MHSOAC
Mental Health Services
Oversight and Accountability Commission

Prevention and Early Intervention

Trends Report 2011

California Counties' Mental Health Services Act Prevention and Early Intervention Plans: Areas of Focus in First Three Years

Executive Summary

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist

In November, 2004, California voters passed, Proposition 63, an initiative that authorized a 1% tax on personal income in excess of $1 million to "expand services and develop innovative programs and integrated service plans for mentally ill children, adults and seniors." The initiative, which became the Mental Health Services Act (MHSA), includes a focus on prevention and early intervention (PEI) as a key strategy "to prevent mental illness from becoming severe and disabling" and improve "timely access for underserved populations." The MHSA requires that 20% of funds be spent for prevention and early intervention. This new inclusion of PEI represents a historic shift in California and nationally.

As of December 31, 2010, the MHSOAC had approved more than $713 million to fund PEI plans for all California counties. This Trends Report, based on an analysis of 485 programs contained in 59 approved PEI plans[1], addresses: 1) intended focus areas; 2) ages intended to be served and programs directed toward specific racial/ethnic communities; and 3) key program features. The analysis assesses whether a program intended to affect any of the MHSA's seven broad prevention goals or the *PEI Guidelines'* key community needs or priority populations. In addition to the focus areas specified in the MHSA and the *PEI Guidelines*, PEI plans were assessed for their inclusion of individuals with co-occurring mental health and substance-use risk factors or disorders, in response to the MHSOAC's policy to prioritize integrated approaches for co-occurring disorders.

The following are some of the key findings of the Trends Analysis. All percentages refer to the percentage of counties offering at least one program that met the criterion:

Ninety-seven percent of the counties included at least one early intervention program and 97% included a prevention program.

- "At-risk children, youth, and young adult populations" was the focus most frequently addressed by counties (100%).
- At least three-quarters of counties included one or more programs to address the MHSA priorities of reducing school failure (95%), stigma and discrimination (86%), incarcerations (76%), and suffering (75%) resulting from untreated mental illness.
- Seventy-six percent of counties included a program intended to reduce mental health disparities.
- Eight-six percent of counties included co-occurring mental health and substance-use issues as an element of at least one PEI program.

[1] The California Code of Regulations Title 9 CCR Section 3200.280 defines a "county" for MHSA funding purposes as "the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per Welfare and Institutions Code Section 5701.5." Sutter and Yuba Counties provide mental health services jointly as Sutter-Yuba Mental Health Services. The city of Berkeley and the Tri-City Mental Health Center (Pomona, Claremont and La Verne) receive MHSA funds as separate entities.

- Seventy-eight percent of counties included at least one program to address the negative impact of trauma.
- Sixty-nine percent of counties included a program to address the initial onset of a serious psychiatric illness.
- Three MHSA prevention focus areas not included in *PEI Guidelines* were least likely to be the focus of counties' PEI programs: unemployment (47%), homelessness (46%), and removal of children from their homes (34%).
- Counties' PEI plans included programs to serve individuals across the life cycle: children (97%), transition-age youth (95%), adults (93%), and older adults (80%) of counties.
- A number of counties prioritized programs that focused explicitly on the needs of specific racial and ethnic groups: Latinos (76%), Asian/Pacific Islanders (44%), Native Americans (44%), and African Americans (37%).
- Fifty-one percent of counties offered at least one program that included outreach or services directed toward lesbian, gay, bisexual, or transgendered (LGBT) individuals.
- Counties committed to provide PEI services at sites where people go for other routine activities, including schools (93%), community-based organizations (86%), primary care (81%), diverse social and community settings (76%), homes (71%), faith-based organizations (64%), and childcare or pre-school (59%).
- Ninety-eight percent of counties included family involvement as a component of at least one PEI program and 80% described at least one program as offering peer support.

The inauguration of PEI by California counties is occurring at a time of many serious challenges, most notably California's funding crisis, with major funding reductions for a wide range of mental health services. Counties are coping with multiple manifestations of this funding crisis, including increased community needs and decreased community and staff resources. The fact that counties and communities are making such a significant commitment to PEI under these circumstances is notable and inspiring. The next critical stage of this investment will be to measure the results of PEI programs – in dollars saved and, more importantly, in lives nourished and sustained.

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Increasing evidence demonstrates that timely and appropriate supports can prevent many mental health problems and reduce the severity of the impact of mental illness for individuals, families, and communities. Understanding how to promote resilience and emotional health is growing. The relationship between mental health and social priorities such as physical health, education, employment, productivity, community/family cohesion, civility, and peace is becoming more evident.

In November, 2004, California voters passed, Proposition 63, an initiative that authorized a 1% income tax on personal income in excess of $1 million to "expand services and develop innovative programs and integrated service plans for mentally ill children, adults and seniors."[2] The initiative, which became the Mental Health Services Act (MHSA), includes a focus on prevention and early intervention (PEI) as a key strategy to "to prevent mental illness from becoming severe and disabling" and improve "timely access for underserved populations."[3] The MHSA requires that 20% of funds be spent for prevention and early intervention.[4] This new inclusion of PEI represents a historic shift in California and nationally.

The MHSA specifies that all funded PEI programs must include:

- Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses
- Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness…and for adults and seniors with severe mental illness…as early in the onset of these conditions as practicable
- Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services and reduction in discrimination against people with mental illness (MHSA, Section 4, Part 3.6 § 5840(b)).

Funded programs are expected to be effective and to "include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives" (MHSA, Section 4, Part 3.6 § 5840(c)).

The MHSA emphasizes the link between PEI and community goals by specifying that funded programs are to "reduce the following negative outcomes that may result from untreated mental illness:

- Suicide

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[2] Official Summary, Proposition 63, California Secretary of State's Voter Information Guide, 2006.
[3] MHSA, Section 4, Part 3.6 § 5840(a).
[4] The creation of a consolidated Prudent Reserve fund, allowing counties to transfer PEI funds or CSS funds to Prudent Reserve and use these funds for either purpose could change the 20% figure in either direction (DMH Information Notice No. 09-16, 8/6/2009).

- Incarcerations
- School failure or drop out
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes" (MHSA, Section 4, Part 3.6 § 5840(d)).

