# APPENDIX V

# PUBLIC COMMENTS

**Ventura County Behavioral Health Department**

Mental Health Services Act

**FY 2009-10 Annual Update**

**30 Day Public Comment – June 16, 2009 – July 16, 2009**

**PUBLIC HEARING – July 20, 2009 - 1:00 p.m.**

Ventura County Behavioral Health Department

1911 Williams Drive - Training Room - Oxnard, CA 93036

Hearing Conducted by MENTAL HEALTH BOARD

**Personal Information (optional)**

Name: Daniel Jordan, PhD, ABPP
Agency/Organization: _None_____
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**My Role in the Behavioral Health System**

☐ Consumer ☐ Family Member ☐ Probation ☐ Education

☐ Service Provider ☐ Social Services ☐ Law Enforcement ☐ X Other: Resident

What do you see as the strengths of this plan?

Very little for teens and young adults. The plan largely maintains the existing service model.

If you have any concerns about the plan, please explain

My concerns are listed below.

Comments may be emailed to: cathy.morrison@ventura.org, or mailed to
MHSA Ventura County Behavioral Health Dept. 1911 Williams Drive Suite 200 Oxnard, CA 93036

To: Behavioral Health
From: Dan Jordan, Community Member
Re: Concerns about the Prevention and Early Intervention (PE&I) Plan for Teens and Young Adults

Many deep serious problems are involved with the VCBH plan. Many of these problems stem from actions taken by the State close to two decades ago when it eliminated, under changes led by the pharmaceutical industry and the Institute of Medicine (IOM) that drastically altered the meaning of "prevention." This tactic eliminated what were then called "Community Client Contacts" and "Mental Health Promotion." Funding for these activities was eliminated by the State, shifting focus to treatment. More of this history is discussed below. VCBH's prevention model is follows the IOM intervention and treatment orientation, ignoring social work and psychology model strategies of prevention that could reduce the need for services. It is stressed here that VCBH could have chosen to include social model prevention strategies, could have taken a broader view, but overtly decided not to do so. VCBH's plan leaves out entire lines of research and practice that could transform both community and provider systems, reducing the need for primary services. By doing nothing to reduce the need for services, VCBH's proposal does nothing to mitigate social problems that cause human distress.

This preselected bias eliminates the opportunity to change conditions in which people live, and also ignores conditions that harm human health and well-being. Presenters at "community forums" overtly stated that only proposals that fit within the existing service system design were to be considered. The presenter stated that community oriented programs were simply not going to be part of the PE&I funding.

Three of the more egregious problems are discussed here, in reference to the department's plan for teens and young adults. The first problem is the plan's paternalism. Community groups are in no way equal partners in this process because it was made clear from the start that "the professionals" would ultimately decide on the strategies to be chosen. The second problem is that the plan is limited to only medical model prevention, instead of employing social model prevention. A summary of the American Psychological Association's analysis of this point is presented below. Taken together, these and other aspects of this process have shown that VCBH's primary interest is in maintaining its existing structure and not making changes that might actually improve community health and well-being. A comment was actually made at one of the forums to the extent that change has to be done in small steps, because it is difficult to manage. In other words, this approach is more for the benefit of the system than the community.

The third critique is that VCBH does not know its own history. Two decades ago a large-scale reorganization was conducted that significantly improved the ways VCBH was linked into the community. The department shifted very strongly to social model systems of care. Of course, with the national remedicalization process, including the shift to IOM model prevention many of these gains were lost. But that does not refute the point that large scale change is possible, and that social model services and activities, based in a social justice framework, can be achieved.

VCBH's approach to PE&I planning represents a loss of opportunity for what could have been done to meet the community as a true equal partner in change that could have led to better outcomes for everyone. The proposed plan represents business as usual, benefiting the existing structure, with just enough window dressing to make it appear to be something new.

## 1. The System as Parent

Behavioral Health's process and plan are paternalistic. It was perfectly clear from the outset that VCBH had no intention of actually considering community input. How could such a complaint be made since BH spent a lot of money, time and energy interviewing community members?

The complaint is made on the basis of the structure of the process and on observation. Yes, months of "community outreach" went into the process. A great deal of money was spent on consultants. But, from the outset VCBH and its consultants made it clear that whatever the community input, "the professionals" would decide what services and activities would be chosen. Thus, no matter how much window dressing of community outreach was conducted, in the end, the so-called professionals would decide what would be done.

**About Evidence-Based Practices Rating Systems**

A second aspect of this paternalism is that VCBH's insistence on "evidence-based practice" has been stunningly wrong-headed. In brief, the programs used for comparison promoted by VCBH and its consultants were all treatment programs, not prevention programs. Thus, VCBH force fit prevention into a treatment oriented model. In addition, the references used as "model programs" were, when examined, an amazing array of clearly bad programs.

Very little actually exists in the literature on true mental health promotion and prevention. How could it, since these kinds of interventions were effectively squelched by political processes (discussed below)? However, a great deal of research has been done on how to plan community-based promotion and prevention. Such work was ignored.

A consultant presented three resources for rating evidence-based practice. These are:

1. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP): http://www.nrepp.samhsa.gov/find.asp
2. California EBP Clearinghouse of Child Welfare Scientific Rating Criteria: http://ebpexchange.wordpress.com/2007/05/07/california-evidence-based-child-welfare-clearinghouse/
3. Helping America's Youth Rating Criteria: http://www.findyouthinfo.gov/

**NREPP Assessment**

Not one of the programs listed in NREPP is a prevention or early intervention program. Therefore NREPP is, at the very least, irrelevant to the PEI planning process, at worst misleading as a tool for assessing prevention and early intervention programs.

**California EBP Clearinghouse of Child Welfare Scientific Rating Criteria**

This web site evaluates child welfare intervention programs, not mental health prevention and early intervention. The topic list does not include a single primary prevention program, even within the child welfare context.

**Helping America's Youth Assessment**

Their web site states: "Helping America's Youth is a nationwide effort, initiated in 2005 by President George W. Bush and led by First Lady Laura Bush, to benefit children and teenagers by helping them forge stronger connections to their families, schools, and communities. As part of this effort, the First Lady unveiled the Community Guide to Helping America's Youth. Developed by nine Federal agencies, the Web-based guide provides up-to-date research on youth development and effective programs in an effort to assist community partnerships in prioritizing issues, identify existing resources, and addressing unmet community needs."

This "initiative" is, when you strip away all the layers wrapped around it, the prior administration's abstinence only education initiative. In other words, "Helping America's Youth," suggested as a tool to evaluate program effectiveness is a slightly glossed over version of the previous administration's abstinence-only program.

Even overlooking the fact that a web site that supposedly promotes scientific research is actually a propaganda piece for an intervention that research clearly shows does not work, Helping America's Youth has a long list of risk factors, categorized as Individual, School, Family and Community. Helping America's Youth does not list exposure to racism as a risk factor. It does not list exposure to classism as a factor. It does not list societal discrimination as a factor. In other words, racism, classism, discrimination are not problems to be considered as possible risk factors in American society.

