardino, PEI programs targeted at preschool aged children were developed for many reasons. Program developers were mindful that preschool programs nationwide were receiving a significant number of violations, (64% of these violations were direct result of classroom management issues). This information led the PSD to decide that a specific classroom curriculum for social/emotional development of young children was needed.

In the first year PSD identified 903 children who were documented as having social/emotional challenges, which were directly affecting their ability to succeed in the classroom. PSD collaborated with the Department of Behavioral Health (DBH) to create the Preschool PEI Project and applied for funding to support its launch.

Together, PSD and DBH collaborated to implement the following PEI programs:

- Teacher and Parent Training: The Incredible Years Program
- Grief and Loss: A bereavement and loss "play therapy" group lead by licensed Psychologists.
- Mentoring/Family Therapy An intern program which provides graduate level psychology interns to work with high risk children and their parents and teachers.

Across San Bernardino's PEI programs for preschool aged children, the focus is on:

- Strengthening teaching and classroom management strategies.
- Promoting appropriate social behaviors and school readiness, reducing classroom aggression and uncooperative behavior with peers and teachers.
- Collaboration between parent and teacher, parent and school involvement, and to promote consistency from school to home.

Early Successes

There have already been numerous successes in terms of reach of the Preschool Early Intervention Programs. In the first year alone the parent and teacher training component, *The Incredible Years*, was provided to over 300 teachers and 100 parents; 100 children participated in grief and loss "play therapy" groups; and mentoring was provided to parents and teachers of 300 children. As a result, there has been a 45% reduction in the number of children experiencing social/emotional issues in the classroom and teachers reported being more able to successfully intervene and redirect children.

Challenges

As with any new initiative, there were challenges along the way. In terms of reaching the target audience, it was difficult to engage the participation of some parents whose children were participating in the "play therapy" program. In many cases, the parent was distracted by their own issues related to grief and loss. In terms of implementation support, it was challenging to find and set aside the time to convene and discuss each programs progress, ways to improve, and goal adjustment. There were also issues with consistency of *Incredible Years* teaching staff.

Lessons to Share

- **Curriculum:** A strong and well supported social/emotional curriculum is a key factor.
- **Parent Engagement:** Parents are a significant part of the child's learning experience.
- **Teacher Focus:** Teachers' understanding the importance of re-directing children early and often is essential.
- **Joint Service Planning:** Behavioral plans must be developed with the help of the parent to provide consistency between the classroom and home.

Stop the Cycle Program, Orange County

Stop the Cycle (STC) Program was created to serve immediate family members of youth who are involved in the juvenile justice system. Its design is to help reduce the progression or development of substance or mental health problems in the family.

STC is a 12 week series with 3 essential components: parent education, a children's program, and childcare. Each family member is provided the specific tools they need to build and strengthen their relationships within the family. The curriculum also teaches them to create a lasting network, within their community, that provides support during times of trauma, conflict and overall family problems.

Referrals

Most referrals are made from schools, the probation department, and other partner agencies. Screenings are done by phone and eligible candidates are either assessed by phone or in home.

Getting Started in the STC Program

Initial assessments are conducted in the family's home to build rapport between the family and staff members. The program itself is conducted at the agency and dinner is provided to the whole family. Bus transportation assistance is also offered if needed. Child care is available for children 6 years old and under. Upon early or on time arrival, each family is entered into a raffle for a chance at a prize, thus incentivizing timeliness and active participation. During this meeting other community-based referrals are made according to the family's needs.

Program Components: *Children's Sessions 1-11*

The children's program is conducted in eleven (11) two hour sessions for children ages 6 – 17. Up to two separate age-appropriate groups are formed based on the number and ages of children enrolled.

Children's program topics include:

- Listening and Speaking
- Learning to say NO to trouble

- Negative effects of alcohol, tobacco, and drugs
- Indentifying “safe people”
- Effective communication within the family
- Understanding and properly identifying feelings
- Resources available in the surrounding community

Program Components: *Parenting Sessions 1-11*

The parenting component is also conducted in eleven two hour sessions, with Class 1 serving as an introduction to the program. There is a 20 person maximum in each class to allow for individualized attention. A set of curriculum materials are given to each couple/parent.

Parenting program topics include:

- Understanding and giving love and affection to children
- Providing supervision
- Creating structure
- Addressing inappropriate behavior
- Recognizing drug use in kids
- Choosing proper peers
- Preventing gang involvement
- Understanding the phases of change in children
- Establishing house rules
- Active listening

Program Components: Session 12: Closing Session and Graduation Ceremony

During the first half of Session 12 each group participates in a “Closing” group activity. The group provides feedback to each other and discuses the impact of the program. For the second half of Session 12 all families are brought together to share individual experiences and then to participate in the graduation ceremony.

Follow-Up and Support Services

Stop the Cycle program provides follow-up and support services to the families in the program. They provide these services by contacting the families weekly, via telephone or in individual sessions. Reunions and booster sessions are also provided as part of follow-up and support.

Actual Data from the Stop the Cycle Program

- Number of families: 45
- Number of parents: 51
- Number of children (6-14): 59
- Beginning of the 7th and 8th series
- Statistically significant changes in Pre/Post scores
- Positive feedback from participants and referral

Successes

Thus far in the program, there is evidence of stigma reduction, in that families feel comfortable accessing the program and are more open in discussing issues related to mental health. Support groups have been well received, and participants are showing (via post test) that they are retaining the new knowledge they have acquired. Further, families are actively participating in booster sessions. The program has received positive feedback from probation.

Challenges

Given that all programs face certain challenges, Stop the Cycle has reported challenges within their program as well. Lack of adequate staffing has become an issue along with the availability of community based facilities. Language barriers have also created a challenge between the staff and clients. Thus STC is also looking to improve their referral process and participation of eligibility.

Positive Solutions Program, San Diego County

The Union of Pan Asian Communities (UPAC) is a non-profit organization that provides services to Asian, Pacific Islander, and other ethnic communities. The main focus is on comprehensive health, and services offered are multilingual and multicultural. UPAC developed the Positive Solutions Program (PSP) in order to reach underserved, isolated, homebound, culturally, and linguistically diverse older adults. The program partners with existing organizations in the community such as: Meals-on Wheels North County, Senior Community Centers, and the Vista Senior Nutrition Program.

The PSP encompasses outreach, and prevention and early intervention services for older adults who receive meals delivered through the Aging and Independence Services Program. Overall the program is designed to increase knowledge of the signs and symptoms of depression and suicide risk. The program also aims to reduce the stigma associated with mental health concerns and disparities in access to services.

Thus, Positive Solutions Program goals include:

- Reduce Stigma
- Increase mental health awareness
- Educate individuals and communities

The Positive Solutions Program Design

Program Component	Purpose/Activities
Outreach	▶ Education ▶ Stigma Reduction ▶ Increase mental health awareness
Screening & Assessment	▶ Determine appropriate services ▶ Assess client's needs
Brief Intervention/ Referral to other treatments	▶ Skill building ▶ Empowerment ▶ Create an action plan ▶ Social Support ▶ Reduce risk and symptoms of depression ▶ Maintain or increase self-sufficiency ▶ Access appropriate care ▶ Reduce suicidal ideation and early mortality
Referral to other Resources & Discharge	▶ Continuum of care ▶ Discharge Plan

Assessments provide the staff with the knowledge and awareness of the individual clients needs. Once this assessment has taken place and the needs are made aware of, a screening is provided to ensure proper services are in place to provide the client the best possible care. The brief intervention is designed to increase empowerment, and includes skill building, action planning. Once a client has received support and completed PEARLS, the program provides the individual with a discharge plan and continues support and care when needed.