This paper reviews the extent to which California's first MHSA PEI component plans address these important challenges. Evaluation of the impact of the MHSA is likely to include an assessment of the extent to which PEI programs contribute to reducing these negative outcomes.

PEI Guidelines: Key Community Needs and Priority Populations

The California Department of Mental Health released *Proposed Guidelines for Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan* in September 2007, and released an amended version of these *Guidelines* in August 2008. The *PEI Guidelines* quotes the Mental Health Services Oversight and Accountability Commission's (MHSOAC) PEI policy paper in conceptualizing prevention as promoting "positive cognitive, social and emotional development" that "encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances."[5]

The *PEI Guidelines* restrict MHSA funding for prevention to universal and selective approaches that occur prior to a diagnosis of a mental illness. *PEI Guidelines* also allow MHSA funding for an early intervention program that "addresses a condition early in its manifestation, is of relatively low intensity, is of relatively short duration (generally less than a year), and intends to support well-being in a major life domain and avoid the need for more extensive mental health services." Early intervention includes individual screening to confirm potential mental health needs. MHSA early intervention programs for individuals experiencing onset of a serious psychiatric illness are exempt from the low intensity and short duration requirements (*PEI Guidelines*, p. 8).

The *Guidelines* require counties to organize their proposed activities and interventions into PEI Projects, each of which is designed to address one or more key community mental health needs and one or more priority populations to meet specific mental health outcomes. The *Guidelines* require that "the scope of each project should not be overly broad or too narrow to achieve the outcomes for the target population."[6] The *PEI Guidelines* specify the following key community needs:

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[5]Lee, D. & Feldman, S. (2006). *Proposed MHSOAC Prevention/Early Intervention Committee Action Plan for the First Three Years*, p. 1. Available at http://mhsoac.ca.gov/docs/ImplementationUpdates/PEI_Action_Plan_Policy_Paper.pdf

Also *PEI Guidelines*, p. 7. Available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/docs/Rev_PEI_Guidelines_Referencing_RM.pdf

[6] *PEI Guidelines*, p. 14.

- *Disparities in Access to Mental Health Services*: reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services
- *Psycho-social Impact of Trauma:* reduce the negative psycho-social impact of trauma on all ages
- *At-Risk Children, Youth, and Young Adult Populations*: increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations
- *Stigma and Discrimination:* reduce stigma and discrimination affecting individuals with mental health illness and mental health problems
- *Suicide Risk:* increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.
- The *PEI Guidelines* also identify the following priority populations:
- *Underserved Cultural Populations*: Those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from PEI programs and interventions
- *Individuals Experiencing Onset of Serious Psychiatric Illness:* Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service
- *Children/Youth in Stressed Families:* Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems
- *Trauma-Exposed:* Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service
- *Children/Youth at Risk for School Failure:* Due to unaddressed emotional and behavioral problems
- *Children/Youth at Risk of or Experiencing Juvenile Justice Involvement:* Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).

Consistent with policy direction from the MHSOAC, counties must serve all age groups, and a minimum of 51 percent of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 *(PEI Guidelines*, p. 25). "Small counties"[7] are excluded from both requirements.

[7] The California Code of Regulations Title 9 CCR Section 3200.260 defines a "small county" as one with a population of less than 200,000, according to the most recent projection by the California State Department of Finance.

Purpose of PEI Trends Report

As of December 31, 2011, the MHSOAC had approved PEI plans for all of California's counties.[8] This Trends Report, based on an analysis of 485 programs contained in 59 approved PEI plans, addresses: 1) intended focus areas: 2) ages intended to be served and programs directed toward specific racial/ethnic communities; and 3) key program features. A list of California counties whose PEI plans were analyzed, including their populations and regions, is included at the end of this report.

PEI Programs/Interventions and Projects: Unit of Analysis

The unit of analysis for this Trends Report is either a county's PEI project or a PEI program within a project. The analysis assesses a project if all programs (interventions) within a project have common elements and address a defined priority population(s) and key community need(s), as required by the *PEI Guidelines.* In many instances, the PEI projects contain too many disparate elements to create a cohesive basis of analysis. In these instances, the basis of analysis is the individual program (intervention) within the project[9]. For simplicity, the report refers to all units of analysis as "programs."

Areas of Focus in First Cycle PEI Plans

The primary purpose of this report is to analyze the areas of PEI that counties selected to address in their first three-year PEI plans. The analysis assesses whether a program is intended to affect any of the MHSA's seven broad prevention goals or the *PEI Guidelines'* key community needs or priority populations. It was necessary to consolidate the MHSA goals, key community needs, and priority populations, since several overlap. For example, the analysis consolidated "psycho-social impact of trauma" (a key community need) and "trauma-exposed" (a priority population).

In addition to the focus areas specified in the MHSA and the *PEI Guidelines*, PEI plans were assessed for their inclusion of individuals with co-occurring mental health and substance-use risk factors or disorders, in response to the MHSOAC's policy direction to prioritize integrated approaches for co-occurring disorders.[10]

The following is a list of consolidated MHSA goals and *Guidelines* community needs/priority populations included in the analysis.

Focus Area	Source	Notes
At-risk children, youth, and young adult populations	PEI Guidelines: key community need	Also included as a PEI Guideline priority population: children and youth in stressed families

[8] The California Code of Regulations Title 9 CCR Section 3200.280 defines a "county" for MHSA funding purposes as "the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per Welfare and Institutions Code Section 5701.5." Sutter and Yuba Counties provide mental health services jointly as Sutter-Yuba Mental Health Services. The city of Berkeley and the Tri-City Mental Health Center (Pomona, Claremont and La Verne) receive MHSA funds as separate entities. .

[9] Five PEI programs from four counties were excluded from the analysis because of a lack of clearly defined intended areas of focus.

[10] *Mental Health Oversight and Accountability Commission Report on Co-Occurring Disorders: Transforming the Mental Health System through Integration*, Revision 5.1, 11/10/2008, available at http://www.dmh.ca.gov/MHSOAC/docs/MHSOACCODReportFinalDraftreleased112008.pdf.

