

Final Report

Prevention & Early Intervention (PEI) Planning Process Phase I

Alameda County Community Meetings & Focus Group Discussion

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Prepared by the

**Health & Human Resource Education Center
2288 Fulton Street, Suite 103
Berkeley, CA 94607**

Director of Behavioral Health Care Services: Dr. Marye Thomas
Assistant Director of Behavioral Health Care Services: Barbara Majack
MHSA Coordinator: Gary Spicer
MHSA Planning Coordinator: Carl Pascual
MHSA Planning Staff: Linda Leung-Flores, Tracy Hazelton, Catherine Chen

Health & Human Resource Education Center Staff/Consultants: Tisha Kenny,
Executive Director, Anne Bacon, Program Coordinator, Consultants Colette Winlock,
Adriana Diaz, and Rachel Anumati Bryant

Final Report Primary Authors: Rachel Anumati Bryant and Anne Bacon
Final Report Editing: Tisha Kenny, Colette Winlock, Adriana Diaz

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Introduction

From mid-November to mid-December of 2007, Alameda County Behavioral Health Care Services enlisted the services of the Health & Human Resource Education Center of Berkeley, California to conduct a series of 25 focus group discussions and 8 large community input meetings throughout Alameda County.

The purpose of these meetings was to identify the most pressing MH needs in the community, and the suggestions for solving these problems. Discussions took place within the context of state-identified “Community Mental Health Needs,” which helped to focus discussions and organize the resulting information. These are: Disparities in Access to Mental Health Services; Psycho-Social Impact of Trauma; At-Risk Children, Youth and Young Adult Populations; Stigma and Discrimination; and Suicide Risk.

A total of 629 community members participated in these meetings. Consumers and their families, teachers, parents/caregivers, youth, elders, Spanish-speaking and other underserved populations represented 16 of the County’s 20 towns and cities. The three ethnicities reporting highest were (in order) Caucasian (24%), African-decent (17%), and Hispanic (13%). (“No Ethnicity Specified” constituted 29% of participants.) The majority of participants were between the ages of 27-59 years. Visual maps and graphs representing this geographic outreach and community participants are represented in a Power Point presentation prepared by the Health & Human Resource Education Center, which serves as a complementary document to this written report.

The data reported here represents the analysis of direct transcripts, additional notes and the experience of those facilitating the meetings and discussions. The initial findings were presented to the General MHSA PEI Planning Panel, and the Underserved Ethnic and Language Populations Panel on Friday January 11, 2008. Full transcripts are available upon request for any of the Community Input Meetings or Focus Group Discussions.

Stand Out Issues

Standout issues are those issues most spoken about in all of the focus groups and community meetings, regardless of county demographics. Although many of these topics are discussed at later points in this report, we thought it important to articulate them multiple times to relay the importance they seem to have among community members.

Language Access:

Language was one of the major access issues that we came across during our meetings. The inadequate number of translators available to people seeking MH services was the primary concern. In particular, though, there is a need for translators who are connected both to the culture being translated, and to the proper language/understanding of MH issues. This applies equally to those whose native tongue is a language other than English and to those who speak only English but who come from a distinct culture.

The reason we were given for this being such an important issue, aside from the basic issue of access, is that when inappropriate or untrained translators are used, as children and random staff such as janitors often are, critical mistakes can be made when trying to convey the nuances of a person's MH problems -which can sometimes lead to mis-diagnosis. It can also create confidentiality issues, as well as acting as a barrier to consumers fully disclosing the extent of the issues they are dealing with.

Transportation and Location:

Transportation and location were reported as major obstacles to accessing services. We were told that the farther a person has to travel to access services, the less likely they are to access them at all. This is true both for urban residents who might have to cross the city to access services, and those in outlying areas of the county who might have to get to the other side of the county.

Increasing costs of transportation, the amount of time required to make multiple transfers or to navigate a public transportation system, and for outlying areas of the county like the Tri-Valley, having to plan several hours of travel time whether on public transportation or sitting in horrendous traffic getting to more dense parts of the county where services are located were all listed as transportation barriers.

School Systems:

School systems, we were told, are the most obvious place to administer services to youth, and yet they suffer in general from a lack of all kinds of health services. As well as lacking school nurses and non-academic counselors, teachers lack the training and proper staff to address MH issues when they arise in the classroom.

Teachers, students, parents and staff all reported the difficulty of having MH problems diagnosed as “behavior problems” due to lack of proper information for identifying early signs and symptoms. We heard that this can often lead to expulsions as early as pre-school and other disciplinary acts that do not address the underlying MH problems.

“School for kids is a microcosm for society. We see it as “this is how they get skills to succeed,” but that’s not how they see it, it’s their whole world, their whole social world.”

[School Administrator, Castro Valley USD]

Stigma:

We found that stigma is deep rooted in all parts of our society including in families, schools, the criminal justice system, with employers and landlords, as well as in the media, our pop culture, and the entire healthcare system. Participants reported a “you’re either crazy or you’re normal” attitude that is passed through all these societal attitudes.

This perception was reported both as a trauma and as a barrier to accessing services, highlighting the relationship we found between stigma and all other identified community mental health needs.

Trauma:

Individuals, families and entire neighborhoods reported experiencing “off the chart” levels of violence, leading to multiple and simultaneous traumas. Community violence, the Iraq war, the violence seen on television, and the general anxiety of living in a violent culture are affecting communities across all lines. As a result, stress, depression, grief, anger and fear are at epidemic proportions in people of all ages, and for varied reasons many individuals and communities are dealing with these deep felt emotions on their own.

We also found that trauma and PTSD can be greatly compounded, especially in immigrant families who have already experienced the trauma that sent them away from their home country, live in fear of deportation, suffer from separation of family and culture, and live in isolation. Many ethnic communities also experience the compounded trauma of racism and discrimination, living in a culture of poverty, and the ongoing trauma associated with widespread drug and alcohol addiction.

Youth:

In general, many youth are exhibiting serious attachment and bonding issues created by social isolation, lack of trust, and trauma. Most alarming are the numbers of youth experiencing the trauma of friends and family being murdered, assaulted, imprisoned, and/or struggling with addiction.

Many reported dealing with the complex emotional responses to these traumas without the support of adults or professionals, leading them to express grief, anger, and depression in ways that lead to being labeled “problematic” or “special ed.”

Preschoolers/(0-5):

The problem of school staff being untrained to identify and address burgeoning MH issues is particularly present at the preschool age, where students are currently being “expelled” at a rate 3 times higher than other grades for “acting out.” Stressed environments, including having parents dealing with MH problems, play a big role in the behavior of these young students.