PEARLS

The Program to Encourage Active and Rewarding Lives for Seniors (PEARLS), a component of the Positive Solutions Program, specifically addresses issues of isolation, depression and suicide among older adults, while improving knowledge and access to mental health care and support. This component of the Positive Solutions Program provides care management and psycho education to reduce stigma and increase mental health awareness for seniors.

PEARLS uses the Patient Health Questionnaire 9: Depression Screener (PHQ-9) to assess their clients before and after treatment. The prospective client answers nine questions regarding their feelings over the last two weeks. They have the choice to answer "Not at all", "Several days", "More than half the days", or "Nearly every day". With possible scores ranging from 0 to 27, a higher score means more severe depression. The PHQ -9 is used in diagnosing depression as well as selecting and monitoring treatment.

Psycho Education Component

Psycho educational sessions generally include 2-4 meetings and are based on the client's individual needs. For example, a 73 year-old Hispanic male who lives with his children presented with diabetes, concern for his wife's chronic medical issues, and was interested in learning more about depression. Following the brief intervention he was referred to his primary care physician for ongoing continuum of care.

Care Management Component

The Care Management program provides up to 5 case management sessions over a maximum period of 3 months. During these sessions, clients work on skill building, modeling appropriate behaviors, and activity planning. Case management services can include, but are not limited to, applying for social benefits and seeking information on appropriate services. For example, a 68 year-old Vietnamese male who lives in downtown was referred by Adult Protective Services. He was socially isolated and fragile. Following brief case management, he was referred to Mobile Physician Services for continuing care.

Success Story

> *"I was laid off and have had no job since 2007. Because of the late payment my telephone service was cut off at that time. In 2009, my electricity and gas were cut off. I lived without electricity and gas for about eight months until the Positive Solutions Program came into my life. I also did not have health insurance, and have not seen a doctor for a long time…I cannot remember how long it has been…I don't have family or relatives living in the US. The Positive Solutions Program helped me to get my Medicare and introduced Mobile Physicians Services into my life. My life has changed a lot because of this program. I now have electricity, gas, as senior ID, insurance, and a primary care physician. Thanks to Positive Solutions Program for their persistence".*

Challenges

Like many PEI programs, the Positive Solutions Program faces challenges in that outreach is limited by stigma, coupled with of lack of mental health awareness, thus recruitment of clients is a slow process. Because of limited resources, building new partnerships can also be challenging.

Outcomes

Since the start of the PEARLS program in November 2009, 501 seniors have been served in the Central Region of San Diego and 286 seniors have been served in the North County. Through cognitive behavioral therapy and other interventions, there has been a significant overall reduction of risk and active symptoms. At the same time, clients are highly satisfied with the program and have endorsed the following statements:

- *I know where to get help when I need it.*
- *I am more comfortable seeking help.*
- *I am better able to handle things.*
- *I feel less isolated.*
- *I have more social support.*

Looking forward, the program is hoping to build on their existing volunteer base, engage in further collaborative efforts, and expand funding in order to sustain the program.

Dare to Be Aware, Riverside County

The Dare to be Aware Youth Conference was created to inform and educate 1,000 Middle and High School students of Riverside County about mental illness. According to recent data collected from the county, 1 out of 5 Americans suffer from mental illness sometime in their lives. Many individuals affected by mental illness face the fear of stigma. This fear may cause them to be reluctant in seeking early intervention and treatment. The goal of *Dare to Be Aware* is to "present an accurate picture of mental illness and to have a lasting impact on the understanding and acceptance of people with mental illness."

The conference is intended to educate and bring awareness to high- risk youth about mental health issues such as substance abuse, suicide prevention, gang awareness, eating disorders, depression awareness, self injury, and teen dating violence. Workshops, which address signs, symptoms, interventions, resources and personal testimonies, are held during the conference.

The conference goals include:

- Increase awareness about the challenges youth face
- Portray mental health issue accurately
- Encourage wellness
- Teach acceptance and understanding of people with mental health challenges
- Provide information about local resources services

Planning

The planning process begins with recruiting a planning committee to organize the conference. Next, collaboration must take place between the county mental health, community agencies, school counselors, and students. Once the general planning of the conference is complete, rules and guidelines for the Art Contest must be set. The art contest is held prior to the conference. Youth from all Riverside County middle schools can submit art work depicting the conference and what Dare to be Aware means to them. The final art work that is selected is displayed throughout the conference.

Below is a sample outline of the Conference Day provided by Riverside County Department of Mental Health:

Dare to Be Aware Youth Conference Activities

- Orientation and Registration
- Explain and resource table
- Opening / Welcom
- Keynote speaker
- 1st Breakout Workshops
- Lunch
- 2nd Breakout Workshops
- Closing

Expected Outcomes from the Conference

Riverside County anticipates that as a result of attending the conference, youth will experience a change in perception and attitude regarding mental health issues, increase in knowledge and awareness about the stigma linked to mental health challenges, and be able to apply what they have learned.

Data/Evaluation

Riverside County Department of Mental Health Research and Evaluation collected data from individuals who participated in the conference. The researchers asked the following question to the participants,

"Did this workshop change your mind/attitude about mental health issues?"

According to Riverside County Department of Mental Health Research and Evaluation, the data collected showed the following results:

- **807 students filled out the survey for the keynote presentation.** However, each student did not answer every question and some students provided multiple comments.
- **88% of the youth agreed that the workshops changed their mind/attitude about mental health issues**. It was reported that the type of change varied from heightened awareness to a new sense of appreciation to an increase in the amount of information they had available to them.
- **6% of the 12%** who did not agree that the workshop changed their mind/attitude about mental health issues indicated that they were somewhat influenced, uncertain if they were influenced or they misread the question.

Riverside uses many methods to evaluate the conference. These methods include, self-evaluations, which are written by each staff member who participated or planned the event, a debriefing meeting with planning committee and all appropriate staff to discuss goals, successes, and ways to improve, along with personal testimony from participants.

Estimated Costs

Cost of the *Dare to Be Aware Conference* held by the Riverside County Department of Mental Health/ County of Riverside/North High School includes:

Convention Center Fee	$ 24,829
Student Transportation	$12,688
Student Materials	$ 2,612
Promotional Items	$ 5,226
Snack Food Items	$ 1,619
Total Expense	**$ 46,974**

It's Up to US, San Diego County

It's Up to Us media campaign was designed to raise awareness regarding mental health illnesses within the County of San Diego. It focuses on empowering people to talk openly about the symptoms, signs, and available resources for individuals struggling with mental health challenges. Its goal is to educate the community, inspire wellness, provide easy access to local services, and reduce the stigma associated with mental health issues.

Research and Best Practices for the Campaign

The evidence base regarding media campaigns indicates that the *It's Up to Us* campaign would have the highest potential for success if it is was:

- Researched based
- Long term
- Multi-faceted
- Sufficiently funded
- Delivered a focused and clear message
- Involved key stakeholders
- Used evaluation results to create future programs

Continuing research and behavioral science suggest that with a public awareness campaign, changes in behavior and attitude are difficult to achieve. However, according to *It's Up to Us*, attitudes and behaviors are more likely to change when strategies target specific mediating and reinforcing factors that influence emotional and behavioral responses to stigmatizing stereotypes.

An example of a person holding on to a **negative attitude** about mental illness:

- Stereotype: Individuals with mental illness will not get better
- Emotional Response: Hopelessness
- Behavioral Response: Do not seek help, remain isolated

An example of a person who holds a **positive attitude** about mental illness:

- Stereotypes: Recovery is possible
- Emotional Response: Hope and empowerment
- Behavioral Response: Participating in life, seeking help, pursing a job, hobby, engaging with family and friends

There are many contributing factors as to why an individual may have a negative outlook and stereotype regarding mental illness. Some of these include lack of knowledge and awareness about mental health issues, cultural differences, age, or gender.