Focus Area	Source	Notes
		This category incorporates several more specific categories from MHSA priorities and PEI Guidelines (children/youth at risk of school failure, children/youth at risk of or experiencing juvenile justice involvement; removal of children from their homes). As noted, 51% of the county's PEI funds are required to be spent on children and/or youth (except small counties).
Incarcerations	MHSA	Also included as a PEI Guideline priority population: children/youth at risk of or experiencing juvenile justice involvement
School failure or drop out	MHSA	Also included as a PEI Guideline priority population: children/youth at risk for school failure
Suicide	MHSA and PEI Guidelines: key community need and priority population	Since the PEI Guidelines identify that suicide prevention will be addressed through a statewide project, it is possible that some counties chose not to prioritize locally
Unemployment	MHSA	Not addressed explicitly by PEI Guidelines as a key community need or priority population; assessed for report if program will address employment issues
Prolonged suffering	MHSA	Not addressed explicitly by PEI Guidelines as a key community need or priority population; assessed for report if program will serve people with serious mental disorder or emotional disturbance
Homelessness	MHSA	Not addressed explicitly by PEI Guidelines as a key community need or priority population; assessed for report if program will focus on preventing homelessness or serve individuals experiencing homelessness
Removal of children from their homes	MHSA	Not addressed explicitly by PEI Guidelines as a key community need or priority population; assessed for report if program will include activities intended to keep families with children together
Disparities in access to mental health services	PEI Guidelines: key community need	Also included as a priority population: underserved cultural populations. Assessed for report if reducing disparities was a significant focus

Focus Area	Source	Notes
Psycho-social impact of trauma	PEI Guidelines: key community need	Also included as a priority population: trauma-exposed. This category is frequently used by counties for programs to serve adults and older adults, since most other PEI key community needs and priority populations specifically refer to children and youth.
Individuals experiencing the onset of serious psychiatric illness	PEI Guidelines: priority population	Consistent with the MHSA focus to prevent mental illness from becoming severe and disabling
Stigma and discrimination	MHSA (overarching priority; not one of the seven listed negative outcomes) PEI Guidelines: key community need	Since the PEI Guidelines identify that preventing stigma and discrimination will be addressed through a statewide project, it is possible that some counties chose not to emphasize this area locally.
Co-occurring mental health and substance-use disorders	Not included as MHSA negative outcome or PEI Guidelines key community need or priority population	This area was included because it is a policy priority of the MHSOAC. Assessed for report if the county's program description referenced inclusion of individuals with co-occurring disorders.

Results: Program Areas

An analysis of PEI plans indicates the following intended areas of focus. The inclusion criterion for "counties" was that some element of the county's description of the specific features or intended outcomes of at least one program supported this classification. The criteria for "programs" are noted in the Table above.

Program Areas	Percentage Counties	Percentage Programs
At-risk children, youth, and young adult populations	100%	63%
School failure or drop out	95%	37%
Co-occurring disorders	86%	36%
Stigma and discrimination	86%	43%
Psycho-social impact of trauma	78%	50%
Incarcerations	76%	28%

Program Areas	Percentage Counties	Percentage Programs
Suicide	76%	32%
Disparities in access to mental health services[11]	76%	42%
Prolonged suffering	75%	34%
Individuals experiencing the onset of serious psychiatric illness	69%	24%
Unemployment	47%	9%
Homelessness	46%	12%
Removal of children from their homes	34%	9%

The results, using this method, are conservative for at least two reasons: 1) Some counties did not specify a particular area of focus or impact for programs that are in fact likely to affect this issue; and 2) Some counties did not include details in their program descriptions or intended outcomes to support that a program will address or have an impact in a stated area.

Discussion of Program Area Results

Since counties (except "small counties") were required to spend 51% of their funds on children and/or youth, it is not surprising that "at-risk children, youth, and young adult populations" was the focus most frequently selected by counties (100%). However, the fact that all counties surveyed included at least one project that served this group

indicates that even small counties chose to address the needs of their younger citizens. This emphasis is consistent with the evidence summarized in the MHSOAC's policy paper on the efficacy of PEI services for children and youth. It is also consistent with the recent report of the Institute of Medicine: *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*: "Several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral (MEB) disorders are greatest by focusing on young people and that early intervention can be effective in delaying or preventing the onset of such disorders" (Summary, p. 1).[12]

It is to be expected that the key community needs and priority populations specified in the *PEI Guidelines* were generally the program areas that counties selected most frequently. The MHSA priorities of preventing homelessness, unemployment, and

[11] Percentage reflects counties that offered programs in which reducing disparities is the primary purpose or a significant area of emphasis.

[12] O'Connell ME, Boat T, et al, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, National Research Council and Institute of Medicine of the National Academies, The National Academies Press, Washington, D.C., 2009. Available at http://www.nap.edu/catalog.php?record_id=12480#toc.

removal of children from their homes were not included in the *PEI Guidelines* as key community needs or priority populations, so counties were less likely to focus in their PEI plans on these issues. Issuing or amending PEI regulations to add these populations and community needs as priorities would probably increase the extent to which counties develop targeted programs in these areas.

It is surprising that 86% of counties included co-occurring mental health and substance-use issues as an element of at least one of their PEI programs, since this was not a *Guideline* key community need or priority population. Counties were most likely to address co-occurring disorders or risk factors in programs directed toward transition-age youth or older adults.

According to the *PEI Guidelines*, all PEI projects are required to include a focus on reducing disparities in mental health across racial/ethnic and socio-economic groups. The *PEI Guidelines* recommend that counties address this goal through any of three different approaches: 1) providing culturally competent and appropriate programs; 2) facilitating access to PEI programs; or 3) improving individual outcomes [presumably for members of underserved racial/ethnic and socio-economic groups] of participants in PEI programs (*PEI Guidelines*, p. 15). This analysis assessed that 93% of counties met this standard for at least one of their PEI programs. Beyond this standard, 76% of counties identified the needs of specific ethnic or cultural populations as either the primary purpose or a key, significant focus for at least one PEI program.

Though not included as an identified key community need or priority population, the *PEI Guidelines* suggest that "programs recognize the underlying role of poverty and other environmental and social factors that impact individuals' wellness" (*PEI Guidelines*, p. 9). A number of counties included PEI programs to ameliorate various negative impacts associated with poverty.

Please refer to the end of the *Trends Report* for several case examples of county PEI programs, either just implemented or about to be implemented, to illustrate some of the program areas.

