CALIFORNIA INSTITUTE FOR MENTAL HEALTH
COMMUNITY CAPACITY-BUILDING LEARNING COLLABORATIVE

FINAL REPORT

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EXECUTIVE SUMMARY

In September 2007 the California Institute of Mental Health (CIMH) asked Luminescence Consulting (formerly John G. Ott and Associates) to design a Learning Collaborative focused on the potential and practice of community capacity-building.

The Learning Collaborative is organized around two core concepts:

- *Community,* defined as people with sufficiently strong relationships that they provide tangible support to each other and can act together; and
- *Capacity-building,* defined as strengthening the ability of communities to act on their own behalf to promote the wellbeing of their members independent of services.

The theory of change at the heart of the Learning Collaborative reflects a simple initial hypothesis: changes in perception lead to changes in action that, over time, can lead to improved outcomes and other measures of success. A first shift in perception related to community capacity-building is that county departments of mental health confront *an adaptive dilemma* of rapidly declining revenues, steadily increasing costs, and rapidly increasing need and expectations. We describe this reality as an *adaptive* dilemma because we believe that county departments cannot resolve these current challenges *and* improve mental and behavioral health outcomes through traditional management strategies. What has worked in the past to avoid significant deterioration in mental health services and outcomes will not be enough now, not even close.

The historical gap between services provided by departments and residents' need for support reveals an often ignored reality: county departments, no matter how efficient and effective, can never serve all people who struggle with mental health issues within a county. The gap is too large, even when limited only to people who struggle with serious and persistent mental illness. *This was true even before the most recent budget cuts*; it is simply more true now.

Despite this yawning gap between the publicly funded services available in a county and the number of people who could benefit from these services, counties are not witnessing an overwhelming number of people presenting with unmanageable symptoms. A reasonable inference to be drawn from this reality is that many people who struggle with mental and behavioral health issues who are not receiving services are nevertheless getting their needs met through relationships and the support of their communities.

This shift in perspective invites an exploration of what communities are *already* doing—without county-funded services—to meet the needs of people with mental and behavioral health challenges. Learning how to strengthen these community efforts could provide a cost-effective way for improving outcomes of community wellbeing across the county.

This shift in perception leads to another: namely, that families and communities have primary responsibility for the health and wellbeing of their members, not county departments. From this perspective, the role of county departments can evolve to include: (1) strengthening the ability of communities to promote the health and wellbeing of their members independent of services; and (2) providing bridge services to people who do not have natural communities of support, or whose needs are beyond the capacity of their families or communities to meet, while helping to establish or strengthen their ties to natural communities of support.

The focus on changes in perception *before* changes in action reflects a premise that unless these shifts in perception occur, county leaders will not likely undertake the substantial work required by, or tolerate the uncertainty associated with, the proposed changes in action. Shifts in perception are not the point, of course; changes in action are. To date, we have mapped at least three distinct ways that counties can begin to act, or already are acting, in alignment with the theory of change:

- Connecting isolated individuals to an existing community in ways that help the individual become part of the community (not defined by their illness);
- Connecting isolated individuals to each other so they become a new community (not defined solely by their illnesses); and
- Working with existing communities to help them become better able to promote the mental and behavioral health of their members.

Beyond these three movements, departments can make a larger commitment to community capacity-building by involving stakeholders and partners in decisions about their budgets. Such processes can begin to challenge the perception that the department is solely responsible for the behavioral health and wellbeing of county residents. These processes can also expand the number of stakeholders willing to join the department in working to improve outcomes of emotional and behavioral wellbeing.

The theory of change for the Learning Collaborative posits that community capacity-building efforts will, over time, lead to improvements in outcomes of wellbeing for communities and their members. The timeframe for the Learning Collaborative has not been long enough to achieve—or assess—any long-term improvement in outcomes. We have, however, distilled seven lessons about what helps or hinders department and community leaders who want to develop community capacity-building initiatives, and what makes community capacity-building such a potentially compelling response to the challenges currently buffeting mental health systems. These lessons document the need for:

- Defining a deeper reason for community capacity-building;
- Developing a focus on wellness and wellbeing, not illness;
- Overcoming a bias toward professionalism;
- Ongoing relationship- and trust-building;
- Ongoing skill building;

- Flexible funding; and
- Adaptive leadership.

This final lesson about leadership is of particular import. Community capacity-building efforts will inevitably experience moments of disappointment and misunderstanding, even failure. When county and community leaders make a sustained commitment to this work, such moments can be overcome, and sometimes even transformed into opportunities for learning and progress. Without such leadership, however, community capacity-building efforts are more likely to be short-lived, undone with the first setback as staff members and community members conclude that there is insufficient will from their leaders to warrant risking a different way. Through the Learning Collaborative, we have identified three dimensions of leadership essential to the success of community capacity-building efforts: focusing attention, creating context and meaning, and modeling a commitment to learning.

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The perspectives, hypotheses, and emerging lessons articulated in this report are directly informed by our work with the nine counties who participated in the Learning Collaborative, and indirectly by our work with communities and human services systems across the state and country for more than twenty years. As people who have received mental health services, and as family members, we are passionate about improving results for people who struggle with mental and behavioral health issues.

This report is also informed by data and analysis developed by Imoyase Community Support Services (ICSS). ICSS is a non-profit organization that uses program evaluation, action research, training, and technical assistance to support communities across California. Since 1991, ICSS has collaborated with hundreds of organizations, including public and private agencies, foundations, educational institutions, faith-based institutions, and other community-based efforts. ICSS provided evaluation support to the first year of the Learning Collaborative. The work contributed by Cheryl Grills, Michelle Anderson, and Sandra Villanueva was invaluable, and we are thankful for their efforts and their support.

We are equally appreciative of the steadfast engagement and dogged persistence of team members from participating counties. We have been deeply inspired by their work to improve results of mental and behavioral wellbeing for people in their counties, and humbled by their commitment to learning, and to partnering with each other and us. We eagerly anticipate how their efforts and others will continue to advance the emerging movement toward community capacity-building building across the state. We are honored and grateful to be a small part of this movement.

Finally, we want to offer a special word of gratitude for our friend and colleague Michael Oprendek, who died on April 7, 2010. As a former CIMH staff member and Director of Solano County Mental Health Department, Michael was a passionate advocate for people who struggle with mental health issues, and someone who believed deeply in the healing power of community. We miss him dearly, and dedicate this report to his memory and his calling.

INTRODUCTION

In September 2007 the California Institute of Mental Health (CIMH) asked Luminescence Consulting (formerly John G. Ott and Associates) to design a Learning Collaborative focused on the potential and practice of community capacity-building. The Learning Collaborative began in the summer of 2008 and continued through June of 2011. Over the course of the three years, four counties—El Dorado, Los Angeles, Placer, and Stanislaus—developed projects exploring the potential of community capacity-building to advance their transformation efforts. Five other counties—Kern, Riverside, Sacramento, San Joaquin, and Ventura—participated in collaborative learning events but ultimately chose not to develop projects.

The Learning Collaborative's theory of change reflects a simple initial hypothesis: *changes in perception lead to changes in action that, over time, lead to improved outcomes and other measures of success.* For the counties who developed community capacity-building projects, the technical assistance provided them sought to affect participants' perceptions, and to help them develop actions in alignment with these new perceptions.

Section One defines the core concepts that create the theoretical foundation for the Learning Collaborative. Section Two outlines the shifts in perception that are essential for department and community leaders to sustain a commitment to community capacity-building. Section Three describes a range of actions that counties have undertaken consistent with these shifts in perception. Section Four then explores a range of lessons that have emerged through our work with participating counties.

SECTION I: CORE CONCEPTS

COMMUNITY AND CAPACITY-BUILDING

Two core concepts figure prominently in the Learning Collaborative. The first is the concept of *community,* defined as people with sufficiently strong relationships that they provide tangible support to each other and can act together.

County department staff and others involved with mental health systems often use the word *community* as an abstraction, or a planning category—e.g., the Native American community, the African American community, or the working class community. This understanding of *community* may be helpful for strategic planning efforts or analyses about equitable distributions of resources, but such usage does little to describe a *relational* reality. Conversations about building community capacity require a more precise and concrete definition of community. A community can act to improve the mental and behavioral wellbeing of its members when community members know each other well enough to ask for and offer each other support.

The second concept is *capacity-building,* by which we mean strengthening the ability of communities to act on their own behalf to promote the wellbeing of their members, independent

of services. Capacity-building efforts can include department staff helping to build and strengthen relationships among community members, helping to increase community members' skills, and helping community members access resources that enable them to take action together.

What capacity-building efforts do *not* include are strategies to improve or expand professionally delivered services—e.g., through collaboration, co-location, on-site delivery, or other similar efforts. As important as these efforts can be, efforts that increase professionally delivered services in a community are not the same as efforts that increase the ability of a community to act on its own behalf.

THE FOUR DIMENSIONS OF CHANGE

Another core concept introduced to Learning Collaborative participants is the four dimensions of change.[1] Any complex change effort involves at least four dimensions of change: the individual and group interior dimensions of change, and the individual and group exterior dimensions of change. The following table graphically represents these four dimensions:

	Interior	Exterior
Individual	▸ Thoughts and feelings ▸ Sense of identity ▸ Motives ▸ Imagination and dreams	▸ Behaviors ▸ Skills & competencies ▸ Public commitments
Group	▸ Shared purpose ▸ Values and norms ▸ Feelings within a group—e.g., safety, fear ▸ Alignment of individual, group, and higher intention ▸ Organizational culture	▸ Budgets ▸ Technology ▸ Systems ▸ Organizational structures ▸ Collaborative agreements

The upper left quadrant represents the individual interior dimension of change, including, for example, an individual's thoughts and feelings, his or her sense of identity and personal history: all of those aspects of an individual's interior life that cannot be known by someone else unless an individual chooses to reveal them.

The lower left quadrant is the group interior dimension of change. This quadrant refers to the interior dimensions of a group or community's experience. For example, how would members define the group's purpose? What are the values and norms that guide the group's actions? What feelings are present within the group? Do people feel safe in the group to speak their truth, or do they feel afraid and anxious? What is the nature of the interaction between members' individual intentions and the group's collective intentions? Are there old wounds or betrayals that continue to undermine trust among members?

The upper right quadrant is the individual exterior dimension of change. This realm involves behaviors, skills and competencies, and other aspects of an individual's life that can be observed by someone else.

The lower right quadrant is the group exterior dimension of change. This realm includes structures, systems, and other external manifestations of group life: budgets, technology systems, strategic plans, policies and procedures, collaborative agreements, organizational reporting structures, job descriptions, and so forth.

In our experience, many change efforts fail to achieve or sustain their desired effect because they focus primarily on the group exterior dimension of change with little or no engagement of the other dimensions. Departments typically spend enormous time creating budgets, new strategic plans, new organizational structures, new program designs, often without considering the other dimensions of change that need to be engaged to support the transformation. An underlying premise of the Learning Collaborative is that any successful effort to embrace community capacity-building will require an active and ongoing engagement with all four dimensions of change.

The next section begins to explore the shifts in perception—changes in the interior dimension of change—that can lead counties to undertake the work of community capacity-building.

SECTION II: ESSENTIAL SHIFTS IN PERCEPTION

THE CURRENT CONTEXT: AN ADAPTIVE DILEMMA

A foundational premise for the Learning Collaborative is that county behavioral and mental health systems in California currently face an adaptive dilemma. Even with the infusion of new funding from the Mental Health Services Act (MHSA), overall county budgets are shrinking, dramatically so in the past two years with the onset of the worldwide recession. Current projections of both federal and state revenues, including MHSA funds, indicate that this decline in funding will continue for a number of years. The financial vise squeezing county departments is made even tighter by rising costs associated with delivering services, particularly health care and pension costs and the costs of providing care to the uninsured.[2]

Departments have responded to rising costs and severe budget cuts by eliminating contracts and staff, resulting in substantial reductions in services.[3] At the same time, while county departments are cutting programs and staff, the number of people struggling with mental health issues is increasing significantly, caused in part by veterans returning home from Iraq and Afghanistan,[4] and families struggling with financial and personal stresses caused by the ongoing recession.[5]

This dilemma of rapidly declining revenues, steadily increasing costs, and sharply increasing need is made worse by the expectations created by the passage of MHSA. Following the passage of Proposition 63 in 2004, many people expected a dramatic expansion of mental health services,[6] and now struggle to understand why clinics are being closed and other services reduced.

We describe this dilemma as an *adaptive dilemma* because we believe that county departments will not be able to resolve these current challenges *and* improve mental and behavioral health outcomes through traditional strategies for managing budget shortfalls. In previous years, mental health leaders have relied on fund balances and other non-recurring funds to address budget shortfalls and avoid significant service curtailments. Over the past several years, however, even with new MHSA funds, many county departments have experienced annual budget shortfalls necessitating the use of fund balances and service curtailments. Having exhausted much or all of their fund balances and other short-term funding sources, county departments now face the most severe funding curtailments—in federal, state, and local funding—in more than a decade.

Reduced to its essence, the analysis that inspired the Learning Collaborative is straightforward: what has worked in the past to avoid significant deterioration in mental health services and outcomes will not be enough now, not even close.

THE IMPLICATIONS OF UNMET NEED

One of the manifestations of the adaptive dilemma now confronting county departments is the yawning gap between the numbers of people who could potentially benefit from department programs and the numbers actually served.

Department leaders rarely discuss the full extent of this unmet need publicly, or even among themselves. Given the challenges of managing a rapidly contracting budget, and the pain of reducing services to people who currently depend upon department support, why draw more attention to the legions of people the department will never be able to serve?

For several reasons.