**Institute for Mental Health Research**

The Institute for Mental Health Research also has a web site that purportedly outlines best practices for mental health prevention. http://www.imhr.org/knowledge-definitions.html

The problem is that it offers no examples, and the only links from that page go to drug abuse prevention web sites. The IMHR web site lists links for "Prevention" as: Substance abuse, suicide, youth violence, school violence, hiv/aids, and college programs. In other words, the Institute for Mental Health Research actually offers no assessment of mental health prevention policy or practice.

**External Validity and Generalizability**

A general complaint about having third party evaluators review programs, and then using such tools to delimit the range of programs that can be proposed is that this assumes generalizability of existing programs, in other locales across the country, to our local conditions. Even if the evaluative web sites were focused on mental health PE&I, which they are not, assuming generalizability must be supported by the research, not just made as an assumption.

**World Health Organization: Participatory Action Research (PAR)**

Had VCBH truly been interested in developing prevention services directly linked to the community, it could have engaged in participatory action research.

*Participatory Action Research (PAR) is research which involves all relevant parties in actively examining together current action (which they experience as problematic) in order to change and improve it... it aims to be active co-research, by and for those to be helped... it tries to be a genuinely democratic or non-coercive process whereby those to be helped determine the purposes and outcomes of their own inquiry."*
- Wadsworth, Y. (1998)

*World Health Organization on Mental Health Prevention and Promotion*
http://www.who.int/mediacentre/factsheets/fs220/en/

The WHO offers guidelines on mental health prevention and promotion as follows.

WHO outlines a definition of mental health as more than the absence of mental disorders. It drives home that mental health is grounded in the well-being of communities (emphasis added).

- Mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.
- Mental health promotion covers a variety of strategies, all aimed at having a positive impact on mental health. Like all health promotion, *mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles.* This includes a range of actions that increase the chances of more people experiencing better mental health.
- *Mental health is determined by socio-economic and environmental factors*
- *Mental health and mental health disorders are determined by multiple and interacting social, psychological, and biological factors, just as health and illness in general.*
- The clearest evidence is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and poor income. Increasing and persisting socio-economic disadvantages for individuals and for communities are recognized risks to mental health.
- The greater vulnerability of disadvantaged people in each community to mental health disorders may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health.
- *A climate that respects and protects basic civil, political, socio-economic and cultural rights is also fundamental to mental health promotion.* Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

**Mental health is linked to behaviour**

- *Mental, social, and behavioural health problems may interact to intensify their effects on behaviour and well-being.*
- Substance abuse, violence, and abuse of women and children on the one hand, and health problems such as HIV/AIDS, depression, and anxiety on the other, are more prevalent and more difficult to cope with in conditions of high unemployment, low income, limited education, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, and human rights violations.
- Enhancing the value and visibility of mental health promotion *mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health.* These would include the socio-economic and environmental factors, described above, as well as behaviour. *This requires mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector.* Particularly important are the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize.

- Cost-effective interventions exist to promote mental health, even in poor populations
- Support to children (e.g. skills building programmes, child and youth development programmes)
- Programmes targeted at vulnerable groups, including minorities, indigenous people . . . and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- Mental health promotion activities in schools (e.g. programmes supporting ecological changes in schools, child-friendly schools)
- Mental health interventions at work (e.g. stress prevention programmes)
- Housing policies (e.g. housing improvement)
- Violence prevention programmes (e.g. community policing initiatives); and
- Community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development)
- *To implement these effective interventions, governments need to adopt a mental health framework as used to advance other areas of health and socio-economic development, and thereby engage all relevant sectors to support and evaluate activities designed to promote mental health.*

The point of quoting this list of WHO definitions of prevention is to detail the different ways in which prevention could be approached, and the ways in which this alternate view could truly improve life.

**Mental Health Prevention and Promotion vs Clinical Intervention and Treatment**

**Structural Critique**

The presentation on research offered by the CIMH had both a "surface message" and a subtext. At the surface, yes, good research should inform policy and practice. But the subtext of the message is that in the end, it will be professionals who decide what will happen. Now their decisions will be based on their reading of relevant research, but the notion of community-partnerships in which each group informs the other is not part of the deal.

"*When psychologists deflect human problems to the mental domain, the social domain remains unchallenged*" (Prilleltensky & Nelson, Doing Psychology Critically, Palgrave, Macmillan, 2002, P. 28, emphasis added).

Prileltensky and Nelson (2002) offer the framework below for assessing the worth of psychological research in the table below. These are among the criteria that we suggest should be used to evaluate research.

| Domain | Questions |
|---|---|
| *Values for* | |
| Personal well-being | |
| Caring and protection of health | Does it promote the expression of care, empathy, and concern for the physical and emotional well-being of other human beings? |
| Self-determination | Does it promote the ability of individuals to pursue their chosen goals without excessive frustration and in consideration of other people's needs? |
| Relational well-being | |
| Human diversity | Does it promote respect and appreciation for diverse social identities? |
| Collaboration and democratic participation | Does it promote the peaceful, respectful, and equitable process whereby citizens have meaningful input into decisions affecting their lives? |
| Collective well-being | |
| Distributive justice | Does it promote the fair and equitable allocation of bargaining powers, resources, and obligations in society? |
| Support for community | Does it support vital collective structures that promote the well-being of the entire community? |
| *Assumptions about* | |
| Power in relationships | Who has more power in relationships? Are there attempts to share power? |
| Professional ethics | Does ethical framework employed invite input from consumers? Are service recipients part of ethical decision-making processes? |
| Research and knowledge | To what end is knowledge used? Is knowledge subordinate to morality or independent from it? What philosophy of science guides research? |
| The good life | What conceptions of the good life are promoted? Are these based on self-interest or cooperation? |
| The good society | What conceptions of the good society are promoted? Are these based on the pursuit of equality or personal gain at the expense of others? |
| *Practices regarding* | |
| Problem definition | What factors are included and excluded from problem definition? Are psychological as well as sociological and economic factors taken into account? |
| Role of client | Is client active or passive? To what extent does client participate in decisions affecting his or her well-being? |
| Role of helper | Is helper a true collaborator or a removed expert imparting advice? |
| Type of intervention | Does intervention focus exclusively on intra-psychic factors, or does it include systems affecting clients? |
| Time of intervention | Is intervention reactive or proactive? Does psychologist wait until victims of unhealthy environments seek help or does he/she try to prevent problems? |
| Focus of intervention | Does intervention focus only on reducing deficits or also on enhancing competencies? |

Cunningham et al. (2000) point out that "although there is considerable evidence regarding the outcome of parent training under optimal (controlled clinical) conditions, there is relatively little known about the utility of this intervention in community settings. In an earlier study Cunningham et al. (1995) found that families from different cultural or linguistic backgrounds were more likely to enrol when parent training was located in neighbourhood schools rather than local clinics."