Demographics

Counties are asked to specify the number of individuals of different age groups expected to be served by their PEI projects. Based on this information, counties anticipated serving the following age cohorts. The percentage for counties refers to counties that indicated they planned to serve this age cohort in at least one program. Many programs serve people across the age span.

Age Cohort	Percentage Counties	Percentage Programs
Children (ages 0-17)	97%	70%
Transition-Age Youth (ages 16-25)	95%	74%

Adults (ages 18-59)	93%	63%
Older Adults (ages 60+)	80%	46%

It is impossible to assess the extent to which various racial/ethnic and language groups can be expected to be served by PEI projects, since PEI *Guidelines* and forms do not require counties to provide this information and do not identify methodology to estimate the racial/ethnic or language groups to be served by their various programs. In many instances, counties will learn this information only after implementation. This *Trends Report* assessed the percentage of counties and programs that focused specifically on various racial and ethnic groups, either as the primary purpose or a significant element of at least one PEI program.

Primary Program Focus on Racial, Ethnic, Language Groups	Percentage Counties	Percentage Programs
Latinos	76%	29%
African Americans	37%	12%
Asian/Pacific Islanders	44%	14%
Native Americans	44%	11%

Fifty-one percent of counties offered at least one program that included outreach or services specifically directed toward lesbian, gay, bisexual, or transgendered (LGBT) individuals; 13% of programs fit this criterion.

Very few counties offered programs with a focus on specific gender. A few offered programs for pregnant or new mothers including programs to prevent or intervene in postpartum depression. And fewer counties included programs focused on the specific needs of young men or fathers.

Features of PEI Programs

The *Trends Report* assessed a few key program elements in counties' PEI plans. Ninety-seven percent of counties included at least one early intervention program and 97% included at least one prevention program.[13] Ninety-eight percent of counties included family involvement as a component of at least one PEI program and 80% described at least one program as offering peer support. Overall, 46% of programs included peer support and 65% include family involvement.

PEI Guidelines emphasize the critical importance of accessible PEI programs, especially for people currently un-served and underserved by the mental health system: "To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations)."[14] It is clear that California's counties are making a significant commitment to locate programs in accessible community sites. Many programs take place in several locations.

[13] This assessment was based on a comparison of the project description and the *PEI Guidelines* definitions of "prevention" and "early intervention."
[14] *PEI Guidelines*, p. 2.

Site for PEI Service or Support	Percentage Counties	Percentage Programs
School	93%	48%
Community-Based Organization	86%	61%
Primary Care	81%	36%
Social/Community	76%	39%
Home	71%	32%
Faith-Based Organization	64%	24%
Child Care Center, Family Day Care, Pre-school	59%	14%
Mental Health	47%	21%
Correction, Justice, Probation, Law Enforcement	46%	14%
Family Resource Center	46%	20%
Substance-Use Treatment	27%	9%

Other examples of sites where PEI services will take place include places of employment, streets, businesses, factories, laundromats, gas stations, grocery stores, child welfare and other government departments, adult day health centers, health fairs, trauma medical centers, vocational training, CalWorks, senior centers and housing, veteran's service centers and facilities, libraries, shelters, crisis clinics, parks, recreation programs, Meals on Wheels home delivery programs, theaters, and galleries. In addition, counties are making rich use of media to deliver PEI information and services, including telephone, Internet, and written and broadcast media, including communication in various languages directed toward diverse communities.

Conclusion

The significant human and economic costs associated with mental illness suggest that prevention and early intervention are urgent priorities. Assessing the trends in counties' first PEI plans is an initial step toward understanding the impact of California's historic investment. Incorporating PEI into California's mental health system has been characterized as moving to "help first" from "fail first."

The inauguration of PEI by California counties has occurred amid many serious challenges, most notably California's funding crisis, with major funding reductions for a wide range of mental health services. Counties are coping with multiple manifestations of this funding crisis, including increased community needs and decreased community and staff resources. The fact that counties and communities are making such a significant commitment to PEI under these circumstances is notable and inspiring.

Examples of PEI Programs

Suicide Prevention

Tulare County is creating a county-wide effort to increase public awareness of suicide risk and to prevent and reduce suicide attempts and completions. In 2007, Tulare County experienced one of its highest recorded suicide rates: 11.9 deaths per population of 100,000. The largest increase in 2007 was among older men. Overall, 58% of suicides in Tulare County were completed by individuals over the age of 40.

PEI will fund the Tulare County Suicide Prevention Task Force to enhance and coordinate community efforts to prevent suicide, including among government agencies, community-based organizations, and volunteers. Strategies include developing training and resources for health care professionals, educators, law enforcement, and communities currently un-served or underserved by mental health. A new program will screen older adults to identify depression and suicide risk, and connect people to life-saving help. The Task Force will create and coordinate reporting systems throughout the county, including emergency rooms, clinics, First Responders, family resource centers, schools, and community-based organizations, to identify people at risk of suicide and provide timely, appropriate intervention and treatment.

Tulare County is also funding effective practices to reduce risky behaviors and suicide risk for un/underserved populations with high suicide risk, such as older adults, Native American youth, and Latina youth. In addition to reducing suicide attempts and completions for specific groups, these strategies intend to increase people's positive support, expand knowledge of available resources, increase the cultural relevance of services, reduce stigma to encourage people to get help, and reduce disparities in access to treatment.

The Tulare Suicide Prevention Task Force has already been very active in reaching out to the community. They organized a successful candlelight vigil and an Awareness Walk for Suicide Prevention Week. They recently worked with Transitions Mental Health to hold a half-day training session and presented a documentary on suicide, called Shaken Tree, to a group of about 60 individuals. After viewing the documentary, several people contacted the Task Force seeking treatment for depression.

One of the Task Force's most successful and innovative programs is a farming webinar, which received attention in the nationally published Western Farm Press. The webinar targets dairy farmers who, due to the current economic state, are experiencing a downturn in milk prices. Consequently, many dairy farmers are facing foreclosure on their farms and are at an increased risk for suicide. Noah Whitaker, head of the Suicide Prevention program, recalled a farmer who contacted the Task Force after viewing the Webinar. The farmer said that the presentation made him realize that he was severely depressed,

and consequently he sought treatment. The Suicide Prevention Task Force has been asked to present at the World Ag Expo in Tulare in February 2010 because of their outreach efforts to dairy farmers.