By focusing attention on the gap between the number of people served by county services and the number of people who struggle with mental health issues, department leaders and their partners may be helped to realize—and acknowledge—that county departments, no matter how efficient and effective, can never provide services to all people who struggle with mental health issues. The gap is too large, even when limited only to people who struggle with serious and persistent mental illness. *This was true even before the most recent budget cuts*; it is simply more true now.[7]

This insight—if fully understood—can quickly lead to another: many people who struggle with mental health issues, even serious and persistent mental illness, are likely getting at least some of their needs met in ways that do not require county services. Why? Because county departments are not being besieged by thousands of people presenting unmanageable symptoms. This is conjecture, of course, and it is undoubtedly true that many people who are not receiving services are not getting their needs met in other ways—e.g., people with mental illness who are in jail and receiving no services, people who appear in emergency rooms with undiagnosed mental illnesses, people who are homeless and have untreated mental health issues, and others. Accounting for these numbers, however, does not resolve the services gap reported by counties.[8] A reasonable hypothesis is that many people who struggle with mental and behavioral health issues who are not receiving services are getting their needs met in other ways.

If this hypothesis is true, then expanding the focus of county leaders and their partners from clients in the system to all people in the county who struggle with mental health issues has several implications. First, this shift in perspective invites an exploration of what communities are *already* doing—without county-funded services—to meet the needs of people with mental and behavioral health challenges. Learning how to support and extend these community efforts could provide a cost-effective way for improving outcomes of community wellbeing, one of the core changes in action recommended by the Learning Collaborative.[9]

THE ROLES OF COMMUNITIES AND COUNTY DEPARTMENTS

Our work with county leaders through the Learning Collaborative suggests that, when leaders accept the premise that the department faces an adaptive dilemma, and acknowledge that many people are getting their needs met without department services, they can more easily embrace the next shift in perspective: namely, that the department is not, and cannot be, the principal source of action to promote mental and behavioral wellbeing for most people in the county.

This additional shift in perspective is crucial: without it, county staff can labor under the illusion that they alone are responsible for the emotional and behavioral wellbeing of all county residents, an impossible (and morale-sapping) charge. Moreover, without this shift away from a "system-centric" and "service-centric" perspective, department leaders and staff will not likely support community-capacity building. Why would they, if department actions are all that matter?

An alternative perspective is that families and communities have primary responsibility for the health and wellbeing of their members, not county departments. From this perspective, the role of county departments would become focused on:

- Strengthening the ability of communities to promote the health and wellbeing of their members *independent of services*; and
- Providing bridge services to people who do not have natural communities of support, or whose needs are beyond the capacity of their families or communities to meet, *while* helping to establish or strengthen their ties to natural communities of support.

Focusing on how to promote communities acting on their own behalf, independent of services, is a dramatic departure from how departments have functioned over the past twenty or more years. Departments have traditionally focused on delivering discrete units of service to (fewer and fewer) individuals with mental illness. Moreover, county-funded programs rarely focus on or track how quickly people can transition out of services into more natural communities of support.[10]

These shifts in perspective—developing a different understanding of community and community capacity-building, understanding the current reality as an adaptive dilemma, confronting the implications of unmet need, and understanding the roles of communities and departments differently—provide the foundation for a commitment to community capacity-building. The focus on changes in perception *before* changes in action reflects a premise that unless these shifts in perception occur, county leaders will not likely undertake the substantial work required by, or tolerate the uncertainty associated with, the proposed changes in action.

Once these shifts in perception occur, however, department and community leaders often need help conceiving and pursuing actions consistent with a commitment to community capacity-building. The next section provides a beginning map for how counties in the Learning Collaborative have moved from changes in perception to changes in action.

SECTION III: FROM SHIFTS IN PERCEPTION TO SHIFTS IN ACTION

Through the Learning Collaborative we have mapped at least three distinct ways that counties can begin to implement, or already are implementing, the theory of change:

- Connecting isolated individuals to each other so they become a new community;
- Connecting isolated individuals to an existing community in ways that help the individual become part of the community; and
- Working with an existing community so that it becomes stronger and better able to promote the mental and behavioral health of its members.

What follows are brief examples of each of these movements.

MOVEMENT 1: CONNECTING ISOLATED INDIVIDUALS TO AN EXISTING COMMUNITY

One way departments can promote community capacity-building is to help people who receive services re-establish or strengthen their connections to natural communities of support. These strategies are most responsive to the adaptive dilemma when people are connected to communities in ways that are not wholly defined by the person's mental illness, and in ways that do not require sustained engagement by paid staff. Examples of this movement include the following:

- When a participant in a Full Serve Partnership program in Placer County expressed an interest in hiking to his clinician, the clinician invited him to her hiking club. The participant knew a lot about hiking and about local trails. Over time, the participant became a leader of the club, and his fellow club members became one of his support communities.

- Staff members of Behavioral Health and Recovery Services in Stanislaus County are considering how to evolve their housing and employment programs to reflect a commitment to community capacity-building. Specifically, they are exploring strategies to train friends and close associates of people who receive housing and employment services to become allies and advocates with landlords and employees. The purpose is to strengthen the ability of families and communities to support the wellbeing of their members, and to insure that these supports remain even if services go away.

- The Los Angeles County Department of Mental Health developed an initiative to refer Native American youths who receive mental health services to tribal communities that provide cultural activities such as drumming, dancing, and healing ceremonies. For urban Native American young people, receiving mentoring and support from other tribal members strengthens their cultural identity, an important factor for developing resiliency and sustained wellbeing.

- Through its Community Services and Supports Plan, Tri-City Mental Health Center [11] established new staff positions called Community Navigators to help connect individuals receiving services to natural communities of support. For example, when an older adult needed but could not afford nutrition supplements, a Community Navigator made an announcement about this need at a local church. Church members responded enthusiastically, asking about her brand and flavor preferences, and then enabling the purchase of caseloads of the supplement. This initial engagement created an opening for an ongoing experience of connection and support between the older adult and the church community.

All of these examples illustrate how an orientation to community capacity-building can inspire departments to help isolated individuals create or re-establish ties to existing communities of support while diminishing dependence upon support from paid staff.

MOVEMENT 2: CONNECTING ISOLATED INDIVIDUALS TO EACH OTHER

One of the concerns that many people express about a shift to community capacity-building is that people who receive mental and behavioral health services are often isolated, separated from their families and outside of natural communities of support. Departments address these issues by helping to organize and assist an array of support structures, including peer support groups, client coalitions, family support groups, and welcome and recovery centers. These efforts represent an impulse to help isolated individuals become a community for each other, a movement consistent with a commitment to community capacity-building.

One weakness of many of these efforts, however, is that the communities are often organized around the experience of illness; that is, people can belong to these communities only if they identify themselves as experiencing, or having experienced, mental illness. As important as peer support is, such community identification can often create unintended and subtle pressures to resist recovery, because getting better could result in being excluded from the community. Another weakness is that these efforts frequently depend on paid staff, positions that are increasingly under pressure given ongoing budget shortfalls.

Several departments have evolved strategies to counter these weaknesses. In Stanislaus County, for example, the Behavioral Health and Recovery Services Department supports the Peer Recovery Art Project. This vital community builds relationships among artists, including artists who struggle with mental health issues. What unites community members is their passion for art. They connect to and support each other without the intervention of professional staff.

Placer County's Prevention and Early Intervention Plan invests in the training of residents who can become volunteer leaders of peer support groups. Part of the emerging strategy for these groups will be to engage participants around common interests that extend beyond their mental health issues.

Tri-City Mental Health Center, like most mental health systems across the state, has experienced a dramatic decline in funds available to support people who do not qualify for Medi-Cal services, and a dramatic increase in the number of people seeking services. One strategy this system has developed is to have a clinical staff member organize support groups among people who cannot qualify for services, or who cannot receive services because of a lack of staff or funding. The focus of these support groups is to help participants get access to available community resources and supports, and to learn how to run their own support groups without staff support. After a defined period of time, the group becomes self-supporting, and the staff member starts another group.

All three of these efforts focus on helping isolated individuals become a community to each other, but in ways that do not organize the community around the experience of mental illness, and in ways that do not require sustained dependence on professional staff.

MOVEMENT 3: HELPING COMMUNITIES PROMOTE THE WELLBEING OF THEIR MEMBERS

A third way departments can commit to community capacity-building is to build partnerships with communities to help strengthen their ability to promote the wellbeing of their members, independent of professionally delivered, publicly funded services.

For example, in Stanislaus County, the Behavioral Health and Recovery Services Department is exploring ways to provide technical assistance and other forms of informal support to help expand and strengthen the burgeoning recovery movement among local churches.

Placer County invested Prevention and Early Intervention resources to support Latino communities across the county. One project helped Latino leaders in the city of Lincoln to organize an all-day health fair. The fair provided screenings, trainings, and other services to residents, all donated by local providers. Community members prepared food for the fair, offered free childcare, and organized other community-building activities.

El Dorado County, Placer County, and Tri-City Mental Health Center have used MHSA funds to create community wellbeing grant programs. These programs provide small amounts of one-time funding to help local communities promote the wellbeing of their members. For example, a veterans' collaborative is promoting the use of healing circles to help veterans and their family members move from dissociation to reintegration. Staff members from a non-profit dealing with domestic violence are learning skills and practices that will lessen the effects of vicarious trauma, compassion fatigue, and burn out.

The Behavioral Health and Recovery Services Department in Stanislaus County has designed a more expansive community capacity-building initiative through its Prevention and Early Intervention and Innovation plan. Under this project community leaders will be supported to

apply a framework called Results-based Accountability [12]to their efforts. Specifically, community leaders will engage in a process to answer seven questions:

1. What communities are we concerned about?
2. What conditions of mental and emotional wellbeing do we want for these communities?
3. What community-defined indicators could we track to tell us if we are making progress toward these results?
4. How are we doing on the most important of these indicators, and why?
5. Who are partners who have a role to play in improving our conditions of mental and emotional wellbeing?
6. What is already working, or can work, in our community to improve these conditions of mental and emotional wellbeing?
7. What do *we* propose to do (including no-cost and low-cost ideas)?

As communities participate in this process, they receive several forms of ongoing support from the Department. First, as in the other three counties, communities can apply for time-limited community wellbeing grants to support their efforts. Second, they receive support to generate and analyze data to assess whether their actions are improving results of wellbeing for their members. Third, members and leaders from participating communities engage in a variety of collective learning processes.

All of these efforts are designed to strengthen networks of relationships in participating communities, and to increase community leaders' skills and resources to develop effective efforts to promote the behavioral health and wellbeing of community members, independent of professional services.

LARGER COMMUNITY CAPACITY-BUILDING EFFORTS: FOCUSING ON DEPARTMENTAL BUDGETS

Beyond the three movements described above, departments can make an even larger commitment to community capacity-building by involving stakeholders and partners in decisions about the department's budget. Such efforts can begin to challenge the perception that the department is solely responsible for the behavioral health and wellbeing of county residents. These efforts also expand the number of stakeholders joining with the department to improve outcomes of emotional and behavioral wellbeing.

The Los Angeles County Department of Mental Health created such a process in 2004, when it faced a projected budget shortfall of more than $50 million. The department engaged over 700 people from 29 stakeholder groups in an extensive process to explore options for how to address the shortfall. The process culminated in consensus recommendations endorsed by all stakeholders, including the department's senior management team. The senior management team forwarded these recommendations to the Board of Supervisors, even though they diverged significantly from the proposals first put forward by the management team. The Board of

Supervisors ultimately approved the stakeholder recommendations by consent. This experience laid the foundation for a more expansive and successful MHSA stakeholder effort that followed.

More recently, Stanislaus County funded an Innovation Project to evolve the ad hoc advisory boards and the MHSA delegates group into a broader stakeholder group. The purpose of this group is to help department leaders develop an integrated, fiscally sustainable behavioral health system committed to clearly defined results. The first phase of the project focused on a significant projected shortfall in the Alcohol and Other Drug (AOD) budget for FY 2011-12. Similar to the Los Angeles County process, the purpose of the stakeholder process was to explore potential responses to the budget shortfall.

Participating stakeholder groups included people in recovery, family members, community leaders, faith-based leaders, non-profit providers, private sector providers, BHRS staff members, union members, BHRS senior leadership team members, senior leaders from other county agencies, representatives from the county CEO's office, representatives from the Advisory Board on Substance Abuse Programs (ABSAP), the Mental Health Board, and others. Each stakeholder group selected delegates and alternates to represent them.

Delegates met for a total of 8 sessions between November 30, 2010 and March 2, 2011. Average attendance, including delegates, alternates, and observers, was over 60 people. During the early stages of the process, participants worked to understand the details of the AOD budget, the reasons for the projected shortfall, the diversity of services and supports available across the county, the scope and focus of the BHRS-funded services most impacted by the budget reductions, and the available data about numbers of people served and the quality of the services provided by BHRS and other providers.

During subsequent sessions, delegates drafted principles to guide their deliberations. They then reviewed cost and service level scenarios for various programs, and worked through small and large group processes to develop multiple iterations of their recommendations. After several rounds of deliberations, delegates explored areas of agreement and divergence. Ultimately, they approved—by consensus—a set of recommendations that was then forwarded to the BHRS senior leadership team. The leadership team formally endorsed these recommendations and forwarded them to the county CEO and Board of Supervisors, who approved them as part of the County's FY 2011-12 budget.

For county leaders to undertake significant change efforts like the Stanislaus County budget process, however, requires a shift in perspective that is related to but distinct from those documented in Section Two. County leaders typically manage their department budget as if they alone are responsible for its development and implementation. This is understandable: department leaders are legally accountable to the Board of Supervisors, and to state and federal regulators. This orientation, however, can reinforce the perception that department leaders and their staff are solely responsible for the mental wellbeing of county residents, and that the department’s budget is the only resource available for this purpose.

An alternative perspective, however, posits that the department's budget is only one part of a much larger array of resources—private sector, non-profit, community, volunteer, and others—that county residents allocate and can access to support their mental and behavioral wellbeing. From this perspective, department leaders are managing the department's resources as part of a much broader effort to benefit as many county residents as possible.

If department leaders understood their role in this way, then a central part of their work would be to engage community leaders and stakeholders as partners in making difficult choices about priorities when budget cuts occur, and about program design and deployment decisions to ensure their maximum impact. This shift in role is beginning to happen in Stanislaus County. Again, a shift in perception created the foundation for a dramatic shift in action.

SECTION IV: EMERGING LESSONS

The theory of change for the Learning Collaborative posits that community capacity-building efforts will, over time, lead to improvements in outcomes of wellbeing for communities and their members. The timeframe for the Learning Collaborative has not been long enough to achieve—or assess—any long-term improvement in outcomes. We have, however, distilled several lessons about what helps or hinders departments that want to develop community capacity-building initiatives, and why community capacity-building can be such a potentially compelling response to the challenges currently buffeting county mental health systems.

The core concept of the four dimensions of change maintains that successful change efforts must engage the individual and group interior dimensions of change, and the individual and group exterior dimensions of change. Like any complex change effort, to create successful community capacity-building efforts requires an ongoing engagement with all four dimensions of change.

Given this understanding, perhaps it is not surprising that the lessons learned reflect both the interior and exterior dimensions of change. The first three lessons—a deeper reason for community capacity-building; a focus on wellbeing, not illness; and overcoming a bias toward professionalism—focus on the interior dimensions of change. The next three lessons—the need for ongoing relationship- and trust-building; the need for ongoing skill building, and the need for flexible funding—focus on the exterior dimensions of change. The final lesson—the essential role of leadership—involves both interior and exterior dimensions of change

A DEEPER REASON FOR COMMUNITY CAPACITY-BUILDING

We began the Learning Collaborative with a hypothesis that unless department and community leaders experienced these shifts in perception—understanding the current reality as an adaptive dilemma, confronting the implications of unmet need, and understanding the roles of communities and departments differently—they would not be willing to undertake the substantial work required by, or tolerate the uncertainty associated with, a commitment to community capacity-building.

For many department and community leaders who chose to sustain their engagement with the Learning Collaborative, these shifts in perception were enough. For some Learning Collaborative participants, however, these shifts in perception were not enough—by themselves—to generate a sustained "yes" to community capacity-building. Many participants who said *yes* found additional, more compelling (for them) reasons to embrace community capacity-building. For example, several department leaders concluded that community capacity-building was the ultimate stigma reduction strategy. That is, these leaders believed that community capacity-building strategies could help increase the inclusion of people with mental illness in natural communities of support, and thus help overcome their experience of being labeled "the other."

For others, particularly community leaders, the stumbling block was not the shifts in perception outlined in the theory of change, but rather the issue of trust: those who could shift their perceptions of their department counterparts and risk trusting that the invitation from department leaders was genuine were far more likely to say *yes* than those who could not or would not risk such trust.

Whether participants needed to discover more compelling reasons to support community capacity-building than the posited shifts in perception, however, the larger pattern articulated in the theory of change held: namely, that the emergence of community capacity-building initiatives first required shifts in perception to help department and community leaders say *yes* to the effort.

A FOCUS ON WELLBEING, NOT ILLNESS

Community capacity-building orients to wellness and wellbeing, not illness. While not everyone suffers from mental illness, everyone seeks and can benefit from wellness. This insight may seem straightforward, even trivial, but our experience in the Learning Collaborative highlights how profound—and difficult—this shift in the interior dimensions of change can be for people engaged in community capacity-building efforts.

Broadly speaking, county mental health budgets consist of two kinds of funds: categorical funds and flexible funds. Departments have no discretion over the amount or allocation of categorical funds: the source of the funds—usually the Federal or State government—determines how much the Department will receive, what population(s) must be served, and what programs must be implemented for these populations. Not only is funding for mental health services declining precipitously, it is also becoming more categorical, focusing scarce resources on increasingly restricted populations, typically adults diagnosed as seriously and persistently mentally ill and/or young people diagnosed as severely emotionally disturbed (SMI/SED).

Although departments are called mental or behavioral *health* departments, their focus is increasingly limited to addressing the most severe illnesses. From a management perspective this narrowing focus is not surprising: it reflects a triage orientation, a commitment to dedicate scarce resources to those people who are suffering the most.

Paradoxically, however, a movement to focus resources only on the most ill can have the unintended consequence of further isolating people who receive mental health services from the larger population. As fewer people are served and affected by public mental health programs, elected officials, community leaders, and large parts of the population who do not suffer from SMI/SED can conclude that conversations about mental health programs and the mental health budget are not relevant to them and their families.

The first two movements of community capacity-building—connecting individuals to natural communities of support in ways not defined by their illness, and helping isolated individuals become a community of support for each other not limited to focusing only on their illnesses—

reflect a conviction that recovery and wellbeing require relationships, and a focus on interests and passions beyond a person's illness. Throughout the Learning Collaborative participants spoke repeatedly about how important—and challenging—this shift in orientation can be. One participant offered this reflection:

> As family member and a county staff person, the whole reason for my job is due to my daughter's illness. It is very confining to have my existence and those of other family members working in the system be about illness every day. What's a different way to introduce myself? How can I emphasize my daughter's gifts and strengths instead of her illness? I understand the need to talk about the illness but it's very confining.

Another participant made this observation:

> [In a county where I worked previously], we had to dis-enroll 150 members due to budget cuts. Many of these client had been with us for many years. This was terrible for everyone, but even more so because we had assumed the clients were members for life. This is a really big but needed shift in thinking.

The third movement of community capacity-building—helping communities promote the wellbeing of their members—most clearly highlights this difference in orientation. Mental health and other human services departments have embraced a commitment to strengths-based work with individuals and families for years. When Departments engage communities, however, they typically ask community members about their *needs,* and what *services* would help address these needs. Such a conversation does not encourage community action and resourcefulness; it instead highlights deficits, and implies that these deficits can only be addressed through services provided by a professional staff member.

Focusing on community-defined results, and helping communities define actions they can undertake by themselves, shifts the focus from services delivered by others to community agency. Beginning these efforts by asking communities what *conditions of wellbeing* they want to create for their members shifts the focus away from needs (what communities lack) to what community members want to create for themselves.

This shift builds on successes that have emerged from Asset Based Community Development (ABCD) and similar frameworks. These approaches, like strengths-based strategies for families, begin with a presumption that communities have strengths and assets that already are supporting their members' health and wellbeing, a presumption explicitly embraced by the Learning Collaborative's theory of change. Our work with counties suggests that, with culturally appropriate support and encouragement, communities can leverage and extend these strengths and assets to improve and sustain the wellbeing of their members over time. One of the Native American participants in the Los Angeles Learning Collaborative project put it this way:

> When working with communities, look for their healers. All communities are able to help their members heal. Learn about these methods and see who the natural healers are. … View mental health as a way of life and pay attention to the little things like small rituals that might be overlooked. All communities can support wellness even if their members' actions seem ordinary or small.[13]

More generally, initiatives focused on wellness and wellbeing can engage and relate to *any* community, and all people within a community. In Stanislaus County and the Tri-City area, their Prevention and Early Intervention projects have attracted interest from a diverse spectrum of communities, including ethnic and cultural communities, faith-based communities, communities of interest and shared experience, communities with different median incomes, and others. Many of these communities would never have participated in an initiative focused only on addressing the needs of people with mental illness.

OVERCOMING A BIAS TOWARD PROFESSIONALISM

We define *professionalism* as an emphasis on specialized knowledge and skills possessed by people—professionals—who have attained high levels of formal education and extensive structured experiences.

Beginning in the early 1900s, and accelerating over the last four decades, there has been an increasing emphasis on professionalism in human services. Efforts to increase the education, training and skills of service providers have created important improvements in the human services system. Over time, however, this emphasis on professionalism has created an (often unspoken) assumption among staff members and contractors that *only* professionals are qualified to provide services and supports to people in need. This assumption creates a barrier to strategies that seek to increase a community's capacity to act on its own behalf. If *only* professionals are qualified to provide support and services, then community-based efforts can be seen as inadequate, or worse, illegitimate.

The increasing use of peer support groups, and efforts to recruit *promotoras* to provide behavioral health education in communities, are two movements that reflect an increasing openness to non-professional strategies. Departments that can recognize this potential bias among staff and contractors and take active steps to address it are more likely to be open to the potential of community capacity-building efforts.

Many community members and leaders also hold this bias toward professionalism, believing that only professional services can improve the health and wellbeing of community members. Others understand that communities have the capacity to promote their own wellbeing, but still focus their efforts exclusively on the service delivery system. Those community leaders who focus primarily on equity issues—"Is my community getting a fair share of public resources?"—or on cultural competency issues—"Are the professional services provided in my community appropriate for my people?"—will be far less likely to devote the time and energy for community

capacity-building. Acting to improve the service delivery system is not inconsistent with a commitment to community capacity-building, but neither is it the same thing, and only those communities and community leaders who understand this distinction will be able to sustain the energy and focus needed for community capacity-building.

THE NEED FOR ONGOING RELATIONSHIP- AND TRUST-BUILDING

Often when department leaders pursue relationships with community members, they are motivated by process requirements or other department-centric imperatives. MHSA, for example, requires departments to engage a broad array of stakeholders in comprehensive planning efforts before departments can access available funds. Of course it is a good idea to engage community leaders and other stakeholders in planning efforts, and no doubt most if not all of these participants welcome the invitation. Such invitations are often made on the department's timeline, however, and framed by departmental priorities and mandates.

Supporting communities in *their* efforts to improve mental and emotional wellbeing requires a different orientation and approach to engagement by department leaders, staff, and contractors: specifically, an ongoing commitment to relationship building with community leaders, and a willingness to understand the dynamics and priorities of community leaders and members.

For example, in Los Angeles County a workgroup that included traditional Native American healers, Native American clinicians, Native American community leaders, Native American youth experiencing severe emotional disturbances, county administrators, and county clinicians met for several months to develop shared understanding about Native American healing traditions. During one of the sessions, a Native American clinician shared that she had never before been in a room with Native healers and county personnel at the same time. She disclosed that she had never thought such a gathering was even possible, given the cultural sensitivities associated with discussing traditional healing services, and the high risk for misunderstanding between Native healers and mental health clinicians.

Toward the end of this process, another participant observed, "We developed a high level of openness and trust with each other, with enough time for everyone to really listen to one another and build relationships." The trust and understanding that emerged through this process created the foundation for a very promising Innovation project focused on building effective referral processes between mental health clinics and traditional healing services, a project that was literally unimaginable before the relationship building that preceded it.

In Stanislaus County an Alcohol and Other Drug (AOD) staff member invited an Asian youth group to participate in a county-planned Youth Summit. When the youth group declined the invitation, rather than giving up, the staff member chose to invite the youth to an informal lunch to listen, inquire, and develop shared understanding about what had happened. During the lunch the youth leaders shared that they did not feel there was a strong enough relationship between them and BHRS staff members to participate in the Youth Summit. Responding to this feedback,

the staff member worked with youth leaders to design an ongoing process, including a one-day retreat, focused on team- and relationship-building.

Community leaders can similarly underestimate the need for relationship-building, sometimes holding an unconscious belief that department staff should just support community efforts no matter what, and therefore not taking the time to get to know staff members and the pressures confronting them. Community leaders who want to partner with departments must work to build reciprocal relationships with staff members, including understanding the funding and other organizational constraints that can circumscribe even the most committed staff members' efforts to support community capacity-building.

Community leaders and department staff both must commit to ongoing relationship- and trust-building, and assume responsibility for initiating often difficult conversations when one or the other group perceives that trust has been violated in the partnership. The failure to name and resolve perceived breaches of trust can quickly erode the goodwill and commitment needed to sustain community capacity-building. Conversely, taking the time to confront and resolve apparent breaches of trust can often strengthen the resolve of both groups to make their partnership work.

THE NEED FOR ONGOING SKILL BUILDING

When departments create a community capacity-building initiative, the shift in roles and responsibilities can be dramatic for staff members and contractors who are steeped in traditional service approaches. Developing staff and contractors' skills to enter into partnerships with community leaders, focused on strengthening the community's capacity to act, cannot be achieved through one-time or ad hoc training efforts; the commitment to skill building must be ongoing, and unfold in multiple forums, including all-staff trainings, small group work, individual meetings, and others. Earning the trust of community leaders and members, and becoming accepted by them as an ally, requires a range of skills and competencies, including:

- Listening skills;
- Relational skills—e.g., the ability to earn trust and inspire confidence among people of diverse cultures, backgrounds, positions, and authority;
- An ability to manage personal interior realities—e.g., the ability to avoid reacting from negative thoughts or emotions;
- An openness to hold and understand the interior realities of others;
- An ability to manage interpersonal and group conflict;
- An ability to assess and understand multiple stakeholder perspectives;
- An ability to help individuals and groups discover their talents and passions; and
- Facilitation skills—e.g., the ability to discern and reflect divergence and convergence without bias.

Mental health professionals may have many of these skills, but often need support in developing and strengthening the entire array of competencies.

A similar commitment must be made to skill building among community leaders, to help them increase their skills to implement more impactful community-driven initiatives, track data to assess the effectiveness of their efforts, and build meaningful partnerships with county and community agencies.

This is a major focus of the efforts described in the previous section by the Behavioral Health and Recovery Services Department in Stanislaus County and Tri-City Mental Health Center. In addition, several counties are exploring efforts to expand the reach and impact of *promotoras*, community members trained to provide health information and education to community members who are difficult to reach by health, human and social service organizations. Both Placer and Stanislaus counties are exploring ways to use *promotoras* to identify and support community leaders in developing community-driven efforts to promote behavioral and emotional wellbeing.

THE NEED FOR FLEXIBLE FUNDING

Community capacity-building generally, and the work of relationship-building in particular, often require flexible funding—i.e., funding not tied to medical necessity or clinical productivity standards. Such funding is becoming more scarce as department budgets contract and become more dependent on categorical funds.

This is another of the many benefits of MHSA funding. State regulations have allowed counties to be more flexible with portions of this funding than other funding sources. Counties participating in the Learning Collaborative have universally relied on MHSA funds (specifically Prevention and Early Intervention funding and Innovation funding) to support their community capacity-building efforts. Additional options explored by participating counties have included federal funding for Alcohol and Other Drug prevention programs, building partnerships with other funders—e.g., United Way, community foundations, First 5 Commissions—and increasing Medi-Cal billable hours for some staff members so that other staff can focus more on non-billable community capacity-building work.

As real as the need for flexible funding is, however, what we learned through the Learning Collaborative was that counties who were committed to community capacity-building—that is, who had found a compelling enough reason to say *yes*—found ways to support their work. For counties who had not yet found compelling reasons to support community capacity building, the challenge of flexible funding further discouraged their efforts.

THE ESSENTIAL ROLE OF LEADERSHIP

Regardless of the funding source(s) identified to support the work, successful community-capacity building efforts require sustained engagement over time. Counties and communities

who approach community capacity-building as a discrete, time-limited project will not realize the same level of success and benefit as those who make a long-term commitment to the work. Such sustained commitment, however, only emerges through effective leadership.

Through the Learning Collaborative we have identified three essential dimensions of leadership required of department staff and community members to support community capacity-building efforts: focusing attention; creating context and meaning; and affirming and modeling a commitment to learning.

With myriad demands for staff and community members' attention, leaders committed to community capacity-building must find ways to constantly focus their members' attention on the change effort. For example, the senior leadership team for the Stanislaus County Behavioral Health and Recovery Services Department began communicating the realities of the adaptive dilemma to managers and line staff in 2008, and have framed their budget decisions and MHSA planning efforts as movements toward community capacity-building ever since. The County's Prevention and Early Intervention plan reflects major investments in community capacity-building, and managers and line staff are engaging in conversations about how to integrate the three movements of community capacity-building into a range of programs across the department, including Alcohol and Drug programs, clinical programs, and MHSA-funded programs.

In El Dorado County, department leaders sponsored a series of half-day orientation sessions to introduce staff members and community leaders from across the county to the core concepts of community capacity-building. These orientations helped raise awareness of community capacity-building in the county, and laid the groundwork for the development of the county's first Innovation project focused on community capacity-building. Community leaders in Placer County have regularly included conversations about community capacity-building in their community meetings, adopting some of the language and skill sets taught through the Learning Collaborative for use in their community change work.

This issue of managing attention was present in a different way for counties who said *no* or *not yet* to the Learning Collaborative. Many of these counties were at the beginning or in the middle of profound budget and other management crises. These crises were all-absorbing; county leaders from these counties could not sustain their staffs' or even their own attention to community capacity-building.

A more vital leadership function than focusing attention is the need to create the context for, and help staff and community members make meaning of, community capacity-building efforts. County leaders in El Dorado County, for example, have worked to embed community capacity-building within a larger change effort focused on the integration of health and mental health services. Confronted by severe budget challenges, the Board of Supervisors disbanded the mental health department several years ago, moving mental health staff and programs into the county health department. That structural change created momentum for efforts already underway to

more closely integrate physical, behavioral, and mental health programs and initiatives. Sensitive to the support and energy already present for this integration effort, department leaders focused their first Innovation project on learning how community capacity-building can support efforts to integrate mental health services and supports within community-based health care facilities.

In Stanislaus County, department leaders have been working since 2006 to evolve a long-term response to the adaptive dilemma. Ultimately they articulated a long-term transformation effort organized around four commitments: a focus on results; community capacity-building; fiscal sustainability; and leadership development. In this context, county leaders describe community capacity-building not as a standalone and peripheral strategy, but as an essential commitment for helping the department remain viable over time. Community leaders have echoed and amplified this story, describing the need for their efforts to evolve from focusing exclusively on services to promoting self-help and community-driven actions to promote members' well-being. Leaders in one community are describing community capacity-building as returning to its community-building and community organizing roots.

Indeed, while the stories told by department and community leaders vary county by county and community by community, a clear pattern has emerged: leaders are working to help staff and community members see community capacity-building as an extension of commitments already made and efforts already underway, rather than as a brand new initiative or approach.

A final leadership task essential for the successful implementation of community capacity-building efforts has been the modeling of a commitment to learn and adapt. Department and community leaders often feel the pressure to approach issues from a stance of already knowing the answer. Given the adaptive dilemma, and the larger policy, political, and economic realities confronting departments and communities, the fear that staff members, community members, and people in authority feel in these times, and their insistence on often easy answers, can seduce even the most secure leaders into premature or hasty decisions and action.

In such times, a profound act of leadership can be to model patience, and a deep commitment to welcome as much information and diverse perspectives as possible. This type of modeling strengthens collective learning and adaptive action, especially when issues are highly complex, controversial, or emotionally charged.

Stanislaus County's AOD stakeholder process provided a context for multiple demonstrations of this type of leadership. Senior department leaders took the extraordinary step of opening the entire AOD budget, and framing a central question to a broad array of stakeholders: how should we respond to the projected 33% reduction in our AOD flexible funding?

The invitation extended by the senior leadership team, and the question it posed to stakeholders demonstrated patience and a deep commitment to collective learning and adaptive action. The senior leadership team, however, was not the only group exercising leadership in this process. Union and staff members participated fully and openly in the process, knowing that the

recommendations could ultimately have a direct impact on county jobs. Community and faith-based leaders also exercised strong leadership, demonstrating a willingness to trust that the invitation and proposed process were real, and that their voices and perspectives would be welcomed. Indeed every stakeholder group demonstrated a steadfast willingness to engage in a *six month* process to reach consensus about how to evolve the AOD system given the budget reductions.

The result: a more integrated AOD system that, even with diminished county resources, has the potential to improve supports for people suffering from alcohol and other addictions. For example, members of a faith community in Stanislaus County, encouraged by the success of the stakeholder process and grounded in a more nuanced understanding of the challenges confronting the county system, independently took the initiative to raise substantial private dollars to insure the continued operation of a treatment program for women and children. Without this funding, these services would have ended.

In El Dorado County, department leaders are holding conversations with community leaders and leaders of community-based health programs to invite their participation in helping to structure and evolve their Innovation project. In Placer County, department and community leaders are holding conversations about how to evolve structures that can effectively integrate community leaders into county program management structures.

The leadership capacity to learn and adapt illustrated by these examples is particularly crucial for the successful development of community capacity-building strategies. Realities vary greatly within and among communities, and frequently change: what may work in one community at one moment in time may be ineffectual in a different community, or even within the same community at a different time. Moreover, community capacity-building efforts will inevitably experience moments of disappointment and misunderstanding, even failure. When county and community leaders make a sustained commitment to learn together, such moments can be overcome, and even transformed into opportunities for greater progress. Without such leadership, however, community capacity-building efforts are more likely to be short-lived, undone with the first setback as staff members and community members conclude that there is not sufficient will from their leaders to warrant them taking a risk on a different way.

CONCLUSION

The Community Capacity-Building Learning Collaborative has emerged from a hypothesis that county departments of mental health confront an adaptive dilemma of rapidly declining revenues, steadily increasing costs, and rapidly increasing need and expectations. Rather than advocating for doing more of the same, or more with less, the Learning Collaborative proposes a different response: that Departments make a commitment to community capacity-building.

Through the work of the Learning Collaborative, counties articulated several distinct ways to pursue community capacity-building, including:

- Connecting isolated individuals to an existing community in ways that help the individual become part of the community;
- Connecting isolated individuals to each other so they become a new community (not defined by illness);
- Working with an existing community so that it becomes stronger and better able to promote the mental and behavioral health of its members without services; and
- Involving stakeholders and community leaders in decisions about balancing budgets and curtailing services.

A number of lessons have emerged from the Learning Collaborative documenting how counties can sustain the leadership, learning, and will essential for success. These lessons reinforce one of the core concepts of the Learning Collaborative, that community capacity building efforts will more likely succeed if they sustain their engagement and learning across all four dimensions of change.

Vaclav Havel, playwright and first President of the Czech Republic, has written:

> Hope is a state of mind, not of the world. Either we have hope within us or we don't. It is a dimension of the soul, and it's not essentially dependent on some particular observation of the world or estimate of the situation. … Hope, in this deep and powerful sense, is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out.

What ultimately will sustain counties in their community capacity-building efforts is the same thing that will inspire them to begin: *hope,* the conviction that community capacity-building makes sense.

ENDNOTES

[1] Luminescence Consulting has developed this framework based on Ken Wilber's work on the evolution of consciousness. See, e.g., Wilber, Ken, *A Brief History of Everything,* Shambhala, 1996.

[2] E.g., Valentine, Joe, "Human Services in a Time of Economic Crisis," Presentation to the Contra Costa Board of Supervisors, April 21, 2009, www.cbocenter.org/pdfs/HumanServicesCCCounty.pdf; Grygiel, Chris, King County's health costs up 28% in four years," *Seattle PI,* August 6, 2009; Lewis, Robert, "The Public Eye: Looking at the county's rising personnel costs," June 4, 2009, p. 1B.

[3] For example, the number of people served by the Behavioral Health and Recovery Services (BHRS) Department in Stanislaus County has declined from over 12,700 in FY 2004-05 to less than 9,500 in FY 2008-09. Source: Denise Hunt, former director, Stanislaus County Behavioral Health and Recovery Services Department.

[4] Dao, James, "Vets Mental Health Diagnoses Rising," *New York Times*, July 16, 2009.

[5] E.g.,, "Demand up for mental health care," *The Denver Post,* November 30, 2008; "Massive layoffs increase demand for mental health counselors," BNet, February 2009, http://jobfunctions.bnet.com/abstract.aspx?docid=931083; "Economy swamps suburban hospitals with depression, substance abuse," *Chicago Daily Herald,* November 20, 2008; Valentine, Joe, *op. cit.*

[6] Romney, Lee, "New funds, enduring ills: while cash from Proposition 63 flows into premium mental health services, budgets for traditional care have suffered," Los Angeles Times, September 16, 2007.

[7] County departments frequently report measures of customer service and numbers served, but rarely report the gaps between the number of people they serve, the total number of people who have mental health issues in the county, and the number of people with mental health issues who could qualify for services. Under the Mental Health Services Act, however, every county had to report on measures of unmet need as part of their Community Services and Supports plan. Every county reported significant numbers and percentages of people with mental health issues who were not receiving any county-funded services. For example, Los Angeles County estimated that the number of people with serious and persistent mental illness who could qualify for county services but received no service was well over 100,000. (See Los Angeles County Community Services and Supports Plan, October 2005, pp. 46-47.)

[8] Here's an example from Stanislaus County. The local Housing Authority estimates the number of people who were homeless in Stanislaus County in early 2009 at 1,800 people, based on the 2009 Homeless Counts initiative. The Sheriff's Department estimates that the number of people in county jails in August 2009 was approximately 1,400 people. Estimates of the prevalence of mental illness and substance abuse addictions vary widely for people who are homeless or in jail, but let's assume that *every* homeless person and *every* person in jail in the County could benefit from services and were not receiving them. That would account for an additional 3,200 people with serious mental health issues who were not receiving services from the County in addition to the over 9,000 people currently receiving some form of County service.

Based on generally accepted prevalence rates for the general population, however, (see www.dmh.ca.gov/Statistics_and_Data_Analysis/CNE/p5wsmi01_caindex1.htm), the total number of people in Stanislaus County who would be expected to struggle with serious and persistent mental illness would be over **35,000.** Since there are not thousands of people showing up every day in the emergency rooms or otherwise publicly presenting with symptoms, it seems a reasonable inference that some sizable portion of the remaining 22,800 people [35,000–(9,500+3,200)] are getting their needs met, however well or imperfectly, without county services.

Remember too that the 35,000 number only estimates the number of people with the most severe and persistent mental illness. If we include less severe mental and behavioral health issues, the number of people affected by these issues would be substantially more than 35,000, meaning that the number of people who are getting their needs met without county services is substantially above 22,800.

[9] If a Department pursues a community capacity-building agenda, such action does not obviate the Department's responsibility to provide a more equitable distribution of public resources. That is, community capacity-building efforts are not a substitute for efforts to provide more culturally appropriate services to unserved and under-served communities, and to redress historical patterns of unequal investment. The implication of the unmet need analysis, however, is that even if Departments achieve an equitable distribution of their resources, there will still be thousands of people who could benefit from support who will receive no services. Put differently, as vital as the equity issue is, redressing this issue will not resolve the issue of unmet need.

[10] This issue is sometimes described as "flow," meaning that Departments should focus more intentionally on helping individuals *flow through* the system, receiving less intensive services over time while receiving more resources from natural communities of support. CIMH has supported a separate Learning Collaborative focused on this issue.

[11] Tri-City Mental Health Center oversees a mental health system that serves residents in the cities of Claremont, La Verne, and Pomona in east Los Angeles County. Although Tri-City Mental Health Center did not participate in the Learning Collaborative, the lead consultants for the Community Capacity-Building Learning Collaborative have also been lead consultants for this system's reorganization and MHSA planning efforts. Over the past several years, Tri-City leaders have joined with community leaders across the three cities to implement a number of community capacity-building efforts.

[12] Friedman, Mark. *Trying Hard is Not Good Enough.* Trafford Publishing, 2005.

[13] Pinard, Rose. "Los Angeles Department of Mental Health Learning Collaborative Project, Phase I: Report of Findings and Recommendations, March 30, 2009.