Reinforcing factors that support positive stereotypes:

- Awareness of available resources
- How to provide and receive support
- Support from family and friends
- Available opportunities

Campaign Objectives

The goal of the campaign is to reduce stigma and prevent suicide in San Diego County. It is based on the premise that a community with more support and fewer stigmas towards those experiencing mental illness would help reach this goal. Overall, these three factors must occur:

1. An increase in **knowledge**
2. An improvement in **attitude**
3. A change in **behavior**

Objective 1: Increase knowledge/Improve attitude

- Know where to find information and seek help
- Know how to recognize warning signs for suicide and mental health problems
- Know how to offer support
- Know that recovery is possible
- Know that mental health challenges are common
- Promote social inclusion

Objective 2: Change behavior

- Talk openly about mental illness
- Encourage friends, family and community members to offer support

It's Up to Us was conducted in three phases, with ongoing activities.

Phase 1- Targeted Campaign: Primary Care Physicians and Nurse Practitioners

Goal: To educate primary care providers about the campaign and inform them of specific questions or needs their patients might have regarding mental health.

Phase 2- Media Campaign

Goal: Focus on seeking help, reducing stigma, and mental health awareness within the General and Hispanic market. The mass media outlets included buses, billboards, movie theatres, television, and radio. Community outreach media materials included the production of calendars, bulletins, materials for Health Promotion Specialists, local newspapers, and specific digital stories.

Phase 3- Continuation of Media Campaign

Goal: Suicide prevention and social media integration for transition age youth

Future Campaign Strategies

Goal: On-going and data driven development of new creative messages

Essential Tools for a Successful Campaign

- Effective communication between staff members
- Flexibility
- Never loosing site of the ultimate goal
- Keeping a strict timeline, yet never skipping steps
- Utilizing the most efficient use of media
- Launch media in phases in order to make data-driven decisions in future

Outcomes

Since the start date of the campaign, September 13, 2010, *Up to Us* has generated over 21,000 visitors to the website. There have also been 313 calls to the Access and Crisis Line where the individual specifically mentioned the campaign.

Conclusion

Bringing awareness and knowledge to the community can help reduce stigma about mental health issues, as well as reduce the number of suicides. On-going media campaigns can continue to educate and inform the public of resources and information to help the continuation of success. One person can make a difference and inspire change.

Section 2

PEI Perspective:
Talking with the Experts

View From the Field

Innovation is evident in the field of PEI every day. We know that individuals on the ground, doing the work of prevention and early intervention in an up close and personal way, have a unique vantage point from which to exercise their peripheral vision to explore a wider view of what is possible. Knowing this inspired us to tap into their insight and passion so that others could make use of it in practical ways to improve prevention and early intervention practice and systems.

Upon arrival, each participant was asked to consider their biggest challenge in doing the work, and was also asked to reflect on how they overcame it and what they learned along the way. Thus challenges and solutions in prevention and early intervention were recorded on green cards (Green for "go!" and "Go let your imagination rise above everyday challenges and barriers to see practical solutions"). Participants were asked to write out their biggest challenge on side 1 of the card they were given. This set the stage for solution-finding throughout the day!

We know that there are challenges in what everyone does, so we encouraged participants to network with each other to identify common themes across counties and across programs within any given county. We did this by inviting folks to share freely and transfer learning without concern for confidentiality, thus all identifying information has been omitted from the following summary. Once solutions were "found", or in some cases already known, the solution was written on the back side of the card. Following the convening, we clustered green cards that reflected similar challenges and solutions. Some of the challenges and solutions offered by participants were related to policy and funding (administrative), others to quality assurance or implementation (program), or finally to inclusion and stigma reduction (community). After grouping them together, the themes that emerged (reflected in "headers" in columns on the pages that follow) were surprisingly similar across the target populations, prevention and early intervention programs, and county demographics represented. We combined like thoughts, but retained participants authentic language wherever feasible.

The generous and profound nature of the responses was quite overwhelming. Contributions came from large as well as small counties, from well-established programs and from start-up efforts. Some of the solutions were provided unknowingly, as they provided a pathway to innovation embedded in the framing of the so called problem.

Solutions were not matched to challenges across the board, so questions remain as a part of the process of finding solutions. Although many unique solutions are offered in this report, others are left for you to discover as you continue to think, work through, and discuss with your partners.

Administrative Challenges and Solutions

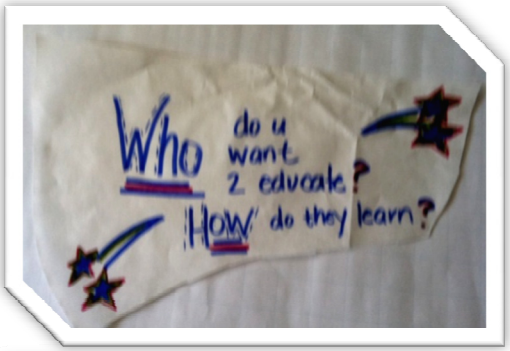
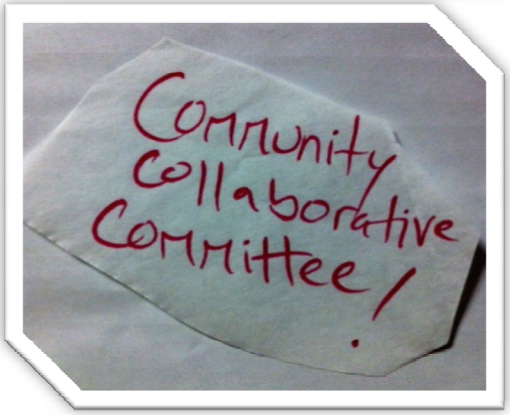
Administrative Challenges	Administrative Solutions by Participants
Statewide Support ▶ Lack of statewide infrastructure and knowledge from DMH	▶ Increase communication with state partners to connect the work at the local, county level.
Implementation - *Administrative* ▶ County bureaucracy and RFP process. ▶ Engaging non-traditional providers in responding to requests for proposals.	▶ Streamline and simplify the process for responding to Requests for Proposals. ▶ Continue outreach to non-traditional providers to engage them as full partners. Provide them with information on how to apply for funds.
Quality Assurance *Data/Outcomes Measures* ▶ Finding outcome measures that demonstrate that prevention is working and making an impact. Many existing measures are also diagnostic or symptom- focused rather than strengths based. ▶ Making prevention work is not a challenge…it is proving it works with obtaining accurate outcome data that is the challenge. ▶ Obtaining accurate outcome data by clearly defining outcomes and measuring them. ▶ Coordinating data collection with programs and county to collect and store data in a uniform way across programs.	▶ Try different data collection methods to discover a fit with the program. ▶ Make it easier to report and gather data. ▶ Utilize outside expertise to work on reconciling state and county outcome data needs. ▶ Develop a highly organized data collection system and educate staff frequently. ▶ Start with brief screening tools and existing measures from evidence-based practices (EBPs) and other prevention programs (e.g. suicide and drug/ alcohol) as well as positive psychology field.
Funding Limitations ▶ Difficult to prioritize with limited funding; too many programs on the "wish list" and not enough money. ▶ County and state budget cuts that impact PEI indirectly (hiring freezes) and have slowed down implementation of programs. ▶ Funding streams often create new programs rather than support existing programs, even models that work.	▶ Make tough prioritization choices based on data. ▶ Try to stay flexible and adjust to changing state and county budget cuts as best we can. ▶ Get better at "making the case" for what has been demonstrated to be effective to sustain funding streams.