Another successful outreach program developed following the suicide of a local youth named Bo. The Task Force began distributing sunflower seed packets, which listed their contact information. People plant the seeds in remembrance of loved ones lost to suicide. The packets have been nicknamed “Bo’s Sunflowers.”

The County plans to link its local efforts to the State-Administered Suicide Prevention Project through the Office of Suicide Prevention. The County will assess a number of outcomes of the program, including decreased suicide completions county-wide, increased knowledge and awareness of at-risk behaviors and protective factors, increased use of resources for suicide prevention, increased cooperation and integration of referrals and programs, and improved data and reporting.

At-Risk Children, Youth, and Young Adult Populations

The following description illustrates Butte County’s creative approach to addressing the needs of children and youth in stressed families. The County’s PEI project will also serve children and youth at risk for school failure, juvenile justice involvement, and, in some instances, homelessness. Butte County’s community planning emphasized the significant need to help teenagers, especially those at risk for serious mental health problems exacerbated and manifested by engagement in risky activities, failing in school, and experiencing family stress. The program is designed to decrease participants’ risk factors and increase protective factors.

The County noted that Gridley is an area whose youth are at particularly high risk. Gridley has a higher percentage of children and youth ages 0-17 compared to the rest of Butte County, high rates of unemployment (recently reported as 12.7% compared to U.S. average of 8.5%), extensive child poverty (35.7% versus the national average of 16.6%), and low rates of high school graduation (59.2% versus the national average of 80%). Many young people live in families who face frequent crises and trauma. Gang activity, violence, and early drug and alcohol use in Gridley affect increasing numbers of youth, co-existing with serious mental health issues. The Gridley-Biggs Police Department experienced a 76% increase in calls for service from Gridley High School in the 2006-2007 school year[15].

According to Butte County’s PEI Plan, many young people in Gridley experience minimal opportunities, support, and services. Gridley, home to Butte County’s largest Latino population (38%), is clearly underserved for mental health. The County’s community planning concluded that Gridley

[15] All statistics are from the Butte County PEI Plan.

youth could benefit from a stronger connection with their community, including services located where they feel comfortable. To address the needs of Gridley's youth, Butte County created Gridley Live Spot, a drop-in resource center available after school for young people ages 12-18, many of whom are Latino. Live Spot's goals are to reduce or prevent depression and suicide, as well as gang involvement, delinquency, and academic failure. Participants help design, implement, and evaluate the program.

Live Spot is located in a community center near the high school. Live Spot provides Gridley youth a safe, supportive, and fun place to get emotional support, build healthy relationships, socialize, and learn life and leadership skills. Clinical support includes mental health education, solution-focused group therapy, brief individual counseling, and case management. Suicide prevention education and efforts to reduce stigma and discrimination associated with mental illness are woven through all Live Spot components. Butte County coordinates Live Spot with its Crisis Stabilization Unit in Chico.

Other Daily Live Spot activities include homework support, tutoring, meals, cooking classes, life skills development, work readiness and job training, mentoring including peer mentoring, community service, tattoo removal, referrals for youth who are homeless, and transportation. Live Spot includes School Success, an intensive 16-week effort to ensure that young people at risk for mental health problems graduate from high school and pursue higher education, and Connecting the Family Circle, which provides support to teen parents and their children. Offshoots of Live Spot offer services in the Gridley high school and middle school. Several of the supportive service models provided through Live Spot have received national awards as exemplary prevention programs.

All photos courtesy of Gridley Live Spot, Butte County

Butte County plans to assess a number of outcomes for program participants, including reductions in depression, anxiety, and suicidal behavior. Although it is too early to evaluate the impact of Live Spot, its success attracting participants is already clear; early attendance has been high, with an average of 20-30 youths per day. One attendee commented, "I am glad that you are fixing the Live Spot so teens have places to go – I don't know where we would be without it." Another youth summed up the program in two words - "It's awesome!"

Promoting Employment

One of the MHSA's goals for Prevention and Early Intervention is reducing unemployment as a consequence of untreated mental illness. This goal is consistent with the Act's emphasis on recovery from mental illness. The World Health Organization has defined positive mental health as "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[16] Increasing opportunities for employment is a particularly critical component of mental health promotion for transition-age youth (TAY). The President's New Freedom Commission on Mental Health reported findings from a national study that only 18% of young adults with serious emotional disturbance were employed full-time, while an additional 21% worked only one or two years after high school.[17]

San Luis Obispo County's PEI Plan includes the Successful Launch Program for At-Risk TAYs to serve youth ages 16-21 who are emancipating from foster care, Wards of the Court who are within six months of turning 18, or students in their final year at San Luis Obispo Community School. The County's PEI community planning emphasized that all three groups are underserved in the County; they are likely to have experienced numerous traumatic events and be vulnerable to developing mental illness, substance abuse, domestic violence, homelessness, criminal activity, and unemployment. This finding is consistent with statewide research that more than half of California youth leaving foster care have one or more significant mental health problems. California research studies have found that more than seventy-five percent of children and youth in foster care need a mental health referral and fifteen percent have considered or attempted suicide.[18]

The Successful Launch Program for At-Risk TAYs expands the Independent Living Program (ILP), a partnership between Cuesta Community College and San Luis Obispo County Department of Social Services. The program's goal is to ensure that "as these high-risk youth turn 18 and are on their own, they are stable, have housing, have momentum for school or work, and are able to adequately cope with life's challenges and demands" (San Luis Obispo PEI plan). The Successful Launch Program provides direct support for mental health and resilience, including information and connections for people who need treatment. TAYs served by this project are unlikely on their own to seek or accept mental health services.