In order for them to get the proper attention they need, these young students need an official MH diagnosis, which many parents are resistant to for fear that it may follow their children throughout their school career and lives.

Teenage and Child Prostitutes:

Children are becoming involved in the sex trade at a much earlier age than ever before. Local middle and high school girls are being transported across city, county and state lines to work as prostitutes and some of these children are even operating as the pimps themselves. Because of the Internet, they are no longer just streetwalkers; many girls are being listed on Craigslist/ Myspace/ Facebook. They are therefore more accessible to pedophiles and able to hide their activities from parents and police.

Local police report that many of these children are being motivated by the “lifestyle” of having a pimp who “loves and provides” for them, rather than the need to support a drug habit as seen in older prostitutes.

Crisis-Driven Services:

Consumers experience difficulty accessing MH services unless at they are at a high crisis point because of the system being overwhelmed. Early intervention was reported as being virtually impossible to receive. As one consumer described the process: *“If I am in a crisis and I call ACCESS, they ask me if I want to hurt myself. If you say, “no,” then they tell you to call back when you feel like you want to hurt yourself.” [Adult Consumer, Pool of Champions]*

At the same time however, consumers, parents, service providers and police reported being frustrated that even crisis services are closed when they are needed most, like evenings and weekends. Crisis situations could be minimized and avoided if alternatives to jail or John George Psychiatric Pavilion were available.

Unique Communities

Several “unique communities” emerged that transcend all ethnic and socio-economic lines. The very nature and circumstances of these groups create distinctive needs for MH services. These unique communities show up throughout our report. An understanding of their “culture” is essential to shaping future PEI services for the following groups:

Consumers Utilizing the System: often use multiple entry points to the MH system, and repeatedly utilize it; they are particularly vulnerable to stigma and the associated traumas;

Dual Diagnosis Consumers: addictions often keep them from accessing the MH services they need, but the MH problems often fuel the addictions causing a vicious cycle;

LGBTQQI Youth: may appear to be part of a “privileged” community, but face particular stigma and traumas that make them vulnerable to homelessness and addiction which often exacerbate or create MH problems;

Deaf Community: particularly vulnerable to family separation, which was one of the leading reported forms of trauma leading to MH problems, and to access barriers due to language and literacy;

Transition Age and Foster Youth: face more compounded trauma than any other population we encountered, often unsupported through the most difficult parts of their transitions, and without meaningful connections;

Parents, Foster Parents and Caregivers: responsible for their own MH and that of children/foster children, making their health needs particularly important;

Seniors: face major transition point as they move into old age, where new habits, addictions and MH problems may develop that never existed before because of compounded traumas related to loss, isolation and grief;

Immigrants: dealing with initial trauma that forced them to leave home, often a second trauma from intermediary country and then the culture shock and multiple traumas relocating in America; undocumented immigrants also face the constant fear of deportation as well as an inability to access services.

Please note that while underserved ethnic communities also represent “unique communities” with distinctive needs, and these needs appear throughout this report, we do not count them in this list because these communities themselves have submitted thorough community-created reports separately.

Community Mental Health Needs

This portion of the report dives into more detail on our findings categorized under the state-identified “Community Mental Health Needs” (CMHN). Those needs include Disparities in Access, Psycho-Social Impact of Trauma, Stigma and Discrimination, At Risk Children, Youth and Young Adults, and Suicide Risk. We open with this quote by a youth reminding us that MH issues know no boundaries, and can affect anyone, regardless of their age, race, or social standing.

“These are all just stereotypes . . . every single one of us is at-risk. Someone could look perfect on the outside, but on the inside could be dying, and they’re not defined as at-risk. Everyone is at risk, and everyone should be helped.” [Youth, Livermore]

Disparities in Access

Access was the CMHN with the most reported issues. From getting to the services, being able to navigate their way into the system, to being able to get appropriate services when they are needed, community members spoke often on this topic.

Getting To the Services:

Geography and Transportation:

The cost, both in money and time away from work, of accessing services located outside of a person’s everyday routine was repeated again and again as one of the biggest barriers to accessing MH services. In general we found that if these kinds of barriers exist, people simply will not access the services. Traffic, multiple public transportation transfers, and distance were mentioned as well, particularly in the Tri-Valley where people often have to travel to Oakland for appointments.

Additionally, some youth reported that they feel uncomfortable asking friends and family members for rides because of confidentiality issues or that they do not have the time and money to travel long distances using public transportation.

Culture of Poverty As A Barrier:

A “culture” of poverty, passed through generations, contributes to a mindset that keeps people from seeking MH services. When “chaos” becomes normalized from the experience of struggling every day to survive, which we heard happens often in families dealing with this “culture of poverty,” people are less likely to identify real problems that need professional help.

Stigma, stereotyping, lack of adult guidance and role models, and the generational PTSD many of those living in a culture of poverty experience add to this constant daily stress, exacerbating underlying MH issues that still never get identified or addressed, sometimes across generations.

“We were brought up in an alcoholic family, it’s almost like you’re in denial, and you don’t deal with it. I didn’t know I was denying what was going on . . . I thought it was just a way of life. My parents had such a hard time.”

[Adult Consumer, Native American Health Center]

Dual Diagnosis:

While in-patient MH treatment centers often require patients to be clean of alcohol and other drug use, the opposite is rarely true. Even though MH concerns are often central to addiction cycles, the places where people seek treatment for alcohol/drug addictions rarely have comprehensive MH programs.

Some consumers who do not have access to or information about MH treatment will turn to alcohol and drugs early on as a form of self-medication, which creates further barriers to being able to get themselves to appointments, be accountable to life changes and delving into the roots of their problems.

Entering the MH System:

Overall, healthcare is inconsistent and disjointed for many communities. The longstanding unavailability of PEI services has created a MH system operating under a crisis driven model- unless there is a crisis there is little or no care available. This crisis-driven model creates an overload on the MH system and leads to other problems like non-working phone numbers, poor customer service, and a general breakdown of communication between service providers, social institutions, families and individuals.

Immediate Access:

Once a person is able to get him/herself to a place of seeking out services, they face a whole new set of barriers. Most notably are the incredibly long waiting lists for early intervention, leading to a delay in dealing with MH problems before they reach crisis. In addition, consumers and service providers report that there is too much “red tape” within the MH system. Sometimes people are sent from one place to another, in person or by phone, without ever receiving any services.