Webster-Stratton (1998b) describes an intervention (PARTNERS) with 210 low-income families and their four year old children involved in the Headstart program. Eighty-eight percent of the parents enrolled in the intervention group attended more than two-thirds of the sessions, leading Webster-Stratton to wonder "*perhaps this population has been 'unreachable' not because of their own characteristics, but because of the characteristics of the intervention they have been offered*" (p. 184).

In summary, the tools offered by VCBH for assessing mental health prevention concepts artificially drive the analysis to mental health treatment frameworks. In addition, the methods for assessing proposals put "the professionals" in the decision-making role, continuing the legacy of paternalism, and ignore the approaches that could actually work to design – through community participation – effective prevention strategies. Alternative approaches that address these problems are offered.

## 2. Medical vs Social Model Prevention

The prevention framework used by VCBH is a medical model approach. This seems odd because one of the primary consultants for VCBH is a psychologist, however, it appears that none of those involved in this process know either the history of the struggle to define prevention, the process of "remedicalization" of mental health, in which the pharmaceutical industry, paired with the medical industry devastated social model systems of care, including Ventura's, nor of Ventura County's own history in this process.

As noted above, until about the mid-1990s, California's mental health funding system included "mental health promotion" and "community client contact" as prevention. Eliminating these aspects of prevention was the first step in the remedicalization of mental health services. Their elimination is directly tied to promotion and adoption of the medical model of prevention pushed by the Institute of Medicine (IOM).

The American Psychological Association's (APA) Task Force on Prevention: Promoting Strength, Resilience, and Health in Young People published an entire American Psychologist edition (2003, 58:6/7) entitled "Special Issue: Prevention that Works for Children and Youth." The task force was formed to assess the trends in prevention thinking, and specifically critiqued the Institute of Medicine's (IOM) medical model of prevention. The APA Task Force defines "primary prevention for young people as involving the dual goals of reducing the incidence of psychological and physical health problems and of enhancing social competence and health" (ibid., p. 427).The Task Force states that prevention should be "directed to essentially well people rather than to those with behavioral problems (i.e., universal prevention) or to those whose life circumstances or recent experiences increase their . . . risk for negative psychosocial outcomes (i.e., selective preventive interventions)" (ibid., p. 427).

The APA Prevention Task Force forcefully states, "The nation must enhance the quality of the environments in which young people are raised and educated. Children will benefit most when families, schools community organizations, health and human-service systems, and policymakers

. . . implement programs that attempt to compensate for perceived deficits in social settings" (ibid., p. 427)

The lead authors, Weissberg, Kumpfer & Seligman note that controversies exist regarding the definitions and philosophies of prevention (ibid. 425-432). They note that historically prevention comprised "primary, secondary and tertiary" activities "based on the behavioral or health status of the group targeted for intervention" (p. 426). Then, more than thirty years ago, the Institute of Medicine (IOM) essentially tried to shift "prevention" to include treatment and maintenance. It is this model that appears to be used by Ventura County Behavioral Health. This model divides prevention into three categories: U*niversal* interventions for those with no individual risk factors; *selective* prevention for those who do have individual risk factors, and *indicated* prevention for high risk individuals who have "detectable symptoms or biological markers . . . but do not meet diagnostic criteria for disorders at the present time" (ibid., p. 427).

The presentations conducted by VCBH make it clear that they have worked within the IOM medical model framework with a focus on selective and indicated prevention. It must be stated that this benefits the existing way of doing business because it requires very little change in the structure and function of existing behavioral health services, allowing the Department to remain essentially static, just with more funds. The presentations also made it very clear that the decisions as to what types of activities would be part of the MHSA PE&I proposal would be made solely by the Department. To be blunt, the message came across quite clearly that the community interviews and focus groups were window dressing that had little or no effect on the decisions made "by the professionals" who presumably know better than the community what the community needs.

The American Psychologist authors make a very direct, bold statement about the design of "prevention" services.

> A "core difference merits discussion and demands that informed participants take a stance. That is, the debate regarding the extent to which youth development, health promotion, competence enhancement, and positive psychology are integral to prevention. Typically primary prevention encompasses disease/disorder prevention, health maintenance, and health promotion and enhancement" (ibid., p. 27)

They go on to state that:

> "primary prevention [involves] actions that help participants (or facilitate participants helping themselves): (1) to prevent predictable and interrelated problems, (2) to protect existing states of health and healthy functioning, and (3) to promote psychosocial wellness for identified populations of people" (ibid., p. 427).

The IOM report distinguishes between prevention and promotion, rather than including promotion in prevention. The IOM model of prevention "medicalizes" prevention by focusing on illness. The APA model of prevention, which is much more in line with a social work approach,

frames prevention in terms of wellness and enhancement of well-being. By transforming communities, social model approaches reduce risk factors that cause personal problems. The promotion component of the social model prevention is achieved through work with individuals, groups or populations "to enhance competence, self-esteem, and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders" (ibid., p. 427). Various authors appropriately criticize the IOM model as too narrow. Young people who are not yet in trouble may still lack the skills needed to become healthy adults, and the range of prevention models within the IOM framework do nothing (or very little) to address these positive needs. These authors go so far as to argue that IOM medical model prevention works best when coordinated with promotion that "enhances competence, connections to others, and contributions to [the] community."

Another way to say this is that, yes, medical model prevention has a place, but has been cast as the one and only right model of prevention. This is a stunning acquiescence to a narrow point of view that overlooks broader ways of solving personal and social problems.

We need to take back the field of prevention, reject the medicalization of our efforts that serve, quite bluntly, existing systems, benefit providers more than communities by demanding little change, and ultimately, the pharmaceutical industry which stands behind remedicalization of health and human services. This is a tragic loss.

**From:** "Jerry Beckerman" <jerry@SegueProgram.org>
**To:** <cathy.morrison@ventura.org>
**Date:** 6/27/2009 4:20 PM
**Subject:** PEI Plan Public Comments
**Attachments:** pastedGraphic.tiff; Susan Kelly lt 5-21-09.pdf; Student Outcomes 0708.pdf; PEI PLAN PUBLIC COMM#3BAEE5.doc

Cathy,

Thank you for this opportunity to comment on your excellent plan and to suggest a critical, valuable, and cost-effective addition that further supports the objectives of your prevention plan. These comments are embodied in two attached documents:

1. Your PEI comment form (attached); and
2. A copy of a recent letter to Susan Kelly (attached).

The letter to Ms. Kelly references a summary bar graph of measured student outcomes and it too is attached here. The 9-minute video that is referenced in the letter, with comments by expert elected officials in the field "prevention" (D.A. Totten, Sheriff Brooks, Probation Chief Brooks, and Judge Colleen White) may be accessed at this link: http://www.segueprogram.org/SegueVideo.html

Further, as I plan to attend your July 20th presentation, I would welcome the opportunity to address the attendees to describe Segue Career Mentors. I'd be happy to serve on a panel you may be assembling, or to speak individually, however it will best serve your objectives.