Program Challenges and Solution

Program Challenges	Program Solutions by Participants
Implementation Program Roll Out ▶ Limited budget indirectly impacts slow implementation. ▶ While staff are "sold" on PEI in concept, it is difficult to implement PEI programs initiatives due to limits in staff time being allotted and "turf wars." ▶ Staff retention in rural areas: funding is not sufficient to maintain necessary staff levels. ▶ Translation of program material from English to Spanish can delay startup of program.	▶ Maintain flexibility to adjust implementation as required. ▶ More agencies/departments need to designate funding for grant writers, so that staff can actually be allotted to PEI related planning and implementation of programs. ▶ Rethink staffing options—get out of the box! ▶ Assign bilingual staff to translate material.
Identifying Target Population ▶ Because prevention is still a concept that is really being tackled for mental health it is difficult to find innovative ways to promote prevention, as there are so many individuals who are actually in need of mental health counseling and treatment. ▶ Applying the concepts to elders. ▶ Every kid is different. It's hard funding what works for each child. ▶ It is difficult to create a plan to managing crisis prevention, especially with a prevention approach.	▶ "Bite the bullet" and begin to incorporate prevention into everyday practice. Promote prevention as a means of lessening the need for more intensive intervention. Stopping a problem before it becomes a full blown crisis is cost-effective! ▶ No schools should put in place scare tactic programs because I believe they are ineffective. ▶ Focus on education programs, proposing mandatory, training in communications and spotting troubled behavior.
Professional Collaboration ▶ Ensuring open doors, open communication with all vested partners. Installing a sense of "we're all in this together." ▶ Integration of physical and behavioral health services and increasing clinical knowledge in all partners. ▶ The language between Health Care agencies and Evaluation. ▶ Getting support from medical providers to integrate behavioral health and PEI into medical and dental health care.	▶ Attend non-traditional meetings, reading, learning, and sharing this info. Go to (or "crash") 3 events so we can better link mental health, public health and physical health. ▶ Create opportunities for partners to learn about each other; invite representatives to existing meetings. ▶ Know what services are available, what contractors are providing. ▶ Keep talking about definitions and dialogue about their meaning.

Engagement and Retention ▶ It is difficult to help people help themselves. They say they want help, but they don't follow the rules on how to help themselves. ▶ Initial contact and earning the clients trust. ▶ Recruiting/ drawing in clients. ▶ Getting buy-in from faculty and staff. ▶ The need to continue reaching out and knowing if individuals actually get the services they need. ▶ Some clients have lack of motivation to make some changes in their life. It's been hard to deal with those clients who don't have motivation and to increase motivation.	▶ Professionals must show compassion, and follow up on program participant's goals. ▶ Increase worker's cultural proficiency. ▶ Facilitate structured conversations between faculty and staff to surface questions, concerns, and possibilities in moving the prevention agenda. ▶ Adapt "Motivational Interviewing" for a prevention population.
Training and Practice Tools ▶ Not enough delivery tools for educational information and skills based trainings on PEI. ▶ Working with and training staff. ▶ Some providers do not understand peer support and family support provided by trained individuals. They do not have job descriptions for peer support that share their particular gifts. (They are different than clinical skills.) ▶ Understanding the scope and all the terms (I'm relatively new at mental health).	▶ Establish an online learning exchange to post and share training videos, CDs, and DVDs. Also post notices of training activities that are open for participation. ▶ Create opportunities for shared learning with partners ▶ Professionalism and patience. ▶ Mental health, addiction, and co-existing challenges wellness tools presented by peer support specialists ▶ More networking with other agencies to "piggyback" on their trainings.

Community Challenges and Solutions

Community Challenges	Community Solutions by Participants
Barriers to Access ▶ Stigma surrounding mental health interferes when unserved/underserved population is deciding whether or not to access mental health services. ▶ I think the biggest challenge in making PEI work is awareness. Most people who need behavioral health services have a tendency to avoid help, possibly due to pride, shame, etc. ▶ Those affected with mental illness cannot ask for the services themselves. When a family member tries to help HIPPAs laws can slow the process and the person in need does not get the services they could benefit from. ▶ Negative media portrayal of mental illness (Tucson Shooting). ▶ Although the community has many resources they are fragmented. It is challenging to ensure they are updated and listed on key resources such as 211. ▶ Drug use among young adults/teens. ▶ Lack of parent support. ▶ Transition Age- Serving youth over the age of 18, specifically 18-28. The stigmatization of mental health ▶ Lack of services that are culturally and language appropriate.	▶ Refrain from talking directly of the label or name of diagnosis but talk about the symptoms and how they are affecting the prospective participant's daily activities how to cope with it. ▶ Promote awareness of the National Alliance on Mental Illness (NAMI), with materials available in Spanish. ▶ Continuous education is needed, especially in more rural parts of the county.  

A Dialog on Improving Systems, Programs, and Communities

For the PEI vision and goals to be fully realized, systems, programs, and the community must work together in new and previously unprecedented ways. This section of the report is essentially a user-friendly pull-out tool created by conference participants who were given the opportunity to engage in structured group discussions related to one of the following areas:

- **Administration**: Policy-setting and system-wide structure
- **Provider/ Program:** Implementation and process
- **Community:** Inclusion of community and stakeholders

These focus areas were determined by the Southern California Counties during the planning of this convening. The purpose was to narrowly focus each individual's perspective during the discussion in order to isolate and amplify each component of the overall PEI initiative. Asking participants to "look through the lens" of one of these focus areas (regardless of their current role) allowed for attendees to have a voice in improving policy and system-wide structure, implementation and processes of programs and increasing community and stakeholder inclusion. For example, a provider may have chosen the administration discussion group in order to discuss what PEI policy *should* look like from a provider perspective. An administrator may have chosen the community discussion group to explore and test ideas about reducing stigma and discrimination through inclusion strategies.

Led by a facilitator, each discussion group was comprised of approximately 20-25 people per group representing large to small counties, urban to rural across California from K-12 and post secondary education, and various community stakeholders, the private sector, mental health providers, county mental health administrators and personnel.

Each group was asked the following:

- How can you apply the strategies presented to underserved communities in your county?
- How is data being used to highlight programs in your community to demonstrate that prevention works?

The discussion highlights that follow represent a summary of how each group responded, the "headlines" of common themes across participants, and a description of the kinds of comments that were offered within each section.

Integrated Summary

Question #1: *How can you apply the strategies presented to underserved communities in your county?*

Administration Perspective *Policy and system-wide structure*	**Program Perspective** *Implementation and process*	**Community Perspective** *Inclusion of community and stakeholders*
From the administrative perspective, in order to apply the strategies presented to serve unserved and underserved communities, policy makers and administrators would need to resolve issues related to local flexibility, closely look at and possibly adapt the prevention framework and definitions, clearly identify the intended service population, negotiate funding and responsibilities with key partners, and do more to get the word out on services that already exist in order to maximize access.	From a providers/program perspective, implementation would require thoughtful, targeted outreach; a clear process for engaging and retaining individuals in the program, consideration of program components that are a match for our priority populations, and a quality assurance mechanism to ensure model fidelity.	From the community perspective, there were several program ideas that were intriguing and had potential for immediate application to inclusion of the community and stakeholders. Discussion participants offered inclusion strategies that ranged from engagement of community leaders to peer-to-peer support.
Critical Factors		
▶ County Flexibility Factors ▶ Framework for Policy Setting ▶ Partnership Interface ▶ Promoting Access to Services (New and Existing) ▶ Target Population	▶ Program Outreach ▶ Program Retention ▶ Program Focus ▶ Quality Assurance	▶ Program ideas that resonated ▶ Inclusion Strategies

Administrative Perspective

Policy and system-wide Structure to better serve unserved and underserved populations

County Flexibility Factors

County flexibility factors are critical because of the wide divergence in population characteristics, assets and resources, and leadership style from county to county, and in some cases from city to city or community to community within the county itself.