However, even when crisis-situation is reached, regardless of demographics, consumers, families and police report that services are not available when they are needed most: 24 hours a day, on weekends, evenings, after school, during summer break, and on holidays. Because of this we heard families say they often have no choice but to use the police as an intervention for a loved one in crisis. This tactic can sometimes be the fastest or only

entry into the MH system (i.e. John George Psychiatric Pavilion). However, in many of these cases there is no criminal activity that warrants police involvement.

Language:

As mentioned in the Stand-Out issues, language is a massive barrier to access. In addition to it being a cause for social isolation, which may lead to MH issues, when competent translators are not available at entry points into the MH system, consumers are unable to access services. Alameda County is unique in that it is home to so many different language groups making the need for competent translators particularly high.

We heard over and over that often children of consumers or people such as janitors are asked to step in as translators, leading to critical mistakes. As one consumer put it: ***“I say ‘I’m hearing voices,’ and I hear (the translator) say ‘oh he’s hallucinating.’ It’s not the same.”*** [Adult Consumer, Pool of Champions] In MH this might mean the difference between two different diagnoses. It also leads to confidentiality problems, and a resistance to full-disclosure of problems.

Again, though, even English-speakers experience access barriers within the system because of cultural misunderstanding and ignorance. ***“It’s not only about being able to talk Spanish but being able to address their needs, especially for Latino people growing up here and only speaking English”***[Young Adult, Hayward] Some consumers reported having to “educate” their therapist or counselor about the particular experience of being a member of their culture.

Appropriate/Ongoing Services:

Uninsured/Working Poor/Medi-Cal:

The “working poor” face particular access issues as they neither qualify for public assistance, nor are able to afford quality or comprehensive insurance policies. For uninsured, working poor and MediCal recipients there are gaps in MH services which keep them from accessing consistent, or quality care. These gaps occur when funding runs out, programs are unable to accept the coverage of the consumer, the insurance providers require a certain course of action, or the coverage requires a diagnosis or crisis to be able to provide services. This often leads to large out of pocket expenses for those who are least able to afford it, creating further stress.

Medication:

Out-of-pocket expenses were reported as a particularly big issue for those who rely on medication. Low-income consumers reported that they do not always have consistent access to medication due to insurance restrictions, and high cost. As one consumer said: ***“Being on MediCal with attention disorder, there is Stratera, which is excellent for me helps me stay on top of things and focus, but MediCal doesn’t cover it so I have to depend on free samples”*** [Adult Consumer, Berkeley Drop-In Center].

Some people also considered medication a barrier to accessing services, in that it is often pushed as the only option when addressing MH problems. Youth and adult consumers also complained that they were often proscribed medication without proper supervision, information about side effects, or ongoing therapy.

Continuity of Care:

Because of the state of funding for MH services over the past years, many providers reported spending much of their time looking for money and other resources. When this happens direct service time to clients suffers. When there is a major client crisis everything else in a program may need to temporarily shut down so that the more immediate crisis can be resolved. This leads to inconsistent, stop-and-go care of clients. The situation is worsened when service providers (i.e. social workers, program managers, and teachers) choose to take time and money away from their own families to meet the needs of clients.

Consumer care can also be disrupted by changes in their own lives, such as re-location, employment issues, and other environmental changes. These kinds of changes, we were told, are frequent for those dealing with MH problems.

Psycho-Social Impact of Trauma

We asked the community to tell us about the impact of traumas, and they overwhelmingly returned to describing the traumas, leading us to believe that the “psycho-social impact of trauma” is that it doesn’t disappear, and that there are so few avenues for people to discuss it that it builds up until it affects every part of their lives. As one consumer told us: ***“I was treated differently than I had been treated pre-trauma . . . because all of a sudden I’m on the bottom rung of life I have nothing and no one, and suddenly it’s like I am nothing”***[Senior, St. Mary’s Center]

This section describes some of the traumas being experienced by different parts of the county. We saw a few different kinds of trauma: those that are abstract and the result of multiple ongoing experiences, those that result from a specific incident and the particularly vulnerable groups who experience a series of specific incidents that compound to create a new trauma.

Collective Fear, Anger and Grief:

Feelings of fear, anger and grief permeate all socio-economic, racial, ethnic and other identity-related lines. Because they may not be related to one specific incident, or because so much of the community is dealing with them on a daily basis, these emotions

often go unnoticed, and unprocessed. These unprocessed emotions may be early warning signs of even greater MH problems, yet they often go unaddressed.

These emotions may stem from violence (war, domestic, or community), death of loved ones, being labeled/judged, racism/fear of different cultures, deportation, being or becoming homeless, job or home loss, having to deal with the police, family separation, loss, and poverty.

Family Separation:

Family separation was mentioned again and again as a major source of trauma. Because the family is the primary source of connection and support for many people even in non-functional families, the loss of that connection means the breakdown of the entire support system for an individual.

Some of our unique communities reported higher levels of family separation: Foster youth who are taken from birth homes and shifted between foster homes on average about ten times before emancipation; Deaf parents who lose hearing children to the foster care system; LBGTQQI youth who are sometimes rejected by their birth families and communities, and who end up in foster care, and/or homeless; Aging seniors dealing with the loss of spouses, friends and family, who tend to become increasingly isolated and depressed; and immigrants who may have already left behind family members in birth countries and who live in fear of additional separation from family they may have had here due to deportation.

We also heard that immigrant families experience a more subtle form of family separation as children being raised in the U.S. become increasingly influenced by American and pop culture which creates cultural rifts between generations living in the same home. Some immigrants reported being unable to communicate with their own children, and facing resistance from their children when they try to keep cultural practices or traditions alive, which creates a slowly growing trauma.

Interaction With Police:

Police are supposed to be “peace-keepers” but we heard over and over again that they are increasingly connected to trauma in our county. Even the police acknowledged that they are being increasingly drawn into non-criminal MH issues, forced to “seek out a crime” in order to resolve a MH crisis. As one officer put it: ***“What we’re really dealing with is a mental health problem that isn’t criminal at all.”*** [Police Officer] As we mentioned, sometimes this is the only entry into the MH system, but it creates a whole new set of traumas. Many consumers and families alike feel traumatized by police intervention due to the use of restraints and sometimes-violent methods employed by law enforcement.

Ironically, some parents and caregivers who have long-standing resentments against the criminal justice system are forced to call the police on their own children and fear for their children in the care of this “enemy”: ***“I had to rely on the police to get my son to***

the hospital. That was the only way. You don't like it because you're fearful of the police and young African American men."[Parent of Consumer, African American MH Support, Oakland]. They reported that this trauma often encouraged them to try to deal with situations on their own until it became out of control or violent.