Please feel free to contact me if I may provide any additional comments, clarifications, or answer any questions.

Additional information may be found on our website at: http://www.segueprogram.org/

Thank you very much for your consideration of these three attachments.

Sincerely,

Jerry Beckerman
Executive Director, Founder

Segue Career Mentors

Empowering, inspiring, and
motivating students to explore,
choose, and act on their life's path.

805 643 3444
www.SegueProgram.org
a 501(c)(3) nonprofit

# Ventura County Behavioral Health Department

## Mental Health Services Act

## Prevention and Early Intervention Component Plan

## 30 Day Public Comment - June 16, 2009 - July 16, 2009

## PUBLIC HEARING - July 20, 2009 - 1:00 p.m.

Ventura County Behavioral Health Department

1911 Williams Drive - Training Room - Oxnard, CA 93036

Hearing Conducted by MENTAL HEALTH BOARD

**Personal Information (optional)**

Name: _____Jerry Beckerman_____

Agency/Organization: __ Segue Career Mentors _____

Phone Number: _____806 643 3444_____ email: jerryb@SegueProgram.org

Mailing address: _____ 2127 Hyland Avenue, Ventura 93001

**My Role in the Behavioral Health System**

| | | | |
|---|---|---|---|
| ☐ Consumer | ☐ Family Member | ☐ Probation | ⊠ Education |
| ⊠ Service Provider | ⊠ Social Services | ☐ Law Enforcement | ⊠ Other: Motivate/Inspire |

What do you see as the strengths of this plan?

The plan is well-conceived with relevant objectives and measurable outcomes.

If you have any concerns about the plan, please explain

The plan is missing a cost-effective and proven methodology to inspire and motivate youth onto to positive and productive life paths while saving local costs, calculated by Rand Corp (2003) to be $243,000 to $388,000 for every high school dropout and $1.3 - $1.5 for every dropout that becomes a career criminal. This methodology is available from SegueCareerMentors.org and generates in youth hope for their future, their seeing the relevance of school now, and their internalization of the real world fact that "more effort now equals more options for their future."

To be included with the concerns requested for this comment box, please see a copy (attached with this email to C. Morrison) of a recent letter to Susan Kelley, dated June x, 2009.

Segue, conceived, demonstrated, with outcomes statistically measured in Ventura County over the past four years, is the only program of its kind in the country. This comment box expands to provide additional summary comments below, as follows: With its online self-scheduling system, Career Mentors (volunteers from a variety of workplaces and professions) share the realities and possibilities of their career paths during classroom presentations. The result is inspired and motivated students that see the relevance of school, and see that it's *in their own best interest* to take responsibility for their lives, now, to stay in school, and to put in more effort. The mentors are living proof to students that long-term goals are achievable and that the path to these goals is through additional education and/or training. Of those planning to drop out of school, 94% report that, due to Segue, they now plan to stay in school and graduate. For students already college bound, Segue helps solve the mystery about career options with real world content from those that have been there. Segue works because the time commitment threshold is low. Teachers control exactly how frequently they participate, and when; Career Mentors commit to less than two hours at a time that fits their calendar, during which they reach about 100 students in three classes. Segue is a 501(c)(3) nonprofit. It is a proven model of results, community engagement, and a level of cost-effectiveness and leverage that no other program approaches.

Comments may be emailed to: cathy.morrison@ventura.org, or mailed to

MHSA Ventura County Behavioral Health Dept. 1911 Williams Drive Suite 200 Oxnard, CA 93036

Segue
Career Path Mentors

*Inspiring youth forward*

*Empowering and motivating students to explore, choose, and act on their life's path*



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Ventura, CA 93001
Tel: 805 643 3444
Fax: 805 643 9303
SegueProgram.org

May 21, 2009

Ms. Susan Kelly, MFT
MHSA Manager
Ventura County Behavioral Health
1911 Williams Drive - Suite 200
Oxnard, CA 93036

Dear Susan:

Thank you for your efforts to develop and manage the Mental Health Services Act. As you know, we are interested in bringing to many thousands of county youth the significant benefits of Segue Career Mentors as an effective and cost-effective methodology for preventing mental illness among its many statistically proven outcomes.

As an experienced professional in this realm, you are well aware of the components which, singly or in the aggregate, can cause mental illness. To provide the context of Segue in this arena, these components include depression, stress, anxiety, feelings of inadequacy, low self-esteem, anger, and loneliness. Incarceration also contributes to mental illness.

Some of these factors just described are generally accepted as existing in at risk and other high school students that have lost hope for their future, that have given up, or that drop out of high school. To the extent that these factors can be mitigated by student participation in the Segue Program, Segue serves to assist in preventing mental illness.

More, because Segue is fuelled primarily by the social capital of volunteers from the workplace, the program is a model of results, community engagement, and a level of cost-effectiveness and leverage generally unheard of either in the social services sector or in education.

Our nonprofit is making school relevant to students, inspiring and motivating them to act for their own futures. According to a school official's letter, Segue "makes graduating high school a new and important priority in [students'] lives." For those already college bound, Segue helps solve the mystery about career options with personal real world insights from those that have been there.

Over 30% of the nation's students drop out of high school and it's increasing each year. Most often this is due to lack of motivation or lack of seeing the relevance of school to their lives. The ratio of students to counselors is well over 500 to 1. A 2003 RAND Corp. study found that each high school dropout costs society up to $388,000 – a career criminal up to $1.5 million.

We've built, piloted and refined a successful platform that inspires and motivates students, shows them how relevant school is and that it's in their own best interest to take responsibility for their own lives by putting in more effort now. Segue provide a conduit to connect members of the workforce to speak in local students' classrooms. We call the speakers Career Path Mentors.

The career mentors, themselves, become living proof to students that long-term goals are achievable while exposing them to the realities of life after high school. The mentors become the evidence that the path to these goals is through additional education or training. Students "hear" the mentors in a way they can't hear their own parents. It's a very satisfying personal experience.

These live presentations ignite in youth their own internal engines that can catapult them forward. The process is analogous to when a young person wants a bicycle and the family budget cannot provide it. That youth finds a way! He/she mows lawns, walks dogs, baby-sits, washes cars. Segue is empowering to youth in a similar way, bringing then the knowledge of what is out there, a path to get there, and the idea that they can have it too if they pay their dues and do good work.

Segue
Career Path Mentors

*Inspiring youth forward*



"Job shadows" (a student spending half a day with an adult at work) can be a positive experience, yet the math on cost-effectiveness overwhelmingly favors Segue: With a job shadow one adult spends at least four hours and serves one youth; with Segue, one adult spends two hours and serves 100 youth (in three classes); half the time and serving 100 vs. 1 equals 200 times more effective.

Having seen a positive future for themselves, 94% of students planning to drop out report that, as a result of Segue, they now plan to stay in school and graduate; 86% now believe that more effort now equals more options in the future; 89% increase their knowledge of career options; and 83% are more likely to continue their education with college, technical, or certification programs.