Participants said…

- *The community who could benefit from PEI services is spread across a wide geographical area. Some residents live a long distance from the clinic.*
- *The current budget allocation is low due to the depressed economy and qualified political will to support the prevention population.*
- *Size of county, staff is an issue in determining the population to be addressed*
- *There is broad cultural and linguistic diversity within the county*
- *At the elementary level, all kid-supporting programs were cut from the budget, so funding is an issue*
- *The target population in some counties is very isolated and/or there are no services available*
  - *County funded programs only target a certain population*
  - *Look for interns for outreach to isolated population*
  - *Programs need to be flexible when another population is found*

A **Framework for Policy Setting** supports PEI goals and outcomes by providing parameters for implementation.

Participants said…

- *Categories and levels can help with a cross-walk to indicators we established, some of which might be combined within this framework.*
- *Clearly identify what prevention is and create an intervention framework.*
- *PEI guidelines need to be flexible and clear. "What is short term intervention?"*
- *Look at medical/environmental approach to PEI. Prevention happens way before it occurs.*
- *Base PEI policy decisions on evidence-based practice; require valid and reliable curriculum.*
- *For long-term sustainability, PEI policy must require long term studies.*
- *PEI policy should emphasize universal prevention.*

Partnership Interface

When you talk about partnership, we really have to think beyond traditional partnerships to expand in unchartered territory. In the work we are attempting to do across all spectrums, cultures and age groups, we must reach out to those who are truly unserved and underserved, while recognizing that we

cannot do it alone. The true depth of what we can accomplish will be measured by tapping into the valuable human and fiscal resources around us. We must also become trained and intentional to recognize the value of resources we would otherwise overlook.

Participants said…

- *Partnership is important. Which partners are able to tap available funding to serve the target population? How do we count clients?*
- *We should require training for county and Family Resource Center workers. Integrated learning is essential for consistency.*
- *Solid collaboration with military and police is an area in which to build further bridges.*
- *Make mental health more multi-cultural in nature, intergenerational, cross departmental, and foster more collaboration between agencies*

Promoting Access to Services (New and Existing)

From the administrative perspective, we must consider whether there are systematic barriers to access.

Participants said…

- *Resources are available. How do we get providers to know that they exist and make referrals? Communication is needed!*
- *The environmental piece is important. We must address stigma of all kinds in mental health so that those in need will be more likely to access services and supports.*
- *Outreach to community leaders will educate broadly and increase awareness of existing PEI services.*
- *Peer support training will connect staff and encourage outreach to the underserved and underserved population.*
- *The translation of outreach materials is a challenge. More threshold language materials are needed.*

Target Population

Administrators play a role in shaping the conversation around who should be served—who the actual unserved and underserved populations in each county are. A primary challenge will be shaping a policy agenda around such diverse populations across cultural, ethnic, and age—children, youth, and elders. Better serving underserved populations may require systems change around directing or redirecting resources. Mental health should target or have a policy requirement to reach out to high school graduates.

Participants said…

- *Mental Health "first aide" (support and intervention at the first signs of risk) should be provided for high school students.*
- *Structurally we cannot hope for all PEI success to occur between the hours of 8:00 am to 5:00 pm. Service hours need to be available all the time.*

- *Structure PEI to provide mental health education in primary and secondary schools.*
- *To be clear on policy, we must identify what "underserved" means within PEI. Various partners may define "underserved" differently.*
- *PEI programs must be structured to address Arabic and Muslim stigma (which is largely cultural and pertains to mental health in general), as these population tend to fear coming to a government agency for "help".*
- *PEI policy around elder program outreach can also be challenging, particularly with those of high status. The PEI system-wide structure may need to undergo a culture shift to look at older adults in the context of ethnic and generational cultures*

Program Perspective

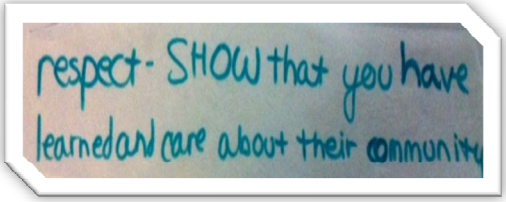
Implementation and program processes to better serve unserved and underserved PEI populations

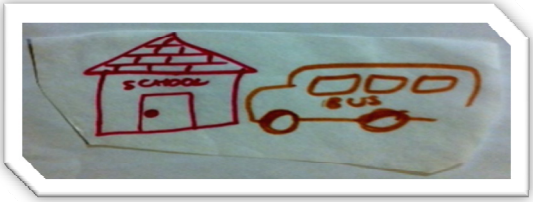
Program Outreach

In this focused discussion breakout group, a wide range of outreach perspectives was discussed, including who (what target populations) to reach out to and how to go about conducting program outreach.

Participants said…

- *Use information gathered at the PEI convening to see that 0-5 population receives appropriate training.*
- *We will engage in greater outreach, and spreading of program information.*
- *We can identify community leaders and provide training to them so that they can inform members of their community.*
- *Also we need to look at underserved communities that were not presented during the convening, such as Native Americans, single parents, first onset, etc.*
- *Creative thinking is needed to expand prevention programs to reach more individuals, including creative ways to talk about what we are doing.*
- *Use the definition of PEI discussed at the convening to redefine prevention for those we serve.*
- *Common language, definitions can lead to greater communication between CPS and in-home support services.*





Program Retention

For prevention and early intervention to take place, programs must identify individuals and families within the target population who are in need of support. Once identified, they must be engaged in a meaningful helping relationship so that they will continue to participate in the program and thus receive the full benefit of their participation.

Participants said…

- *Engagement with whole families is key!*
- *Make use of TIY to involve parents.*
- *Use incentives within the program to engage program participants.*
- *For long-term retention we need to meet client where they are at; this includes providing continuous support*

Program Focus:

Members of this discussion group had varying ideas about what the focus of a PEI program in their community should be.

Participants said…

- *Focus on psycho-education on mental health and advocacy to empower the voice of the consumers.*
- *PEI programs should focus on raising awareness of community resources*
- *One point of entry for a preschool PEI program is stages of grief; help children learn to express their feelings.*
- *PEI programs should create space for a dialogue about what stigma looks like in order to reduce it.*
- *Focus on stages of grief for newly diagnosed clients.*
- *PEI programs should have a peer component.*
- *Part of every PEI program should be structured follow up.*
- *Look at social/emotional development as the centerpiece of the PEI program.*

Quality Assurance:

Participants in this discussion group were clear that quality assurance is a major factor for PEI. They had a wide range of ideas regarding how to implement quality assurance.

Participants said…

- *PEI programs need to focus on improving fidelity with specific populations they serve.*
- *Balance fidelity (research) with meeting needs of lower-income Hispanic clients.*
- *Train providers on how to effectively data collection. Highlight the importance of data and its value.*
- *Secure and disseminate measures in threshold languages.*
- *Think through long term follow-up to measure impact. We need to think about how we come up with meaningful data.*
- *Use suicide data from Healthy 2020 for planning purposes.*
- *TIY provides a good example of how to measure for long term results. Be sure to factor in educators time for data collection and data entry.*
- *Translate PEI program material as needed; this is a measure of cultural competence.*
- *Need universal PEI measures.*
- *Make sure data that is collected is valuable and meaningful.*

Community Perspective

How to promote the inclusion of community and stakeholders in serving unserved/underserved PEI populations

Inclusion process

During the discussion, participants applied program models to inclusion in the following ways:

Participants said…

- *Use Dr. Sarkin's model/questions to apply to Native Americans*
- *Working with Seniors along the lines of the PEARLS Program*
- *Utilize community members and stakeholders to promote and advocate for social/human rights*
- *Interact with the whole person/community; Don't look at individuals as merely "clients"*
- *Serve the family as a whole, not just the "identified" child. Build rapport with family.*
- *Provide dinner, transportation, appropriate times of service, go to the family's home as needed to promote inclusion.*
- *Use an interdisciplinary approach such as the 5 stages of prevention model*
- *Use local celebrities to help promote PEI programs*
- *Work with youth and their family, as in the Parenting Project*
- *Expand outreach efforts.*
- *Individual who identify themselves as Lesbian-Gay-Bisexual-Transgender-Queer (LGBTQ) don't tend to seek out services; but advertising services can be effective in reaching them.*
- *Conduct more outreach to educate individuals and the community to reduce stigma.*
- *Following early recognition of symptoms, implement Mental Health First Aid*
- *Tailor services flexibly to be income/culture specific, not all oriented towards the middle class.*
- *To become more inclusive, we need to address clients who are inappropriately served, in addition to underserved.*
- *Make connection between services and skills that a client can gain.*
- *Make it possible for whole families to have easy access services.*
- *Outreach-how much is done? Funding is not balanced to allow for the amount of outreach that would be beneficial in promoting inclusion.*
- *Be sure to look at substance abuse and mental health as separate, not one single illness.*
- *Hold programs accountable for outcomes and let the community know it, making them more likely to participate in services.*
- *Program staff needs to be well trained.*
- *As defined in the universal tier of prevention, go into the community. Don't try to do outreach from your office or clinic.*

- *Do not assume we know what clients want or need. We must ask them directly and respect what they tell us.*

Programs and ideas that resonated

Participants were excited about the practical tools and tips they were able to glean from the convening. The following are a few examples of programs they felt did a good job of promoting inclusion:

Participants said…

- *Dr. Chau's presentation gave me so many ideas that I hadn't previously thought about!*
- *The Positive Solutions Program made me think about:*
- *How important it is that staff can relate to clients*
- *The value of "Promotoras"- Peer to peer aspect*
- *Creative outreach through use of mentor/advocates*
- *How the PEARLS model educates the whole family about the "system"*
- *The "Incredible Years" program works because it targets the first 5 years and is universal/readily available. It also has program elements for parents and teachers.*
- *Mental Health "First Aid": Decrease stigma while increasing a caring environment*
- *Parenting project- working with youth and family*
- *How is "selective prevention" different than intervention?*

Integrated Summary

Question #2: *How is data being used to highlight programs in your community to demonstrate that prevention works?*

Community-based Evidence	Program Evidence	Administrative Support
Through the lens of community, there was discussion of the value of client involvement in the process of gathering and evaluating data to show that prevention works. Their authentic voice "tells the story" better than numbers can. The community perspective also focuses on cultural proficiency in gathering evidence to insure processes and tools are respectful and culturally appropriate.	In using data to show that prevention works, providers tended to focus on PEI indicators and preferred evaluation tools during their discussion. They also elucidated general methodology, including self-report, pre- and post-testing, surveys, and integration of multiple measures.	Administrators set policy and provide the resources staff needs to gather data to show that prevention works. In their discussion, administrators touched on the need to look at integrated data systems to facilitate the appropriate sharing of information, and also looked at policy guidance as to the parameters of data gathering.

Community Perspective

Evidence that Prevention Works

Participants said…

- *Include clients in the evaluation process. Their involvement and authentic voice is crucial to getting good results.*
- *Surveys help us to collaborate with providers and thereby "inspire hope".*
- *Hard to have one survey for all populations.*
- *It is a struggle to capture data accurately.*
- *Make sure tools are culturally appropriate or don't use them.*
- *Considering the diversity of our clients and communities, it is a challenge to collect demographics in a respectful and accurate manner.*

Administrative Perspective

Support for Gathering Evidence that Prevention Works

Participants said…

- *We created a database which will be disseminated to community providers.*
- *We set policy that data be collected at Intake and Follow Up (at a minimum.*
- *Administrators have a role in analyzing data and using data for program improvement.*
- *Selection of culturally appropriate tools that measure impact with validity and reliability.*
- *Generate funding support to improve long term sustainability by conducting long-term studies.*
- *Emphasis on universal prevention.*
- *Data collection that reflects on how we know the PEI program works, not just quantitative data.*
- *Make sure data that is collected is valuable and meaningful.*
- *Adapt measures based on other project's statewide outcomes.*
- *Integrated source systems (Management Information Systems).*
- *Training for work force staff to understand and value data, and to collect it reliably.*

Program Perspective
Evidence that Prevention Works

Participants said…

General Methodology:

- *Multiple measures-some validated, some program-generated; Pre and Post testing.*
- *Cases are turning over, which adheres to EBP timeframes for reduced length of time in treatment.*
- *Staff should document activities in case notes.*
- *Our intake forms are designed to gather baseline data.*
- *Self reporting is our primary evaluation tool.*
- *We conduct qualitative research.*
- *It would be great if information from surveys could help with specific reports; right now the two are disconnected.*

Preferred Evaluation Tools:

- *PSI- validates outcome measures to measure change*
- *MORS-done quarterly*
- *CBITS (Cognitive Behavioral Intervention for Trauma in Schools)*
- *We measure impact via the Patient Health Quality Assessment*

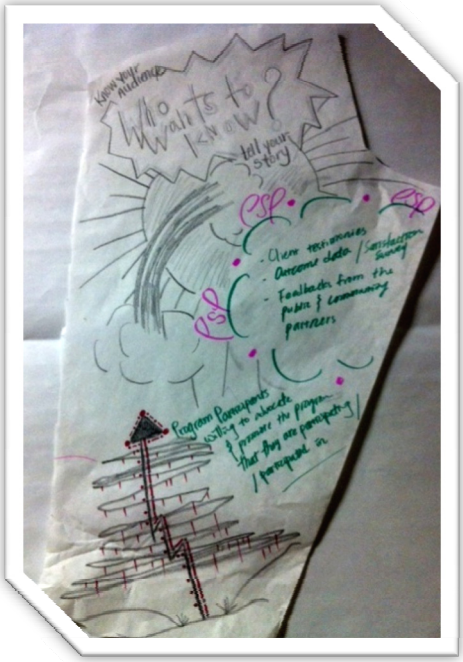
Indicators:

- *Improvement of cost savings in health savings.*
- *Increased awareness, decreased stigma.*
- *Increased self reliance, decreased use of other systems*
- *Improved overall wellness, including increased physical health and family structure/ relationships.*
- *Increased number of referrals and use of community resources*
- *Decreased school drop outs, suicide attempts*
- *Core competencies of staff and providers; we are also able to track competencies that clients acquire.*
- *Employment is tracked and used as a long-term indicator.*

Conversation Café

Conversation Cafés are structured conversations designed to engage people in a fun, inviting, open, dialog where creative thinking generates new ideas with broader solutions. As with any facilitated discussion, selecting the right facilitators, referred to as "hosts" in Conversation Cafés, is key to ensuring discussions are fun, inviting, open, and inclusive, generating new ideas with each group. As we mentioned at the beginning of this report, many of the Southern California County MHSA and PEI Coordinators and their colleagues served as hosts of the 15 small group conversations that took place.

This unique activity entails hosts remaining at their table while groups rotated every 10 minutes. Each host was given a pre-determined question for groups to respond to. Beginning with the responses given from group 1, the hosts' engage each subsequent group by initiating the conversation building upon the key points from the groups prior. Participants remain in their groups as they go from table to table ensuring everyone has an opportunity to respond to each of the questions. The questions attendees discussed are listed on the following page.



Each Conversation Café table had butcher paper laid out like table cloth for participants to doodle freely during conversations.

Following are the questions that guided the conversations:

- How do you educate the community on available PEI Services?
- How do you reach underserved communities?
- How do we do it?
- How do you reduce stigma in underserved communities?