Likewise, undocumented immigrants live in constant fear of deportation and family separation, and will not seek police help until a MH crisis becomes very violent or beyond their control. This leads to increased anxiety, fear and isolation for many immigrants.

Compounded Trauma:

The term "compounded" trauma came up over and over, particularly among immigrants & their children, youth living in a culture of poverty, instability and violence, foster youth, and seniors. All of these groups are experiencing multiple, ongoing traumas that never get healed, and often are entirely unaddressed. They report higher levels of fear, anxiety and depression, and are at a higher risk for experiencing even more trauma because of their vulnerability.

Generational and Historical Trauma:

"Generational" and "Historical" trauma were also talked about, often in the same breath as compounded trauma. Though it typically is the result of compounded trauma, it differs in that these traumas are passed through generations. Poverty and addiction were mentioned as generational trauma, and the histories of slavery and genocide were mentioned as historical traumas.

Living in a culture of poverty over many generations weakens the family structure due to high occurrences of incarceration, violence, and drug and alcohol addiction. This normalizes for children a set of behaviors, attitudes and methods for dealing with trauma that are unhealthy. In addition, parents, elders, and role models, contributing to the ongoing cycle of trauma, often pass addictions hereditarily and culturally.

War, slavery, genocide, re-location of whole nations of people, these all are Historical traumas that have gone under-addressed by society. Because society has not properly healed from these traumas, individuals face enormous obstacles in healing from them in their own lives. The legacies of these traumas include institutional and societal racism, and the breakdown of communities.

"The African American community has the war on drugs since the beginning of the crack epidemic . . . and then we have post traumatic slave syndrome . . . and post traumatic prison syndrome . . . And it's crazy making for the whole family."

[Adult, Holistic Health Conductors, Oakland]

At-Risk Children, Youth and Young Adult Populations

While people of all communities requested prevention and early intervention services, youth naturally became the focus of many conversations. As one teacher so aptly put it: ***“By the time they get to high school, no one knows what to do with them anymore.”*** [Teacher, Castro Valley USD]. We found some youth populations were more at risk of experiencing trauma, stigma, and access issues due to lack of proper supervision or support, and because of some form of stigma, including children in “unique communities” (as defined at beginning of report), foster youth (especially at transition age), ethnic minorities, especially boys, children in stressed environments, youth experiencing first onset of mental illness, and children in “culture of poverty.”

The main issues that all youth report being stressed out about are school, grades, family, friends, and community violence. Many times we heard them say that they do not know the difference between simply “being stressed out” and when they or a friend may be experiencing a more serious MH problem. Youth are often processing depression, fear, grief and anxiety alone or with peers. They don’t want to be judged; they fear the backlash of stigma; they do not trust adults, or they think that their confidentiality will be breached.

First Onset

For youth experiencing their first onset of mental illness, these otherwise “normal” life challenges that all youth report experiencing become serious challenges and barriers to maintaining good MH. Without proper support and early identification, many of these youth simply ‘fall through the cracks’ until they begin having school problems, become criminal, and/or engaged in alcohol/drugs or in other risky behaviors. One youth experiencing first onset told us: ***“Smoking [marijuana] was a way to escape feelings of loss, being alone, being sent away all the time, no family to talk to . . . I didn’t want to deal with those things.”*** [Youth, STARS, San Leandro]

Foster Youth:

Although we did not interview any foster children, their caregivers, service providers and family members tell us that they tend to experience the most severe compounded trauma, stigma and PTSD. They experience the initial trauma that causes the separation from their birth family, and continue to be traumatized by a system in which they may be moved an average of ten times before emancipation. This population is particularly in need of PEI services.

Because they are moved around so many times within the foster system, many foster youth never take root in a long-term family structure. Every re-location is traumatic and impairs their social and mental development. Eventually many of them experience a major regression as they approach emancipation having never fully developed the skills for independent living and/or healed from multiple traumas.

We heard many times from parents, caregivers and providers that there is a sense of the “system” doing more damage than good for these youth. They said the foster care system does not prioritize the re-unification of birth families, so that initial trauma goes unhealed, and foster youth grow up feeling “abandoned” by their birth family, and by all the families between whom they’re bounced before being emancipated. This unresolved initial trauma also comes into play at emancipation, however, when many foster youth choose to return to birth families without any support to heal the old wounds.

During this entire process foster youth become increasingly vulnerable to sexual abuse, prostitution and addiction. We heard from police, caregivers, parents and providers that a large percentage of youth prostitutes are runaways, many of them running away from foster homes, and are attracted to a life where someone “loves and cares for” them at last.

As one provider said:

“Children in foster care about to “age out” are in this intense cycle and no one’s holding space for them. They’re at the mercy of the county, completely separated from their families and anyone they’ve stayed connected with, so they run away. They’re at risk in every way and have been repeatedly exposed to trauma and discriminated against.”
[Provider, Foster Youth Alliance]

0-5 Population:

Alarming, we heard that the preschool aged population is experiencing expulsion rates 3 times higher than those of K-12 students. Many of these children are being expelled due to “behavioral problems” that can be traced to stressed environments, often with one or more parent experiencing MH problems. Parents and caregivers alike are not prepared to deal with this early onset of behavioral problems and may not be able to identify the behavior as early signs and symptoms of future MH problems. As one provider described the problem: ***“In families who have mental illness the children start to show behaviors and the teachers don’t know what to do and neither do the families.” [0-5 Provider, Oakland CM]***

Because of specific requirements within MediCal and many other service providers, diagnosis is necessary to receive any kind of service. Without an actual diagnosis for MH problems many of these preschoolers and their families do not receive early intervention services in order to properly address behavior issues.

Schools:

Schools are the portal that almost every child goes through. It is the center of their social and emotional world, as one teacher said, as well as being the place they are supposed to be getting the skills to succeed later in life. The lack of health care at school sites and the unmet health needs of children disrupt this learning and working environment. In particular, youth reported there are not enough nurses, social workers, mentors and non-academic counselors working in schools to meet the whole-person needs of students.

As one student said: ***“At my high school we don’t even have a school nurse. If you get sick, like if you have a headache you can’t even go to the nurse’s office and lay down.”***
[Youth, Fremont CM]

Furthermore, both students and teachers agreed that there is too much emphasis on academics and that the school system is strained by “teaching to the test,” referring specifically to requirements set out by the “No Child Left Behind” Act. Art, music, sports and other creative outlets that could help students reduce stress and maintain balance have lost funding, and standing as school activities.