As you recall from our recent conversations, I had made a presentation to you and a distinguished group years ago at the government center public forum about the value of Segue to cost-effectively help prevent mental illness among youth in our county. At that time, you indicated your interest in Segue yet noted that "prevention" is not the first category in which you planned to focus. I have been regularly in touch with you since to determine when I might make our case for funding to help prevent mental health from the sources available to you.

Now that prevention *is* a focus of your agency, I'd be grateful for your guidance regarding next steps so that your agency might support Segue funding as it seeks to support the 80,000 youth in high school and middle school in Ventura County. The more we can help our youth onto positive and productive life paths, the less mental illness we will have in the county, both now as youths and later throughout their adult lives. It's almost that simple.

Enclosed with this letter is a nine-minute introductory DVD about Segue with several excerpts from county officials that point to the success that Segue provides. These professionals include Dr. Trudy Arriaga, Sherrif Brooks, DA Totten, Judge White, and Probation Chief Staples.

Please consider how you can help Segue help our youth, and thereby reduce mental illness and its incumbent costs for our county population as it matures. Thank you very much.

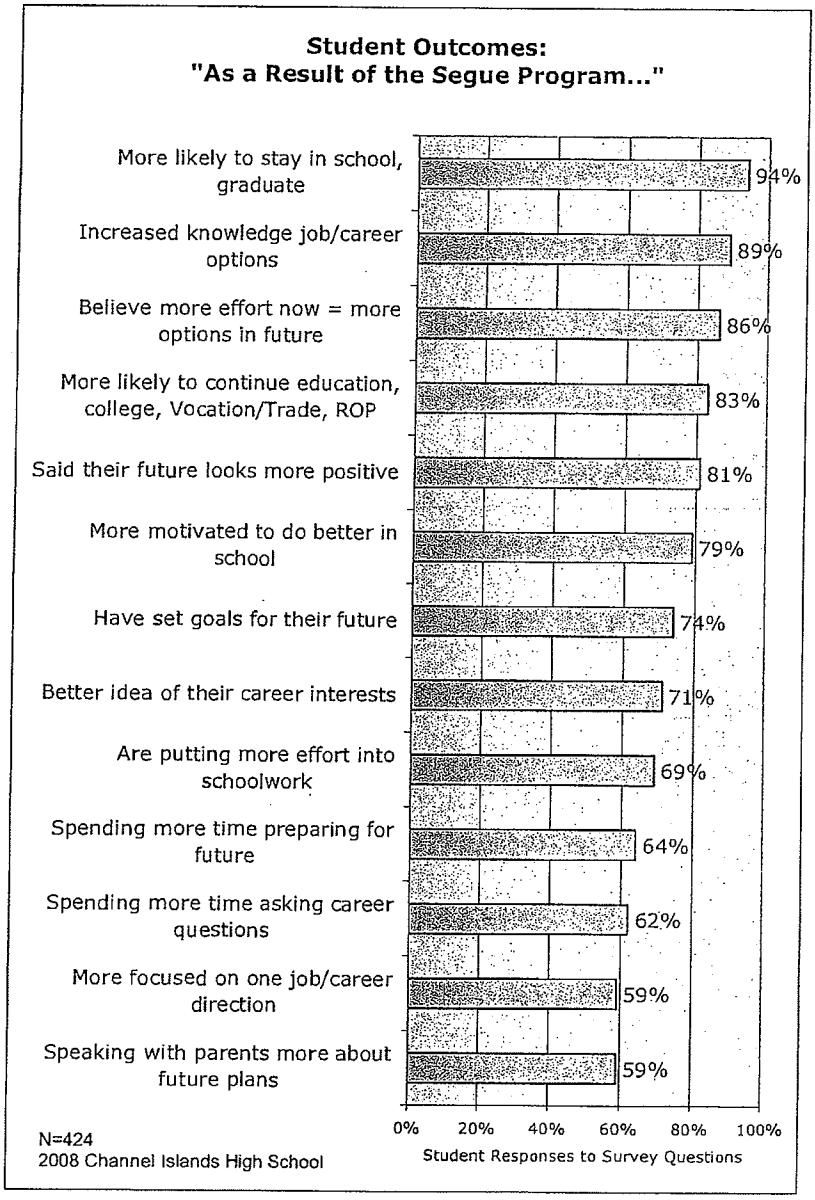
With all respect,

Jerry Beckerman
Executive Director, Founder

Encl: Segue introductory DVD
Bar graph summary of statistical student outcomes

# MEASURED STUDENT OUTCOMES (June 2008)

The key benefits of the Segue Program are demonstrated in the positive feedback from students. These results, below, were gathered in June 2008 from Channel Islands High School in Oxnard.




These results are based on a quantitative survey instrument that was reviewed by Dr. James Valadez, the Director of the Educational Research and Leadership Institute at California Lutheran University. To demonstrate internal consistency and integrity of the survey instrument, each question was asked twice, once with a yes/no answer choice option, and once with a four point agree/disagree scale.

| | |
|---|---|
| **From:** | "Jim Gilmer" <gilmerj@roadrunner.com> |
| **To:** | "'Cathy Morrison'" <Cathy.Morrison@ventura.org> |
| **Date:** | 7/16/2009 2:21 PM |
| **Subject:** | VCBHD PEI PLAN PUBLIC COMMENTS |
| **Attachments:** | VCBH PEI PUBLIC COMMENTS.FINAL.pdf |

Good Morning. The attached document is to be submitted as public comments for the proposed VCBHD PEI plan. Thank you for your consideration of these recommendations and maximizing input from other community members in the implementation of the PEI process.

Through ongoing collaboration with several ethnic organizations and community members,

Jim Gilmer

(805) 228-2386

**Ventura County Behavioral Health Department**

Mental Health Services Act

**FY 2009-10 Annual Update**

**30 Day Public Comment – June 16, 2009 – July 16, 2009**

**PUBLIC HEARING – July 20, 2009 - 1:00 p.m.**

Ventura County Behavioral Health Department

1911 Williams Drive - Training Room - Oxnard, CA 93036

Hearing Conducted by MENTAL HEALTH BOARD

**Personal Information (optional)**

Name: Jim Gilmer (lead contact for several community members from the CSS Process)

Agency/Organization: several ethnic organizations and other community residents

email: gilmerjAroadrunner.com

**My Role in the Behavioral Health System**

☐ xxConsumer ☐☒☒ Family Member ☐ Probation ☐ Education
☐ Service Provider ☐ Social Services ☐ Law Enforcement ☐ Other: xxxx Cultural-Specific

Prevention/Non-traditional services/Advocacy

What do you see as the strengths of this plan?

The collaboration with juvenile justice and schools increased.

If you have any concerns about the plan, please explain

Detailed comments, concerns, and cultural-specific recommendations are attached. We look forward to continuing to eliminate barriers to mental health and inclusion in the PEI implementation process to reduce racial/ethnic disparities in our communities.