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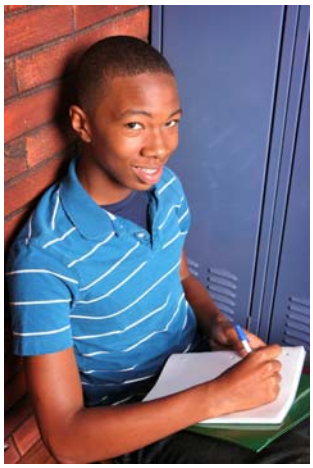
[16] *The world health report 2001. Mental health: new understanding, new hope.* Geneva, World Health Organization, 2001. Available at http://www.who.int/whr/2001/en/index.html

[17] New Freedom Commission on Mental Health, *Achieving the promise: Transforming mental health care in America, Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD, 2003. Available at http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/InsideCover.pdf

[18] Bernstein, N. *Helping Those Who Need it Most: Meeting the Mental Health Care Needs of Youth in the Foster Care and Juvenile Justice Systems*. California Family Impact Seminar, Sacramento, CA, 2005. Available at http://www.library.ca.gov/crb/05/04/05-004.pdf

The project offers skill-building classes and practical training on such topics as decision making, healthy relationships, budgeting and banking, cooking, computer studies, college preparation including scholarships, career exploration, automotives, employment, and housing. Life coaches provide stable (at least one year) support, including help coping with mental health and emotional challenges, managing daily responsibilities, and developing skills essential to the transition to early adulthood. The project includes a peer support network, with older and former participants providing encouragement, role modeling, mentoring, and skill building for younger and newer participants. Program components are designed to promote social, emotional, and intellectual protective factors likely to enhance participants' mental health and buffer TAYs from potential mental illness.



A Vocational Development component of the Successful Launch Program features Employment Specialists who help youth explore careers, locate available jobs, prepare for interviews, and create employment portfolios to manage their job search. Employment Specialists support participants as they "hit the streets" in search of jobs, transport them to businesses for job interviews, help them to follow up with leads, and teach them crucial job retention skills once they find employment. The project offers stipends to businesses that place TAYs in jobs and that provide training, support, and performance evaluation.

The County will assess participants' mental health outcomes, as well as outcomes related to self-sufficiency.

Prolonged Suffering from Untreated Mental Illness

Reducing prolonged suffering from untreated mental illness is one of the MHSA's goals for prevention and early intervention. Contra Costa County is addressing this issue with its Elders' Actualization Project/Elders' Learning Community and the Senior Network & Activity Program (SNAP!), operated by LifeLong Medical Care. Isolation, loss of loved ones, declining health, reduced income, physical changes including to the brain, and various kinds of trauma and grief all contribute to a significant risk of mental illness for people in this age group. Contra Costa older adults who are homeless, non-English speaking, substance abusing, or physically disabled are at particular risk. Older adults in Contra Costa County attempt suicide at significantly higher rates (16.9 per 100,000) than the County's overall suicide rate (9.9 per 100,000).

Photo courtesy of Supporting Older Adults, Contra Costa County

Older adults are at particular risk for depression, which is often overlooked, particularly when the older adult is isolated. Many depressed seniors are reluctant to seek help. Building and enhancing supportive relationships and communities is a critically important component of preventing, recognizing, and intervening early in depression.

To get older adults out of isolation and to foster connections that promote mental and physical well-being, Contra Costa County features peer counseling with other older

adults. Peer counselors are taught how to recognize signs of a possible mental health problem and to help people get treatment if needed, especially from the programs Contra Costa is developing for various cultural and learning communities. Peer counselors assess the mental wellness of the seniors and support them with friendly companionship. They act as “first responders” to stressful situations in older adults’ lives and to early signs of developing mental health problems. They also help seniors connect to community resources. The project focuses on recruiting and training peer counselors who speak Spanish, Vietnamese, or at least one other Asian language in order to reach older adults who are less likely to be served by mental health programs.

The stories below illustrate how Contra Costa County’s programs develop supportive and respectful relationships with seniors, recognize and build on their strengths, and foster community, resilience, and wellness.

> *Mrs. Jackson was a professional seamstress and hat maker. She had her own hat shop in Richmond. She is still very interested in hat making but has been unable to pursue her interest without support due to multiple medical problems. She is also mildly confused and depressed. Mrs. Jackson lives with family members, but her daily social and creative activities are limited. Mrs. Gayton has been meeting with her in her home, almost weekly, for about two months. Mrs. Gayton helps her with cutting out fabric and laying out hat patterns. Mrs. Jackson is teaching Mrs. Gayton how she designs and makes hats.*
>
> *Another new participant, Mrs. Jones, has a lifelong interest in different kinds of creativity, from painting to macramé and crochet. She lives alone and has a lot of stress and symptoms of depression that have kept her from many realms of life, including pursuing her artistic interests. Mrs. Gayton and Mrs. Jones began their Learning Partnership with macramé. Mrs. Jones is teaching Mrs. Gayton how it is done, while Mrs. Gayton provides the materials and encouragement. The developing trust in their relationship is making it easier for Mrs. Gayton to support Mrs. Jones with her loneliness, losses, and mental health issues, as well as to re-connect her with something she loves.*
>
> *As the creative partnerships continue and develop, we are offering the opportunity to meet with other participants who also love art. Mrs. Jackson and Mrs. Jones have talked about watching a couple of art history DVDs together and they plan to visit the Richmond Art Center. We hope they will grow into a community.*

The County’s programs provide links to community supports, including any needed transportation. Older adult participants are already expressing their enthusiasm, as illustrated by the following story from LifeLong Medical Care’s SNAP! program.

> *Last Thursday, we had our first big activity at senior housing. We had live music and dancing, and lots of residents came down. One woman in particular danced the entire time. She even went up to her apartment to get better shoes so she could really learn the dance moves. Later on she mentioned that she had to leave to go to Physical Therapy, and she was excited to tell her therapist she had been dancing because it was a workout for her. She’s supposed to go out walking, but she doesn’t like to do that. This lady said it felt good to be dancing and moving because she gets so depressed staying in her apartment with nothing to do. She thanked me for the music and said that she had a lot of fun. I assured her that we would have creative movement monthly right in her building.*

Seniors who participate in social activities and whose bodies and minds are active are less vulnerable to depression. And those who are in regular contact with peer counselors are less likely to have symptoms of depression, or other mental health issues, go unnoticed. Contra Costa will assess participants' mental health outcomes, including lowered depression, increased ability to manage stress, and decreased need for acute psychiatric services including hospitalization.