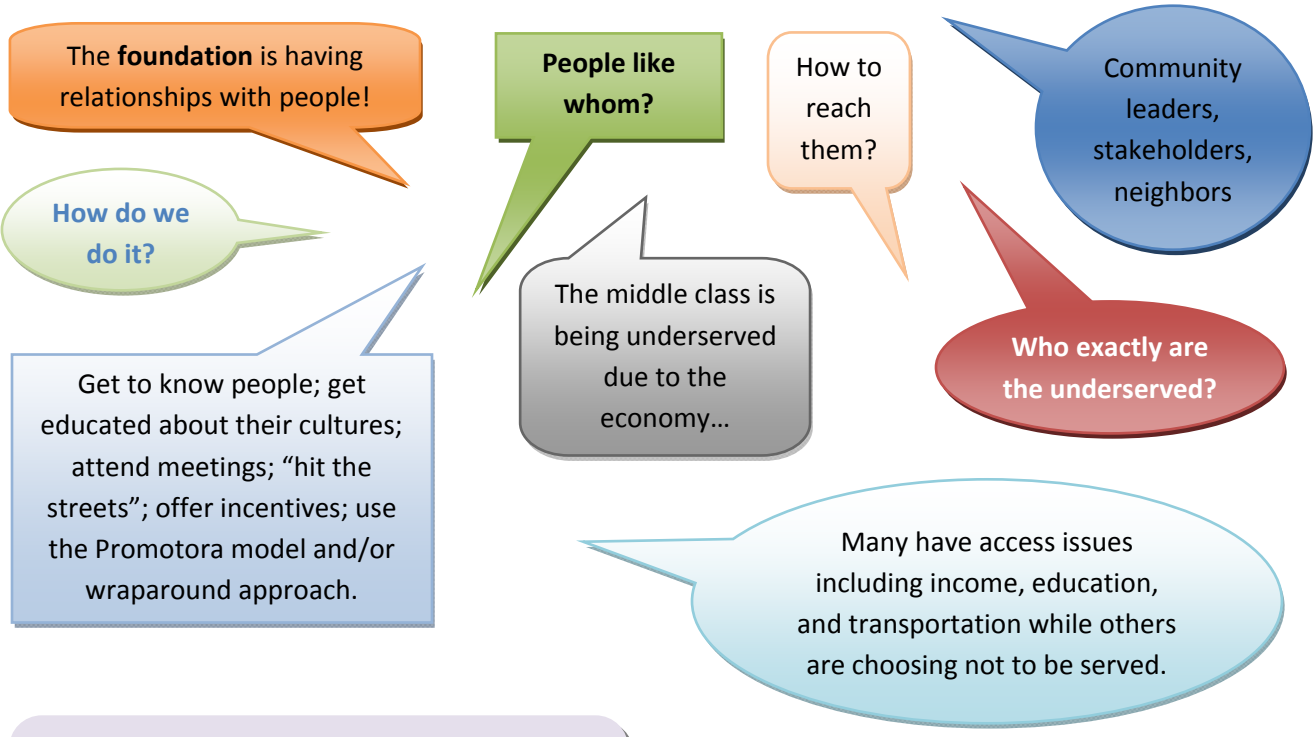
All materials were collected, reviewed, and transcribed. Natural themes emerged from the discussions multiple groups engaged upon in response to each of questions presented. For this section we opted to convey the creative ideas and exploration of thoughts by selecting fun, colorful themes to highlight suggested areas for action that resulted from great discussions.

Conversation Cafe

How do you educate the community on available PEI Services?

Conversation Cafe

How do you reach underserved communities?



Develop a community-based approach

- Grassroots efforts are needed to reach underserved communities. The Promotora model is effective because it creates community where communities did not exist before. Translate this model for other cultures. Not just training on mental health topics, but also advocacy.
- It is important to build relationships with community leaders; those in a position to influence others.
- Open up free community workshops.
- Identify gatekeepers and train them to identify individuals with mental health problems and provide them with resource lists. This includes mail carriers, pharmacists, etc.

Be on a journey towards cultural proficiency

- Communities have layers within them and not every layer gets along, for example clans on reservations. Therefore it is important not to "clump" together everyone in a community.
- Recognize that individuals respond differently to "government workers".
- Go where people are in the community. Use language that fits their culture.
- Work with communities to identify what will work with them vs. telling them what works.
- "Be humble learners".
- "Stop judging first".

Conversation Cafe

How do you reduce stigma in underserved communities?

How to we get to a point where stigma is insignificant in underserved communities?

Peer to Peer Outreach

- Utilizing peer to peer model. Individual vs. universal services. Utilizing peers with similar backgrounds especially for isolated rural communities. Similar cultural/social/economic/language/education. Using Promotoras to deliver services to the Latino communities.
- Professionals increasing consumers in traditional treatment. Including consumers in treatment teams.

Community Involvement

- Providing locations of service that are not stigmatizing.
- Introducing Mental Health issues in early education in the schools. Mental Health issues bearing same weight in school curriculum as other health issues.

Use of Media:
How Mental Illness is Conveyed

1. Embracing Public Health Frame – (See report on Usin PH Model for MH: Quality of life)
2. Working with Media/Hollywwod to portray positive images of Mental Illness.

Government

- Work to change at a higher system level. Policy change will impact behavior and attitude change
- County and State acting as role model for community , setting standards for policy language and creating an de-stigmatizing atmosphere for consumers.

Educate and Train

- Training entire agency, front office staff, regarding welcoming strategies “validating their stage in mental illness”
- Training community business, other non-mental health business regarding mental health.
- Educating supporting family, friends, workplace, school, and community about recovery
- Peer Panels at Staff trainings. Consumer voice informed trainings. Using consumers who are moderately successful.
- Increasing successful stories of recovery.
- Not holding thresholds for success when speaking about recovery

Cultural Sensitivity

- Consider language when marketing/branding services to underserved communities.
- Making it acceptable to seek MH services, increase initial access.

Conversation Cafe

How do you leverage resources to enhance services?

Bring Partners to the Table

- San Luis Obispo was able to bring the information into youth programs and begin mental health conversations.
- Build on partnerships
- Get people in the same room
- Make sure that organizations with similar goals know about each other
- Create forums to share knowledge
- Have all county mental health provider meetings
- Have a supportive infrastructure-meetings need to have a purpose and next steps should always be developed
- Cross training and collaboration with non-traditional partners
- Need to identify who is missing from the table. Need medical professionals, firemen, police departments, and teachers

Cross-Train & Work Together

- Cross training and collaboration with non-traditional partners
- Train the workforce outside of behavioral health
- Share resources and data more freely
- Lose the competition and work together
- Cross training

"Check" Ourselves

- Need to reduce the stigma that exists in us, the "helpers"
- Need to be less "rule" bound
- Communicate more and share more resources
- Resources = money + manpower; not enough money means an attitude of "I would love to help but I need a job"

Diversified Resources

- Funding makes us competitive; look for an evidence based program/practice and give it to a senior prevention program with enough money for them to subcontract for all the necessary components to stop competition
- Consult with a counsel of elders and counsel of youth to tap into the real reasons for life's problems.
- Utilize personal strengths
- Ask consumers to identify resources needed and available in the community

Section 3

Next Steps in Prevention WORKS

PEI Prevention WORKS Checklist

Administration: Policy-setting and system-wide structure

- ☐ Allow for **County Flexibility Factors**, which are critical because of the wide divergence in population characteristics, assets and resources, and leadership style from county to county, and in some cases from city to city or community to community within the county itself.
- ☐ Develop or adopt a **Framework for Policy Setting** that supports PEI goals and outcomes by providing parameters for implementation.
- ☐ Invest in **high-performance partnerships** by thinking beyond traditional partnerships to expand in unchartered territory. Reach out to those who are truly unserved and underserved, while recognizing that we cannot do it alone.
- ☐ Design simple, user-friendly, streamlined process for responding to Requests for Proposals
- ☐ Engage non-traditional providers in responding to Requests for Proposals.
- ☐ Continue outreach to non-traditional providers to engage them as full partners. Provide them with information on how to apply for funds.
- ☐ Find outcome measures that demonstrate that prevention is working and making an impact.
- ☐ Try different data collection methods to discover a fit with the program.
- ☐ Make it easier to report and gather data.
- ☐ Utilize outside expertise to work on reconciling state and county outcome data needs.
- ☐ Develop a highly organized data collection system and educate staff frequently.
- ☐ Coordinate data collection with programs and county to collect and store data in a uniform way across programs.
- ☐ Get better at "making the case" for what has been demonstrated to be effective to sustain funding streams.
- ☐ Make tough prioritization choices based on data. Maintain flexibility to adjust to changing state and county budget challenges.