Comments may be emailed to: cathy.morrison@ventura.org, or mailed to

MHSA Ventura County Behavioral Health Dept. 1911 Williams Drive Suite 200 Oxnard, CA 93036

**VENTURA COUNTY**
**PREVENTION AND EARLY INTERVENTION PLAN**

***A SERIES OF MISSED OPPORTUNITIES:***

**TO MAXIMIZE COMMUNITY PLANNING, TO BUILD UPON CULTURAL-SPECIFIC/COMMUNITY-DRIVEN LESSONS LEARNED IN CSS, TO ELIMINATE BARRIERS IN THE MENTAL HEALTH DEPARTMENT, TO ENGAGE AND BRING FORWARD INTO PEI TARGETED COMMUNITY DEFINED SOLUTIONS AND RECOMMENDATIONS FOR REDUCING RACIAL AND ETHNIC DISPARTIES IN MENTAL HEALTH**

*The momentum for addressing ethnic/racial disparities in behavioral health care was at an all-time high from 2005-2008 throughout the Oxnard Plains and other segments of Ventura County.* This enthusiasm was developed over the course of three years through a *Community Development Outreach and Engagement Model* in tandem with national reports, including the Surgeon General's *Mental Health: Culture, Race and Ethnicity* (2001), the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Smedley, BD, Stith, AY and Nelson, AR, 2002), and the President's New Freedom Commission on Mental Health's *Achieving the Promise:Transforming Mental Health Care in America* (2003) which all gave impetus to the dialogue on disparities. Taken together, these reports proclaim a public health imperative to meet the needs of diverse racial, ethnic and cultural populations in the United States. *Unfortunately, VCBHD continues to plan and design some systems and services that actually hinder broad effective engagement of racial community stakeholders and delivery of cultural specific/community-driven prevention and early intervention strategies.* Therefore, there are pockets of continued mistrust in certain racial/ethnic communities, fear of increased misdiagnosis with so much reliance on traditional structures/mental health treatment, a greater disability burden from emotional disorders because of racial/ethnic minorities being unserved, inappropriately served, and underserved in the mental health system at the depth and connectivity recommended by some community members.

**The "Wicked Problem" of Behavioral Health Disparities in Our Community**

Disparities have been defined as "differences in diseases, conditions, and health outcomes based on race and ethnicity" (Carter-Pokras & Baquet, 2002) or "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (Carter-Pokras & Baquet, 2002). Racial, ethnic, and cultural disparities persist in all aspects of American society and can appropriately be considered **"wicked problems"** (Clarke & Stewart, 2000). Emanating from the public policy management literature, the term "wicked problems" is used to describe problems that seem intractable, defy easy solutions or linear processes, interact with other deep-seated social and economic conditions, and persist because the design of systems put in place to solve the

problems actually hinder the development of effective solutions. **These problems "present a special challenge to government because they defy precise definition, cut across policy and service areas, and resist solutions offered by the single-agency or 'silo' approach (Keast et.al, 2004)."**

VCBHD made a critical decision in August 2008 (CSS Plan Update, 8/7/2008, page 2) which typifies how the "wicked problem," is exacerbated for local ethnic populations. *The department reported concerning Outreach and Engagement the following:*

The engagement of stakeholders, representative of the constituencies to be served by this Project, with a shared focus aimed at reducing disparities and improving access to culturally appropriate services for underserved ethnic, racial and rural SED children, has been challenging. These challenges will be addressed in the upcoming months as this program is revitalized. One of the lessons learned from this implementation is that Outreach and Engagement activities are most successful and culturally relevant when they occur within the context of ongoing, vital community activities and projects.

As a result of this lesson learned:

- The primary focus of this project in the future will be to embed Outreach and Engagement into existing community infrastructure. One such project will be a three-way collaboration in Fillmore between *One Step A La Vez*, which was developed 4 years ago as a youth mentoring program, Big Brother's/Big Sister's Program which has been in existence providing support and service to the Fillmore community for 38 years, and the Behavioral Health Department. Similarly conceived Outreach and Engagement collaborations will be developed for the other identified communities of Oxnard Plains and Santa Paula.

It is evident as reported by the department that working with cultural/racial community stakeholders was a challenge in tandem with the previous citation (Keast et.al, 2004). Their direction resulted in a universal approach by focusing on embedding cultural-specific outreach and engagement with "ongoing, established, activities and projects." They also cited that "existing infrastructure," is necessary to engage cultural-specific populations in MHSA outreach and engagement. *The lessons learned from CSS as stated by the department were not inclusive of "ethnic/community stakeholder input," so the shift in policy lacked the connectivity to and depth of the involvement of the very communities that they seek to serve. This shift in policy further alienated valuable involvement of cultural/racial community stakeholders from their input in the PEI planning process.*

**Maximizing Access to PEI Community Planning**

The proposed plan **does not maximize community program planning** from key cultural/racial specific individual community experts particularly from many who were involved in the CSS projects. The CSS representatives were from primarily unserved, inappropriately served and underserved populations and communities in tandem with State MHSA PEI guidelines. These indigenous representatives contributed extensively during CSS in the area of Outreach and Engagement for priority populations yet their meaningful involvement and engagement in the 2009-2010 PEI Community Planning process is missing. Specific notation of racial/cultural specific coalitions and key individuals are missing from all elements of the PEI process from the Planning Committee to area work teams and some community focus groups. *As a result of this oversight and lack of cultural specific input from the CSS process, racial/cultural disparity is set back in time to the beginning of the MHSA process when VCBHD should be much further ahead in transformation of mental health systems and services.*

The proposed PEI plan cites efforts currently underway to address racial disparities in behavioral health care. Around Ventura County and more importantly the Oxnard Plain, there are pockets of culturally adapted services to reduce disparities. However, much of this activity remains fragmented and disconnected. There is a wealth of information, insights, and knowledge that is simply not being shared or used to enhance or create more effective strategies for eliminating racial disparities in our community. *We noted that even though many of us were left out of the planning process for whatever reasons, that one focus group of seven African Americans came to the same conclusions of the former CSS group regarding the following Priority PEI Resources and Services:*

***"Education in the effects of racism and white supremacy with specific attention to the relationship of racism and mental health issues...." (Countywide Focus Group, Service Area 3, Evalcorp, April 2009).***

**Building on Existing Cultural Specific Research, Reports and Activities**

In an effort to address these concerns and build on existing policy reports, CSS activities and recommendations focusing on reduction of disparities, several community representatives continued to meet, plan and advocate for the core principles of the MHSA. The intentions of these members are to constructively address the areas of mistrust of the system, fear of misdiagnosis, and the greater disability burden from emotional disorders because of certain racial/ethnic minorities being inappropriately served relative to community-driven recommendations.