Psycho-Social Impact of Trauma

Unresolved, untreated trauma is a key risk factor for developing many serious and persistent mental health, medical, substance abuse, criminal, and social problems.[19] In recognition of the seriousness of this issue, SAMHSA's Center for Health Services has convened a National Center for Trauma-Informed Care to promote effective practices in programs and services to help heal the after-effects of trauma.[20]

Imperial County determined that a priority for PEI services was people experiencing trauma, both one-time events and chronic or cumulative trauma. Examples of trauma cited by Imperial County's PEI plan include child or domestic abuse, chronic neglect, enduring deprivation and poverty, homelessness, violence (personal or witnessed), racism and discrimination, intergenerational or historical trauma, the experience of refugees fleeing war and violence, loss of loved ones, and natural and human disasters.

Imperial County's PEI Project for Trauma-Exposed Individuals includes the Program to Encourage Active and Rewarding Lives for Seniors (PEARLS), an in-home intervention for older adults who have experienced traumatic loss and who show early indications of depression. The program's goal is to reduce symptoms of depression and prevent the progression of untreated mental illness, including decompensation, loss of independence, and accompanying substance abuse. The isolated older adults expected to be engaged by PEARLS are underserved in Imperial County.

PEARLS helps older adults become more active physically, socialize more, and experience more pleasant activities. Participants, with support from counselors, select the problems they want to address and their preferred solutions. Research has shown PEARLS to be effective in reducing early and minor depression and improving older adults' quality of life and emotional well-being. The fact that PEARLS is offered in homes makes it more convenient, especially for people with physical limitations or transportation barriers.

Imperial County's second program, Trauma-Focused Cognitive Behavioral Therapy, is for children under 18 who have endured traumatic experiences. The many children in Imperial County who are refugees and immigrants are particularly likely to have experienced trauma. Immigrant children often face serious and sometimes traumatic

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[19] Jennings A. The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the Behavioral Health System. National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning, 2004. Available at http://mentalhealth.samhsa.gov/nctic/publications.asp#impact.

[20] SAMHSA's Mental Health Information Center, National Center for Trauma-Informed Care. Available at http://mentalhealth.samhsa.gov/nctic/default.asp.

challenges related to acculturation: for example, linguistic and cultural isolation, experiences of prejudice and discrimination, conflicts between the values of their new country and their country of origin, and family stress. Imperial County has the largest percentage of families living in poverty of any California county, exacerbating the stresses and risk factors. An estimated 86.6% of Imperial's K-12 school-age children in 2006-2007 were Latino, the highest percentage of any California county.

Trauma-Focused Cognitive Behavioral Therapy will serve Imperial County children ages 3 to 18 who show early indications of reactions to traumatic stress, such as poor sense of themselves, behavior problems, unstable emotions, difficulty in relationships, substance abuse, self-injury, or emotionally based physical symptoms. Services including a variety of therapy and supports for children and their parents will be available in family resource centers, schools, and at home. Trauma-Focused Cognitive Behavioral Therapy has been shown to be effective with children from a broad range of socio-economic backgrounds who have experienced diverse forms of trauma.

Disparities in Access to Mental Health Services

Fresno County, rich in its diversity with many immigrants and numerous cultural and ethnic groups, identified underserved cultural populations as the highest priority for PEI funding. In Fresno County, almost half of the population is of Latino or Hispanic origin.[21] Other communities prioritized for PEI include Hmong, Native American, African American, and Southeast Asian. Fresno recognized in its PEI plan significant differences among underserved cultural populations, including differences related to language, legal status, income, geography, and time in the United States. The County used varied methods to elicit input from members of its underserved communities to inform the development of the PEI plan.

Fresno's PEI Project, Cultural-Based Access-Navigation Specialists and Peer Support Clinics, relies on community health workers (CHWs), trusted experts from each underserved community. Research and successful pilot interventions validate the CHW approach; Fresno's PEI plan cites examples in the United States of successful models, including the Navajo Community Health Representatives and migrant farm worker programs of the 1950s and 1960s, as well as international support from the World Health Organization. The Center for Multi-Cultural Development at the California Institute of Mental Health has published a paper on how counties can partner with community health workers (promotores) in advancing the goals of the MHSA.[22] Fresno envisions that for its PEI project CHWs will be individuals who are highly respected within a cultural community, including Hmong Shamans and Native American Spiritual Leaders.

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[21] U.S. Census Bureau, State and County Quick Facts, 2008.

[22] Rhett-Mariscal, W. Promotores in mental health in California and the prevention and early intervention component of the MHSA. Center for Multicultural Development at the California Institute of Mental Health, 2008.

CHWs reaches out to underserved individuals to provide a personal connection to mental health resources and programs located within each community. The program includes peer support groups to help people cope with stress that can lead to mental health problems: for example, traumas related to immigration or violence. The project also includes a focus on education and advocacy in response to the expressed needs of individuals and communities.

Fresno County is committed to offering timely help in people's preferred language in natural, accessible, welcoming community settings. The project emphasizes serving people where they already are: "To reach the unreachable, the CHWs go where people congregate. This could be at events such as health fairs, church and neighborhood meetings, factories, laundromats, gas stations, and grocery stores, among other locations" (Fresno County PEI Plan, p. 79). Services are available in people's homes, when indicated. Faith-based organizations of all denominations help spread the word about the program, since many underserved groups within Fresno County trust these organizations.

CHWs receive extensive training about relevant mental health topics, including how to recognize early signs and symptoms of substance abuse and mental health problems. Fresno expects that CHWs to help develop culturally relevant educational material, contribute to building mental health coalitions that strengthen communities' resilience and wellness, and increase the County's capacity to deliver culturally sensitive mental health services. The project prioritizes services to individuals who are frequent users of acute psychiatric hospitalization or caught in a cycle of involvement in the justice system and/or homelessness, caused or exacerbated by mental health issues. Reducing stigma related to mental illness is a key intended outcome of the project.

New Hope for Native Americans

By Callie Shanafelt, *Reprinted with permission*

On the days Wanda Bearquiver Bulletti couldn't get out of bed because of depression and pain, she wore out the battery on her phone calling for help. She wasn't trying to get medical care for herself. Her daughter, Courtney Cummings, said her mother's concern extended to the wider Native American community in Richmond.

Bulletti, who battled depression, often dealt with doctors who had never treated Native American patients. The doctors simply prescribed medication for back pain. Bulletti was convinced that individual healing was tied to healing for the whole community.