Because teachers and administrators are so overwhelmed with requirements just to keep the schools open, they are less able to seek out information and assistance when students have special needs. Teachers and school staff are poised to be one of the first points of entry for a student into the MH system, but lack proper education and support, especially in identifying early signs and symptoms.

This lack of information often leads to students with MH problems being labeled “special-ed” or “problematic” when in fact they may need MH services. Others are medicated without adequate therapy and supervision. Many parents fear that these “labels” and diagnoses may carry life-long implications and place their children at greater risk for entering the criminal justice system.

It was reported that many children and youth exhibiting behavioral problems at school are living in stressed environments. Some are experiencing ongoing abuse, neglect, and violence, while others are dealing with one or more parent who has a MH problem. Many are also dealing with poverty and community violence, having walk through “war zones” just to get to school. One adult consumer described her school experience this way: ***“At home there was no love or bonding, so I’d go to school and take it out on the kids, throw all the blocks, tear the heads off the dolls, because my mother done spanked me and sent me to school.”******[Adult consumer, Berkeley Drop-In Center]***

Students, teachers, parents and staff named parent involvement, or the general lack thereof at schools as a contributing factor to school problems. It was however recognized that low parental participation is often be related to parental stress, time conflicts due to working multiple jobs, or language and cultural barriers.

Inconsistent Care:

Inconsistent care is particularly harmful to youth with MH problems. When their care is disrupted for any reason, they are re-traumatized making it harder and harder to deal with root issues. Youth take time to build trust with and open up to new therapists and/or adult mentors so when services end due to lack of program funding, insurance coverage ends or when a therapist moves on, the youth can shut down completely. As one grandmother described it: ***“MediCal is wonderful about providing therapy, but they can only have interns, those run 9-12 months, about the time the child starts opening up, the intern leaves, it’s abandonment all over.”******[Grandmother of Consumer, Fremont]***

Stigma and Discrimination

One consumer said it perfectly when she told us: *“Stigma impacts all of the list [of community mental health needs] . . . until we can deal with stigma that happens as early as birth, it still is not even (going to) damper the other points here”*[Adult Consumer, Oakland CM] We heard three primary types of stigma being discussed: external (coming at a person from outside themselves or their families; internal (including from within the family); and systemic, specifically relating to the MH system, but also mentioning the criminal justice system.

External:

Societal / Media Stereotypes:

Overwhelmingly consumers and providers told us of a general, societal attitude that you are either “crazy” or “normal.” Lack of information about the spectrum of MH issues, and lack of models of “crazy” people functioning “normal” in society contribute to this.

Moreover, they reported the stereotype that once you’re “crazy” you’re “crazy forever,” despite much research and real life experience of people healing from serious psychiatric disorders and living perfectly “normal” lives. This creates fear and anxiety about addressing MH problems, and barriers to open communication about MH issues in families and in society.

We also heard about the stereotype of MH people being violent as a rule.

Employment / Housing Discrimination:

Another place that stigma and discrimination show up externally is in employment and housing. Consumers are more at risk of losing employment and housing because of stigma and discrimination. Employers want explanations for gaps in employment history that consumers do not feel comfortable disclosing for fear of discrimination, and landlords want explanations for SSI or disability income. For example, one consumer said: *“They always wanna know why you’re on SSI, and then you don’t get the job when they find out its mental health problem”* [Adult Consumer, PEERS, Oakland]

Because of these discriminations, consumers often have to their quit job, use up vacation time or take leaves of absence when they have to take care of their MH problems, rather than explain their MH history to employers. Some consumers reported having to relocate each time they quit their job.

Internal:

Cultural/Familial Attitudes:

Many communities have longstanding cultural traditions including “Cultures of Shame and Honor,” that dictate how families deal with MH problems. It is considered a “shame” to discuss a MH problem, and an “Honor” to deal with problems on your own. MH issues are considered “family business” not to be talked about in public. In some cases this is for fear of discrimination, or the family being broken up. This attitude is especially prevalent in immigrant families and those communities that have a general mistrust of institutions and governmental systems. For example: *“Talking outside of the family sometimes gets social services into the family and you don’t want those strangers around” [Youth, Youth Uprising, Oakland]*

Sometimes, especially where MH problems have existed across generations, there is complete denial that MH problems exist at all, creating an “I’m not crazy” attitude. In addition, many families do not have the technical language, personal history and/or points of reference to speak about or access the MH system. As one consumer said: *“I didn’t know there were names for the feelings I was having until I saw a therapist.” [Adult Consumer]*

This quote by an adult consumer speaks to these cultural and familial attitudes perfectly: *“For males it’s a little bit harder than for females, because as Latinos we have been educated that we don’t cry. Depression is for girls, so whenever you’re getting into your first break it’s hard to look for help.” [Adult Consumer, San Leandro CM]*

Stigma As a Barrier to Access:

These internalized stigmas often show up as barriers to accessing the MH system. We heard one community member say: *“I’m an alcoholic, in recovery and drug addict, and I’ll say that in front of 2,000 people, I won’t say I’m mentally ill in front of 2,000 people, not because I’m ashamed of it, but because it doesn’t serve my best interest” [Adult Consumer, PEERS, Oakland]* It becomes easier to talk about problems that society is okay hearing about, and MH can either be couched in those terms, or just be swept under the rug.

The stigma becomes so deep that it creates isolation and shame for consumers and keeps them from getting the help they need. They feel like there is no one, not even loved ones, who are open to talking about what they may be experiencing inside. As one consumer said: *“There are people like myself who have to go through their crisis alone because they feel ashamed. Your self-esteem goes down because people judge you . . . It’s really hard to talk to people about these types of things.” [Adult Consumer, Fremont CM]*

Still many others see “asking for help” as a sign of weakness: *“She’s not able to see her feelings as legitimate feelings. She feels like she’s strong and if she went to counseling*

she'd be giving in. She's supposed to take care of her stuff, no one else is supposed to know her business." [Adult, Holistic Healthcare Providers, Oakland]

Stigma As Trauma:

For consumers, every act of stigma and discrimination is internalized as trauma. For those who already deal with stigmas stemming from racism, disability, or dual diagnosis etc. the burden is even greater. The more they experience, the deeper inward they turn and the less likely they are to seek out help for MH problems.

Systemic:

Consumers related experiencing stigma and discrimination throughout the entire MH system. It begins with having to seek out MH services in a separate place from general healthcare services. Once they have entered the system, they feel judged, stereotyped and "pushed" through the system based on diagnosis rather than their individual needs. As one consumer reported: *"The doctor only spends like 5 minutes with me, and asks me "are you having suicide thoughts?" Then just gives me my medication and dismisses me, doesn't talk to me about what's going on with me"*[Adult Consumer, Berkeley Drop-In Center]

In addition, there are not enough consumers working as peer educators, counselors, or therapists. Consumers reported feeling like some professionals were unable to empathize with them in the way they needed. They also reported worrying that a professional might make stereotypes about their behavior based on something they say (because of mandated reporting laws), comments that someone who had been in their position would take in context, understanding the difference between stress and serious threat.

Consumers also mentioned stigma within the criminal justice system, though it was not elaborated upon.

Suicide Risk

Despite being recognized as a major issue in almost every community, suicide was merely mentioned and rarely discussed at any of our focus groups or community input meetings. We did not hear clear explanations for this silence, and were not given enough information to even make guesses.

The three places where suicide was discussed at all were the Tri-Valley region, (where teen suicide rates are reportedly the highest in the county); by immigrant communities, and those "cut off" from their cultures (i.e. Native Americans, and the Deaf); and in Berkeley where a couple of recent murder-suicides occurred that were preceded by rampant warning signs that went unaddressed.

Suggested Solutions

Suggested Solutions for Addressing Disparities in Access

General Access Suggestions:

Consumers, families and providers alike want more options available for when and how they receive MH services. General suggestions included creating more of a culture of caring by integrating humor, laughter and “play” at all levels. Also, fostering connections, and collaborations between people, services, and the community to increase the capacity of the existing MH system.

County-Specific:

The main suggestion we heard directed at the County system was to increase the capacity of proven, existing services. It was also suggested that the County focus on connecting existing MH services with other established resources in the community, such as churches, mosques and temples, schools, community centers and especially general healthcare providers (clinics, hospitals, doctors’ offices). As one provider said: ***“90% of the people identified with problems were helped by people they already work with. It’s a different model of providing services and its easier to find these high risk populations if you’re working through the community.”*** [Adult Service Provider, Hume Center]

It was also impressed over and over again that the County address some of the longstanding issues that have continually come up in needs assessments. The most often mentioned of these were the issues of expanding services to the Tri-Valley, increasing the language and cultural competency of staff and services (discussed more below), addressing the county’s ‘ACCESS’ hotline problems, and improving public awareness of how to access services.

It was also suggested to increase access of services to a more diverse community that the county develop hotlines specific to unique communities (Deaf, LGBTQI, and language specific services); provide 24/7 services including after-hours and evening appointments; create a holding/triage place to take people to rather than jail or psychiatric units; and reducing waiting lists & “red tape.”

Creating a shift from the current model of “crisis entry” into MH to accessibility of PEI services was also listed as a solution. This could happen through making PEI services available without need for “diagnosis,” integrating Physical and Mental Health services, like making MH services available in health clinics; and creating a special fund for marginal, under-insured families who are not typically able to access services unless they are in crisis.

Language & Culture:

Language and culture were repeatedly addressed as being crucial to breaking down barriers to accessing MH services. It was suggested that ACBHCS continue to develop staff and administrators competent in multiple languages, as well as translating general information (brochures, website, media campaigns).

The County could also use existing cultural and spiritual centers as a way of disseminating PEI services. This approach would empower community and cultural leaders to create and implement culturally specific programs within the communities they are already working with. As one community member explained:

“We understand some of the psychological aspects of the community, and we’re looking not for Western professionals to come in and work with us, but just to get the resources. One of the models we’re talking about is for the community itself to help itself.”
[Adult, Afghan Coalition, Fremont]

Another suggestion to address this issue was to increase home visits for individuals and families isolated by language barriers to better assess and address underlying problems that may be preventing access into the MH system.

Consumer-Led Services:

Consumers overwhelmingly agreed that they would like to see more of their peers trained to work as peer counselors, therapists, and group therapy leaders (“para-professionals”). An important part of this process would be for the County to provide ongoing support to consumer MH para-professionals, and professionals. This would create the option for new consumers to choose whether to work with non-consumer or consumer para/professionals.

Youth/School-Based Access Services:

As stated, the school system provides an incredible opportunity to disseminate information, and identify the early signs and symptoms of MH problems. We heard at every focus group and every community input meeting about the importance of integrating MH services into schools. This integration needs to happen on every level at schools, starting as early as pre-school.

Providing high-level school administrators, teachers and staff, as well as students and parents with the resources and information to identify the early onset of MH problems could be one of the best forms of PEI. One means of doing this would be to develop an age-appropriate curriculum for youth about MH issues, which could be incorporated into existing classes much the same way that sex education has been incorporated into health classes.

Another suggested avenue for integrating MH into schools was to place MH PEI workers directly in school based clinics/nurses' offices. These workers could provide non-academic counseling, as well as acting as a human resource guide for those who are experiencing MH problems, or have friends who they want to help.

Providing after school activities that have built in MH components was suggested, which introduces another important factor: assuring continuity of care for students by extending their access to school-based services. As it stands many students are at a loss when the end of the school day or year comes around, or when there are vacations. If services could extend beyond the school day, and continue into the summer, students would have more consistent access to needed services.

Schools can also be an important way to access parents or caregivers, particularly those who are working, or who have language barriers that prevent them from more ongoing participation in the school. Every student has to be enrolled in school, and it was suggested that the schools use this opportunity to provide parents/caregivers with information about how to identify MH issues in themselves as well as in their children.

Creative Approaches:

One creative approach that emerged again and again as a way of reaching the community with MH information was to create or work with existing neighborhood-based centers. Placing PEI services directly in neighborhoods increases the likelihood of the services being accessed in times other than crisis.

Providing ongoing trauma support groups, peer support, and parenting classes within community centers ultimately empowers the community. This would create an opportunity for youth, parents and community leaders to recognize and assist loved ones that may be exhibiting the early signs and symptoms of MH issues.

It was also suggested that "Mobile Crisis Teams" made up of MH professionals, spiritual leaders and holistic practitioners be developed as first responders for local trauma. These teams could serve as a resource and triage for the already overwhelmed and crisis-driven MH system. One holistic health provider described it this way: *"Every city has "hot spots." It would be interesting to have teams in those hot spots; give us 6 months . . . Pay us to give whoever comes through the door free [holistic health services] and see if we can't change the hot spots. Even for our youth to be exposed to a simple massage."* [Adult, Holistic Healthcare Providers, Oakland]

Alternative and holistic options in the types of services a person is able to access were also mentioned many times. Across the board, the community would like to see these alternatives integrated into the existing MH system. The specific suggestions offered included utilizing creative arts, music, recreational programs, field trips, holistic health (yoga, nutrition, meditation), culturally based practices/healers and activities, and spiritually based practices/healers and activities. We were told that many of these

services already exist outside of the MH system and could be connected, rather than created, with the support of additional resources.