The current VCBHD PEI plan does not reflect the interests, attitudes, histories, priorities of a **maximized community planning effort** at the *depth or connectivity necessary* to

reduce racial/ethnic disparities from a *community-driven perspective.* There is strong alignment in certain ethnic/racial communities with alternatively defined mental health practices, cultural-specific research and policy, and collaboration with existing multi-ethnic national, state and regional networks to reduce racial/ethnic disparities. *Brief outlines of major elements are listed below, and it is our recommendation that these problems be addressed in the PEI plan and all other MHSA activities:*

According to the National Network to Eliminate Disparities in Behavioral Health the following racial and ethnic disparities are considered "wicked" problems in American society because they have many characteristics that make them appear to be without adequate resolution:

- Racial and ethnic disparities are a part of the foundation of American society, deeply rooted in its culture from the very beginning – from the conquest of the Indians' land to African slavery to current treatment of undocumented immigrants– inequities based on class, race, and culture have been embedded in the development of our country. Disparities have a long and extensive history and are found in every sector of American society.

- These disparities are embedded in differences in income, access to information, cultural traditions and social structures (Davis, 2005).

- Disparities tend to beget disparities, resulting in a cumulative impact of inequalities that constantly perpetuate wider societal gaps. Growing up in a poor, segregated community of color leads to less opportunity for home ownership, good education, and higher wage jobs, which in turn impact access to good health care, etc.

- Racial and ethnic disparities tend to produce disproportionate results – either less access to opportunity or greater probability of adverse consequences and outcomes. For example, in his discussion of racial and ethnic disparities in behavioral health systems, Davis (2003) illustrates this point by documenting that groups of color have "less" access to many of the more positive aspects of the system (i.e., early intervention and community-based programs, culturally appropriate providers and assessments, family support, resiliency and recovery programs, etc.) and "greater" involvement with those aspects of the system that tend to produce poor outcomes (longer stays in public inpatient facilities, likelihood of inaccurate diagnoses and poorer prognoses, involuntary commitments and involvement with police and criminal justice systems, etc.). Thus, disparities are characterized by disproportionate over-representation in restrictive, compulsory systems (e.g., justice, child welfare, etc.) and underrepresentation in more positive, well-being oriented systems.

- Racial and ethnic disparities are maintained by an interactive process between communities of color and systems put in place to address social problems. The tendency has been to place "blame" on the culture, community or the individual, hence the term

"culturally disadvantaged," and not on addressing the insidious nature of disparities.

- The pervasiveness of disparities has led to chronic "learned helplessness" in communities and systems, so that racial and ethnic disparities become the proverbial "elephant in the room" (i.e., ignored or not acknowledged) or garner only periodic, lackluster attention without adequate funding and support. Thus, action occurs in small, disconnected, incremental steps that often fail to produce visible or lasting results. A tacit acceptance that "disparities will always be with us" keeps efforts fragmented, poorly funded, easily overlooked and consequently with minimal expectations for change.

- There is an underlying assumption that proposed solutions (such as cultural and linguistic competence) should be derived from an empirically based scientific method that is the centerpiece of the systems that consistently perpetuate and reproduce disparities. The idea that "wicked" problems, like racial, ethnic and cultural disparities, can be solved only through the use of western epistemologies and problem-solving approaches have produced an incredibly rich documentation of theories on why disparities exist, but few, if any, effective strategies for eliminating them.
Racial, ethnic and cultural disparities become even more complex and complicated when they
are embedded in a behavioral health system that experiences its own intrinsic disparity and lack of parity with other health care systems. The President's New Freedom Commission Report (2003) states clearly that the mental health system itself is "fragmented and in disarray...leading to unnecessary and costly disability, homelessness, school failure and incarceration" (p.3). Thus, in many ways, behavioral health systems experience disparities in relationship to health care and other care-giving systems.

*Given these conditions, it is important to question whether eliminating racial and ethnic disparities can occur through a focus on increasing access and services in the present behavioral health care system.* This adds another dimension to the solutions that must be created to improve behavioral health for diverse racial and ethnic communities. In order to effectively address the "wicked problems" of racial, ethnic and cultural disparities within behavioral health systems, a new approach and organizational structure is required.

*These issues cannot be successfully addressed within existing structures, processes, and organizational cultures.* Many more cultural-specific network structures are needed to transform the mental health system. **Network structures involve multiple inter-connected organizations where one unit is not merely the formal subordinate of others.** A network structure usually has a broad mission, joint, strategically interdependent action, a strong commitment to overarching goals, and members that agree to commit various significant resources (e.g., human capital, funding, etc.) over a long period of time. A network approach allows for the greatest level of flexibility and inclusion, while maintaining the integrity of each participant organization. A network enhances knowledge creation and innovation, and provides timely access to knowledge

and resources that are otherwise unavailable to many. A network structure also combines multiple skill sets, innovations and technologies that no one single organization or program could support.

*In efforts to eliminate behavioral health disparities, the Multi-Cultural Community Planning Group wants the proposed PEI plan to address issues of access, availability, quality and outcomes that are essential to the inclusion of all populations in the successful transformation of behavioral health care in the Ventura County.* Yet, to begin to reduce disparities, it is essential to target the issues of under-representation of people of color in quality behavioral health planning, policy development, fiscal distribution, and cultural-specific services. *Much more dialogue needs to occur to increase involvement from priority populations with particular outreach to those groups who are disenfranchised from the CSS process due to perceived* ***"system challenges"*** *to be more culturally inclusive.* System challenges must not become reasons to ex-communicate or erect barriers to meaningful involvement and engagement of diverse, racial/ethnic community stakeholders who may have a different vision of MHSA than VCBHD. We believe that, "iron sharpens iron," and effective collaboration/communication begins with the understanding of process and contextual issues within diverse communities. More flexibility is needed to realize a transformed mental health system sensitive to the needs of all people. *This ensures building of community capacity where "established infrastructure is non-existent or weak and ongoing, vital cultural-specific mental health services are not available."*

***CALL FOR RENEWED VISION, MISSION AND GUIDING VALUES FOR VENTURA COUNTY PEI***

It is our dream that one day Ventura County Behavioral Health has the commitment and leadership to embody the following vision for MHSA priority racial/ethnic populations:

| |
|---|
| ALL culturally, racially, and ethnically diverse individuals and families thrive in, participate in, and contribute to healthy communities. |

This statement reflects that there are structural inequalities resident within the current VCBHD PEI plan and the existing behavioral health system that has many systemic challenges. *We are not suggesting that all racial/ethnic families and individuals have access to the existing system of mental health services offered in the proposed plan.* Rather, our specific interest is in tackling the, "wicked," problem and issues of racial disparity, so the behavioral health system in our county will be transformed while functioning much better to meet the needs of all people.