"For Native Americans it's not a brain chemistry problem. It's a response to genocide," Janet King, of the Native American Health Center in Oakland, said. Courtney Cummings traces her own struggles with school and substance abuse to the historical trauma passed down through generations of her family. Cummings' grandparents told her their teachers hit the pupils if they spoke the Arikara language in boarding school. "So I grew up scared of teachers," said Cummings, who never graduated from high school.

In 2000 Bulletti finally found a psychiatrist sensitive to Native American patients. She told her daughter she was diagnosed with depression. "Immediately I was like, 'What? You're not crazy,'" Cummings said. Native Americans resent being stigmatized as

having mental health issues, according to King. Cummings prefers to see healing as a part of the traditional concept of the medicine wheel. For her, the medicine wheel envisions harmony in four parts, representing mental, physical, emotional and spiritual needs.

The Native Wellness Center is dedicated to Wanda Bearquiver Bulletti

When Buletti's mental and physical well-being improved, she wanted other Native Americans in Richmond to have the opportunity to heal through their culture. So, she wore out the battery on her phone calling Janet King to create a healing space in Contra Costa County. Bulletti offered her small front room if needed.

In 2004, the state Mental Health Services Act became law. Through a 1 percent property tax, the MHSA funds mental health prevention and intervention programs in California counties. King was instrumental in ensuring that Native Americans be identified as an underserved population qualifying for these programs. "If it isn't spelled out, Native Americans always get overlooked," said King.

Native Americans are only 1.2 percent of the population in Richmond, according to Census estimates. Administrators from Contra Costa mental health asked King to connect them with this small community. On a stormy evening, February 2, 2008, 16 people gathered at the Richmond library to participate in a focus group.

Participants primarily identified the need for accurate education and counseling. However, Native Americans don't need individual or formal counseling, said King. "When native people get together they help each other out. They give each other advice and share resources." Richmond participants wanted a space where elders could have talking circles, where they could help youth navigate the non-Native community.

Parents wanted schools to include the Native American perspective on Thanksgiving and Columbus Day. One teen told a story about bringing sage to school for cultural show and tell. She said she was escorted out by a uniformed police officer who thought she had drugs. Focus group participants wanted a place to teach the youth their cultural heritage. "We know that Natives who are engaged in community are less likely to commit suicide, drop out, join a gang, or despair," said King.

The Native Wellness Center officially opened its doors in the old Greyhound station near 23rd St and Macdonald Ave, October 16. Wanda Bearquiver Bulletti died before her vision came to fruition. But her daughter is following in her footsteps as a prevention assistant at the center. "My mom still guides me today," said Cummings. The center was dedicated to Bulletti during the opening ceremony. King said Bulletti was a shy and quiet woman. "She had the voice of a little singing bird. That singing bird was able to make change."

The center focuses on the mental and cultural well-being of Native Americans in Richmond. Support groups for elders, parents and youth already happen on a weekly basis. Cummings is also planning cultural activities such as drumming and regalia

making. However, no medical services are provided at the Richmond office. Cummings refers clients with medical needs to the Oakland clinic. Cummings said the doors are open to everyone. “If you want to learn more about us,” says Cummings. “Come down to the Wellness Center and say, ‘I want to learn more about you.’ Everyone is invited.”

Counties Included in Analysis

County	Population[23]	Region
Alameda	1,543,000	Bay Area
Alpine	1,222	Central
Amador	38,022	Central
Berkeley	105,385	Bay Area
Butte	220,407	Superior
Calaveras	46,127	Central
Colusa	21,910	Superior
Contra Costa	1,051,674	Bay Area
Del Norte	29,673	Superior
El Dorado	182,019	Central
Fresno	931,098	Central
Glenn	29,195	Superior
Humboldt	132,821	Superior
Imperial	176,158	Southern
Inyo	18,152	Superior
Kern	817,517	Southern
Kings	156,289	Central
Lake	64,053	Superior
Lassen	35,757	Superior
Los Angeles	10,441,080	Los Angeles
Madera	150,887	Central
Marin	257,406	Bay Area
Mariposa	18,406	Central
Mendocino	90,289	Superior
Merced	255,250	Central
Modoc	9,702	Central
Mono	13,759	Central
Monterey	428,549	Bay Area
Napa	138,917	Bay Area
Nevada	99,186	Superior
Orange	3,166,461	Southern
Placer	333,401	Central
Plumas	20,917	Superior

[23] California State Association of Counties, 2010

County	Population[23]	Region
Riverside	2,088,322	Southern
Sacramento	1,445,327	Central
San Benito	57,784	Bay Area
San Bernardino	2,073,149	Southern
San Diego	3,146,274	Southern
San Francisco	856,095	Bay Area
San Joaquin	694,293	Central
San Luis Obispo	267,154	Southern
San Mateo	754,285	Bay Area
Santa Barbara	434,481	Southern
Santa Clara	1,880,876	Bay Area
Santa Cruz	265,183	Bay Area
Shasta	181,380	Superior
Sierra	3,303	Superior
Siskiyou	46,010	Superior
Solano	427,837	Bay Area
Sonoma	493,285	Bay Area
Stanislaus	525,903	Central
Sutter-Yuba	172,534	Central
Tehama	62,100	Central
Tri-Cities	228,336	Southern
Trinity	13,898	Superior
Tulare	447,814	Central
Tuolumne	56,086	Central
Ventura	844,713	Southern
Yolo	202,953	Central

Acknowledgments

I am very grateful to the following people who helped with this report:

- Amy Shearer (data analysis)
- Clark Marshall (data analysis)
- Christina Call
- Aaron Carruthers
- Ann Collentine
- Monika Grass
- Carol Hood
- Matt Lieberman
- Jose Oseguera
- Thomas Powers
- Danielle Thompson
- Bev Whitcomb
- Filomena Yeroshek

Thanks to Emily Nahat, Joan Meisel, Bertha MacDonald, and other Department of Mental Health team members, for their visionary work on the *PEI Guidelines*.

Thanks to Dr. Saul Feldman, one of the original MHSOAC Commissioners, who has spent a lifetime working to improve mental health services, and who has contributed significantly to realizing the MHSA's potential, especially for prevention and early intervention.

Thanks to the people in California who are working with so much dedication, creativity, courage, and love to bring prevention and early intervention interventions to their communities.