“Unique Communities” with Specific Access Issues:

Several of our “unique communities” who face specific access issues, will need specific responses to their issues. This is what we heard suggested by and for these communities:

Deaf Community: Employ more ASL signers and professionals who understand the deaf community and its related MH issues, and improve access to and training for existing deaf-technology (DSL, video phones (V-Log)).

Dual Diagnosis Consumers: Provide comprehensive MH services in AOD treatment centers, and create volunteer teams to help people in recovery address their living environment so that it supports their recovery. As one consumer provider explained: *“My sense of recovery is that people do it from a standpoint of internal stuff but the outer stuff has just as much of an impact, so to . . . create a (sanctuary) in your home, so you can always say, ‘oh this is unsafe, I’m going to go to my home’”* [Consumer/Provider, Oakland]

Immigrants and Non-English Speakers: Use Radio to reach non-English speakers and immigrants (i.e. Piolín and other language and culture specific programming), and for undocumented immigrants, minimize documentation requirements for receiving services.

Suggested Solutions for Addressing Psycho-Social Impact of Trauma

Neighborhood and Community Suggestions:

Creation of and/or links to existing community centers was suggested not only as a way of improving people’s ability to access services, but also as a way to ensure that the services they are receiving are addressing problems like psycho-social impact of trauma. Specifically people want a place they can go to “decompress” and feel supported when faced with trauma. This request for this was made in every city in the County.

The specific services people want to see in these centers are support groups for trauma related experiences, “quiet” places to get away from the street, classes and groups for all ages so that the whole family has something to do there, and information about how to

access MH services for more serious problems. People also wanted to see traditional caregivers and healing modalities integrated into these centers as PEI providers. It was also suggested that the County create some kind of media campaign happen to increase awareness of, and services for PTSD caused by community and domestic violence. This might look like a billboard campaign, a television or radio campaign or some kind of leaflet/brochure handed out at existing community centers.

School-Based Suggestions:

For youth dealing with trauma, ongoing therapy support groups are not only age appropriate for teenagers, but they also have been proven effective. School counselors told us that these groups provide the youth with meaningful connections to other youth experiencing the same emotions or traumas, while also optimizing the dissemination of MH information. MH education could be incorporated into existing groups and/or new groups for teens and parents could be created.

More school-based, supervised group activities during after-school hours would provide something for youth to do rather than being on sometimes violent streets. Ideally these activities would approach the youth as whole beings: academic, athletic, creative and playful.

Finally, we heard that conflict resolution and anger management classes would greatly benefit students, teachers and parents dealing with stress and anxiety, acting as an effective way to resolve problems before they become more serious. Many youth reported these types of classes as having made significant differences in their lives, and they specifically asked that they be made more widely available for other youth.

System-Police Relationships:

We heard solutions for addressing police-related trauma from police, consumers and services providers. Overwhelmingly we heard that in order to reduce the occurrence of inappropriate police involvement in MH issues, more collaboration and partnerships between police and service providers need to be created.

Expanding the “community policing” model would strengthen relationships with homeless, who are often the ones being criminalized for MH issues. However, once police are involved, they requested having alternatives to incarceration for individuals and families experiencing MH issues. One way to assure that they have this information is to provide police with a clearinghouse of MH resources.

“Unique Communities” Dealing with Specific Trauma Issues:

As explained in the Suggested Solution for addressing Access issues, some communities have unique MH needs and need services that address these needs. When it comes to trauma the communities experiencing the most “compounded” (repeated) trauma are the ones who are most in need of MH services, namely: Foster youth / transition age youth,

LGBTQQI youth, Teenage/child prostitutes, (these groups are discussed in depth in the next section: “Suggested Solutions for addressing At-Risk Children, Youth and Young Adult Populations”); Immigrants /Refugees of war and other violence; and Dual Diagnosis persons, especially those who are homeless.

Suggested Solutions For Addressing At-Risk Children, Youth & Young Adult Populations

Some of these suggestions have shown up under the Access and Psycho-Social Impact of Trauma sections. They are repeated here and expanded upon as a way of demonstrating a comprehensive approach to addressing the needs of at-risk children, youth and young adults. This section is arranged chronologically, beginning with those suggestions that cross all age lines.

General Suggestions:

Almost all youth reported a preference for utilizing peers for support, and adults for information and assistance in figuring out the difference between stress and serious issues. They are often interested in asking for the help they need if they know they have someone trustworthy to ask. As one youth consumer put it: *“Have teachers, school counselors talk to me, instead of assuming that I [am] angry or just messed up. They need to really ask me what [is] going on. Pulling me aside, ask me questions, etc. would have been pretty helpful.”* [Youth Consumer, STARS, San Leandro]

It was suggested that the County provide more training for teen peer counselors in MH issues and create more mentoring programs that are youth driven, as well as adult mentors or role models who will “check in” on youth without the need for an appointment. Increasing opportunities for inter-generational interaction and communication was reported as especially important in immigrant families.

Youth want more “safe” places to hang out, and socialize as part of their age-appropriate MH prevention, as well as more meaningful activities that include non-academic skill building, paid work, and internships to build their confidence and self-esteem.

They also need immediate grief and counseling services to help cope with the trauma they experience from witnessing acts of community or domestic violence. To reduce stigma and access barriers, these services could be incorporated into existing services being offered at school sites and in community centers. Services would also need to be culturally relevant and engaging so that youth will want to participate.

Parents and caregivers requested more information and support to identify and address MH issues. Some suggestions include required classes for new parents about MH and childhood development issues, as well as classes where parents could better understand teen issues, learn to set appropriate boundaries, and monitor their children's internet activities. Some kind of universal guidelines and criteria on how to work with youth who have MH issues, especially how to recognize early signs and symptoms, was requested as well.

Isolated parents that may “fall through the cracks” of the MH system, including new immigrants, MH consumers, the deaf, and non English speakers, would benefit from ongoing support groups and outreach.

0-5 Population:

The first suggested step for dealing with the 0-5 population was to integrate MH services into pre-natal and post-partum care so that new parents experiencing MH problems receive support early on and as part of their routine care. This type of early screening and intervention model could also identify and serve other young children in the same household.

Once young children are in preschool, Head Start and other childcare or development centers, MH workers and services could be in their class/playrooms to monitor behavior and help teachers and staff identify the early signs and symptoms of MH issues associated with early behavioral problems. Providing parents and caregivers with this information as well, provides additional support for identifying potential problems early and getting children proper services and support.

When a problem is identified, it is important for PEI services to be available to children age 0-5 that do not require a diagnosis. This makes PEI services more accessible to families by reducing the stigma and fear of “lifetime markers” associated with an early diagnosis.

Primary-School Aged:

As previously discussed, community members expressed overwhelmingly the need to integrate MH information and training directly into classroom curriculums. Another option for addressing in-class issues that may be related to MH problems was to provide in-class support options for teachers. For example, placing a MH professional, posing as a guest, who observes the behaviors of students in-class and supports teachers outside of the classroom in developing strategies for addressing specific issues.

Most schools, we heard, would benefit from more non-academic counseling staff to support and meet the complete health needs of students, such as nurses and MH counselors. Providing places for youth to “hang out,” connect with adult mentors and meet for age-appropriate adolescent group therapy are important for assuring that teens have consistent care when working through their issues of grief, anger and stress.

Many parents/caregivers requested reducing the tracking in schools that occurs from being labeled “special education.” One way to do this is to incorporate more non-academic skill building for youth who may not excel at math or science, such as art, music, sports, and technical and vocational skills, giving youth a chance to build self-esteem and break the stigma of them as being incapable of learning or succeeding.

Also, at this age it becomes particularly important to provide and extend services to the entire family in situations where a child, parent, or caregiver is identified as experiencing a MH issue.

Foster Youth:

The most important thing we heard for addressing the specific needs of foster youth was for the system to be very clear in policy as well as action about prioritizing the re-unification of the birth family. One suggestion for this included summer camps that brought the foster youth and their birth parents and siblings together in a way that they could each receive services and support while sharing time and safe space together. One example specifically for hearing youth taken from deaf parents is to provide American Sign Language training so that they can continue to communicate with their birth parents.

Another suggestion for working with birth families and foster youth was to provide child-parent interactive therapy and/or trauma-focused cognitive behavioral therapy. This kind of therapy could also be useful in more long-term foster home placements to improve relationships.

We also heard from provider and caregivers that foster youth need specific PEI services that recognize their unique and compounded traumas, addressing their perceived abandonment, potential social and emotional under-development and bonding issues.

Youth about to age-out of the foster system need an expansion of transitional support services. Specifically, they need life skills such as cooking, basic finance, and finding housing, as well as a continuation of MH support and care.

College-Based:

Many MH consumers experience their “first break” under the pressure of college. To meet their PEI needs, it was suggested that on-campus MH services at community colleges and universities be provided. These might include basic opportunities to talk about MH, sleep, time management and maintaining physical and mental health. First year students would be particularly appropriate for in-class presentations about available MH resources and signs and symptoms.

Teen/Child Prostitution:

Further research may need to be done to develop PEI services for the growing number of child, and teen prostitutes in Alameda County. However, some general suggestions

included recognizing foster youth's particular vulnerability to this lifestyle; educating parents, caregivers and other adults to monitor teens' Internet activities and to be aware of what sites their children are visiting and who they are communicating with online; and reaching out to young women on the issue of healthy relationships.

Suggested Solutions for Addressing Stigma and Discrimination

The loudest and most clear message we were given on this topic was that consumers would like to see ACBHCS allocate 10% of PEI funds to a consumer-created anti-stigma campaign.

Anti-Stigma Media Campaigns:

A mass media campaign would act primarily to stimulate public dialogue and increase awareness about MH issues. Consumers believe this will help reduce some of the longstanding stigma and myths about MH, and bring the topic into the mainstream. It is important that the messages are culturally relevant and available in multiple languages.

Consumers request that this campaign would be consumer-created and as widespread as Kaiser's "Thrive" campaign, using the consumers themselves as models of wellness to counteract stigmas about the face and future of people with MH problems.

Systemic Changes:

We heard many suggestions for how the MH system could address stigma in its own ranks. To start off, the system needs a paradigm shift in how MH is discussed. They can begin the process of reducing stigma and discrimination about MH by using language that focuses on mental "wellness" instead of mental "illness".

The County could also create a campaign of '*LISTENING-CARING-RESPECT*' among providers, administrators, and consumers to address the sense consumers have of being mistreated and judged by administrators, intake workers and service providers. It was further suggested that the County adopt a zero-tolerance policy for the mistreatment of consumers including negative attitudes and tone within the current MH system. Provide a system-wide training to support this effort including outreach to the criminal justice system and other community partners.

Also, consumers want to be able to relate to other consumers who understand what they are going through. Therefore support for a consumer empowerment model is vital, including creating a consumer speaker's bureau and training consumer peer educators.

One important suggestion that came up many times was changing the actual term “mental health” to something that is less stigmatized in the vernacular, some suggestions for alternate names included “Support services,” “Wellness,” “Emotional wellness,” “Stress prevention” or just plain “Health”

Suggested Solutions for Addressing Suicide Risk

Although suicide was barely discussed in the focus groups and community meetings, a few suggestions did arise. These primarily stemmed around increasing awareness of early warning signs: Trainings for students, parents, teachers and school staff, and informational media campaigns about suicide-prevention resources already available in the community, particularly on college campuses.

For those who may have attempted suicide, a suggestion that came up in two different groups was to use a follow-up “We Care” card to let them know someone cares and is available for continued support. This would not be a form, or computerized letter, but would be accessible enough for someone to download off a computer and add his or her own personal touch before sending it on. The sender could either be a MH or general health worker or a friend or family member.

Closing

Overall, we were astounded *by the resiliency* demonstrated across all socio-economic, racial and ethnic lines. Although all community members are in some way or another processing long-standing, multiple and compounded traumas, constantly navigating personal lifestyle changes, and even working through serious MH issues, there is still a strong sense of “caring” for one another as evidenced by the number of residents who participated in the focus groups and community meetings and their willingness to share their intimate stories. However, *Resiliency* was mainly demonstrated in their ability to “*make it through life*” in the face of these challenges.

We heard overwhelmingly of a need to foster community and connection, and to encourage meaningful relationships between people of all ages and races. At the end of the day, a young man told us, “*The most important thing you can give someone is yourself.*” We hope that this point is central when determining how the MHSA PEI funds are allocated.