The racial/ethnic Community Planning group emerging from CSS brought new vigor to the goal of eliminating racial, ethnic and cultural disparities with the creation of different types of structures (clubs, councils, networks, community ambassadors, & key subject matter experts). There are inherent strengths of relational and holistic approaches

rather than traditional or linear thinking (old paradigm ---- organizational development/structures, management, administration, & financial policies). Transformational vision and mission necessary for PEI is predicated upon the assumption that VCBHD understands that there are feasible and realistic cultural-specific strategies to reduce disparities; this knowledge and capacity lies within communities and the individuals that live in them experience daily such disparities in behavioral health, and not solely or predominantly because of the assistance of outside experts or researchers.

*This Renewed Vision, Mission, and Guiding Values acknowledges from its Community Planning foundation that ALL researchers, policy makers, behavioral health professionals, consumers, families, youths, community sites/locations, faith-based, racial/ethnic-based, and other knowledge-generating organizations and entities ALSO HAVE KNOWLEDGE AND SKILLS, that will be helpful.* **Input from many different types of community stakeholders both new and those from past CSS activities are required to effectively eliminate racial/ethnic disparities in mental health.** Knowledge creation and innovation is within this community, which is so important to reducing racial/ethnic disparities.

## A COMMUNITY-DRIVEN, CULTURALLY COMPETENT FRAMEWORK FOR THE VCBH PEI PLAN TO UNDERSTAND AFRICAN AMERICAN MENTAL HEALTH TO REDUCE RACIAL/ETHNIC DISPARITIES

### *NOTES ON UNDERSTANDING AFRICAN AMERICAN MENTAL HEALTH*

***Thomas A Parham, 2005***

The psychology of people of African descent really is about the soul or the spirit. As a consequence, most "clinical" efforts at "treating" African American people are contaminated by the desire to quantify or objectively measure every dimension of the personality, rather than seeking to understand and gain insight into the essence of the individual humanity or spirituality.

Thus, in assessing the functionality of the African Americans we treat, our study cannot be relegated to manifestations of cognitive, affective, and behavioral phenomena. We cannot simply view people as objects with an emphasis on objective methods for studying and assessing them.

The life force or spirit is best understood through an examination of individual and collective struggle by African descent people. Sometimes the struggle is with self, sometimes that struggle is with another person, and occasionally that struggle is against a social force (e.g... oppression, racism, sexism, classism, etc.). Irrespective of the object, a person's spirit is characterized in the fundamental ways he or she engages life circumstances and synthesizes the life force that allows for integration, transformation, and transcendence.

For African people, that struggle is frequently against forces of evil and oppression. West (1996) reminds us that spirituality is reflected in the ways African American people cope with unjustified suffering, unmerited pain, and undeserved harm. Once experienced, the question then becomes how a person achieves some critical distance, and then transcendence, from that pain in order to reengage the situation in an effort to overcome it and transform it.

Understanding African American clients will require, then, some recognition of how a particular client has accomplished this transfiguration. The next step, after understanding and empathizing, is to give voice to what West (1996) describes as the psychic scares, existential bruises, and ontological wounds reflected in the stories our clients disclose. In that way, we access their spirituality and help them to engage it on a more conscious level.

PUBLIC COMMENTS
7/20/2009
RAJAN BHAVNANI

I generally support the PEI Plan
I thank Gabino Aguirre, Susan Kelly, the VCBH staff and our team of consultants
We have a good, solid, group of programs

I generally support the CSS 2009/10 plan update.
With respect to Program #16, I strongly recommend to VCBH that the transformational advocate(s) mentioned be converted to Family Advocate(s) And further that this position or positions be housed within a community organization such as NAMI, rather than within VCBH.

**Ventura County Behavioral Health Department**

Mental Health Services Act

**Prevention and Early Intervention Component Plan**

**30 Day Public Comment - June 16, 2009 - July 16, 2009**

**PUBLIC HEARING - July 20, 2009 - 1:00 p.m.**

Ventura County Behavioral Health Department

1911 Williams Drive - Training Room - Oxnard, CA 93036

Hearing Conducted by MENTAL HEALTH BOARD

**Personal Information (optional)**

Name: Fran Arner-Costello

Agency/Organization: Ventura Co. SELPA

Phone Number: 437-1560 email: farnerco@vcoe.org

Mailing address: _____

**My Role in the Behavioral Health System**

☐ Consumer ☐ Family Member ☐ Probation ☒ Education

☐ Service Provider ☐ Social Services ☐ Law Enforcement ☐ Other: _____

What do you see as the strengths of this plan?

Focuses on some good "selective" programs.

If you have any concerns about the plan, please explain

Not enough emphasis on Universal interventions in schools. Strategies for general ed teachers to promote resiliency + wellness, coupled w/ Universal screening tools to identify children/youth at need ~~risk~~ for selective intervention.

Comments may be emailed to: cathy.morrison@ventura.org, or mailed to

MHSA Ventura County Behavioral Health Dept. 1911 Williams Drive Suite 200 Oxnard, CA 93036

**Public Comment, MHSA/PEI Public Hearing, 7/20/09**

Good afternoon, Board Members.

My name is Deanna Handel, and I am a Program Manager with First 5 Ventura County. Our Director of Program and Evaluation, Charlotte Torres, and I have been involved with the PEI planning process, through serving on the PEI Planning Committee as well as area groups.

First 5 funds 11 Neighborhoods for Learning, which are community-based access points for services relevant to children 0-5 and their families, county-wide. Our Neighborhood for Learning parent participants, staff, and partners have been involved in the planning process through key informant interviews, area planning groups, community forums, and focus groups.

Having been involved in the planning process at multiple levels, we wish to commend Behavioral Health for the ***extensive, broad, and in-depth needs assessment*** work that was successful in bringing to the table voices that were both representative of our County's demographic make-up as well as of the communities that are often under-represented in mental health and County services.

We were honored to hear the perspectives of members of our faith community, mental health consumers and their families, representatives of our Mixteco farm worker population, and community youth – all who shared valuable insight on making services more relevant, accessible, and sensitive to the needs of the populations they represent.

We also appreciated the careful foresight of seeking geographically diverse representation. Ventura County is made of many culturally and geographically diverse communities – and we know that what may work in one part of the County may not be as successful in another. This deliberate planning, and the community level data collection process that underpinned it, will enable a rapid, need-focused deployment if the plan is approved.

A key outcome of this diverse and representative process that is very evident is a program design that brings prevention and early intervention oriented services to venues, such as schools and primary care, that are not traditional venues for mental health services. These community sites are more accessible, ***more likely to serve a population for whom prevention and early intervention services are needed,*** and don't carry the stigma of traditional mental health venues.

Lastly, we commend the wisdom of selecting ***documented, evidence-based interventions*** to be implemented through this valuable funding stream, which is more precious than ever in the face of extensive state-wide budget cuts. As program planners and implementers, we often discuss the need to fund prevention and early intervention rather than more expensive approaches further downstream.

– that take into account the existing County service system

Evidence-based practices, that have been carefully fitted with local needs and that can be adapted to serve diverse communities stand the best chance achieving outcomes that support of the true intent of this funding stream.

Thank you.

Deanna Handel, MPH
Program Manager, First 5 Ventura County