PEI Prevention WORKS Checklist

Program: Implementation and Process

- ☐ Conduct **Program Outreach** that is specifically tailored to target population. Identify individuals and families within the target population who are in need of support.
- ☐ Promote **Program Retention** by engaging participants in a meaningful helping relationship so that they will continue to participate in the program and thus receive the full benefit of their participation.
- ☐ Design and implement a robust **Quality Assurance System** with attention to model fidelity and program improvement efforts.
- ☐ Maintain flexibility to adjust implementation as required.
- ☐ Designate funding for grant writers, so that staff can actually be allotted to PEI related planning and implementation of programs.
- ☐ Rethink staffing options—get out of the box!
- ☐ Assign bilingual staff to translate material.
- ☐ Ensure open doors and open communication with all vested partners. Install a sense of "we're all in this together."
- ☐ Create opportunities for partners to learn about each other; invite representatives to existing meetings.
- ☐ Know what services are available, what contractors are providing.
- ☐ Keep talking about definitions and dialogue about their meaning.
- ☐ Professionals must show compassion, and follow up on program participant's goals.
- ☐ Increase worker's cultural proficiency.
- ☐ Facilitate structured conversations between faculty and staff to surface questions, concerns, and possibilities in moving the prevention agenda.
- ☐ Adapt "Motivational Interviewing" for a prevention population

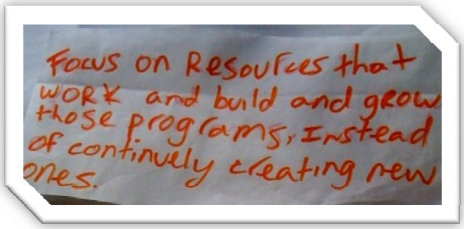
PEI Prevention WORKS Checklist

Community: Inclusion of community and stakeholders

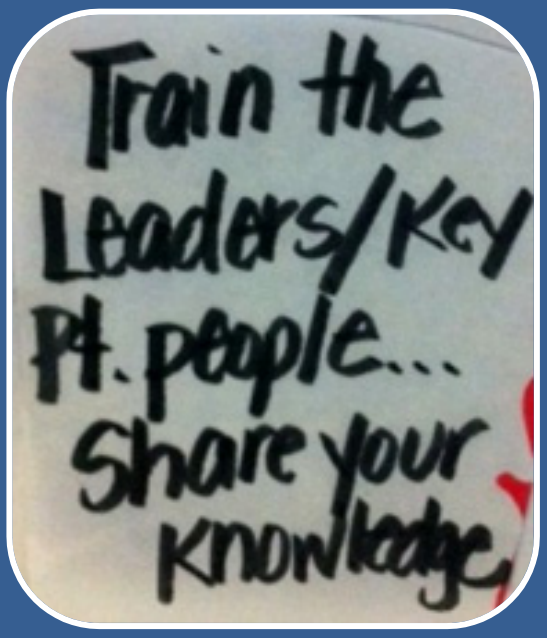
- ☐ Utilize community members and stakeholders to promote and advocate for social/human rights.
- ☐ Serve the family as a whole, not just the "identified" child. Build rapport with family.
- ☐ Provide dinner, transportation, appropriate times of service, go to the family's home as needed to promote inclusion.
- ☐ Use an interdisciplinary approach such as the five stages of prevention model.
- ☐ Use local celebrities to help promote PEI programs.
- ☐ Work with youth and their family, as in the Parenting Project.
- ☐ Conduct more outreach to educate individuals and the community to reduce stigma.
- ☐ Following early recognition of symptoms, implement Mental Health First Aid.
- ☐ Tailor services flexibly to be income/culture specific, not all oriented towards the middle class.
- ☐ To become more inclusive, address clients who are inappropriately served, in addition to underserved.
- ☐ Make it possible for whole families to have easy access services.
- ☐ Look at substance abuse and mental health as separate, not one single illness.
- ☐ Hold programs accountable for outcomes and let the community know it, making them more likely to participate in services.
- ☐ Go into the community. Don't try to do outreach from your office or clinic.
- ☐ Do not assume we know what clients want or need. We must ask them directly and respect what they tell us.

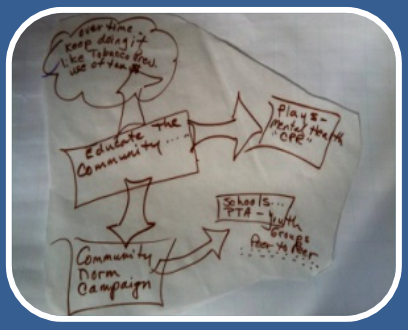
Resources

Just Click n' Connect



- **California Department of Mental Health-MHSA (Prop 63)**
  http://www.dmh.ca.gov/Prop_63/MHSA
- **Child and Adolescent Services Research Center**
  http://www.casrc.org
- **County of Orange Mental Health Services Act – Prevention and Early Intervention**
  http://ochealthinfo.com/mhsa/pei
- **County of San Bernardino Department of Behavioral Health**
  www.sbcounty.gov/behavorialhealth
- **County of San Bernardino Preschool Services Department**
  http://hss.sbcounty.gov/psd/Default.aspx
- **County of San Diego-Behavioral Health Services (includes a list of programs funded by San Diego County)**
  http://www.sdcounty.ca.gov/hhsa/programs/bhs
- **County of San Diego's Network of Care**
  http://sandiego.networkofcare.org/mh/home/index.cfm
- **County of San Diego's Network of Care-PEI**
  http://sandiego.networkofcare.org/mh/countycontent/san-diego/PEI.cfm
- **Healthy People 2020: The Road Ahead**
  http://www.ok.gov/strongandhealthy/documents/HealthyPeople2020.pdf
- **It's Up to Us**
  http://www.up2sd.org
- **Orange County Health Care Agency, Behavioral Health Services | Prevention & Intervention Division - Mental Health Services Act (MHSA) - Stop the Cycle (STC) Program**
  http://orange.networkofcare.org/mh/resource/agencydetail.cfm?pid=StoptheCycleProgram
- **Outcome Evaluation Process for San Diego's PEI Programs**
  Prevention of Mental Disorders Effective Interventions and Policy Options
  http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf
- **Riverside County Department of Mental Health**
  http://rcdmh.org
- **Riverside Network of Care (Provides information regarding resources in Riverside)**
  www.riverside.networkofcare.org
- **Up2Riverside (Provides information regarding mental health and mental illness)**
  www.Up2Riverside.org
- **UCSD Health Services Research Center**
  http://hsrcreports.ucsd.edu
- **UPAC Positive Solutions Program**
  www.upacsd.com





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County of San Diego Behavioral Health Services Project
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Prevention and Early Intervention

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY