CAPE | Community Assessment and Education to Promote Behavioral Health Planning and Evaluation

Community Action Planning Worksheet

This worksheet is intended to help CAPE program participants build an effective action plan for improving behavioral health conditions in the community.

Project:

Combating Opioids: A Community Action Plan

Getting Started

To start, we need to articulate the change we would like to see take place. To do so, we need to recognize the **existing situation** we believe can be improved. Consideration of the many data and community survey information resources generated through the program can bolster the case for needed action. We can't accomplish everything at once, so we need a **sense of priority** about what we should do now rather than later. Finally, we need to articulate the goal or **intended outcome** we would like to see achieved.

What's the **Situation** you'd like to see changed? What are the behavioral health needs or problems to be addressed?

The **opioid crisis** is ravaging many communities across the country. Currently, over 47,000 deaths annually result from opioid overdose (cite). The epidemic's progression has been striking as it spreads geographically. Currently, researchers' project the number of deaths from opioid overdose will more than double in the next four years before leveling off around 2022.[1] That means nearly 100,000 people will die from opioid overdose every year.

The problem in Kansas has yet to reach the rates seen in other states. However, its geographic spread assures it will become a larger problem in the years ahead. Rather than wait until it is a full-fledged crisis in my state and my community, we will need to be proactive in prevention efforts. Currently, Kansas ranks in the lowest 20% quintile in the rate of opioid overdose deaths. The **goal** of this action plan is to keep Kansas in that quintile, even as the rates of death continue to increase.

The opioid problem is complex and multifaceted. Opioid abuse occurs with both legal prescription drugs as well as illegal drug use. There is no single agency or entity that can effectively deal with the problem. Response is required at all levels of government, including broad-based local community involvement.

This action plan focuses on local-level response priorities. Its intended emphasis is prevention. This plan is limited in its scope to what one person can accomplish on behalf of his home community and state-wide in his role as a university extension outreach specialist. The initiatives offered are modest in scope, it is believed that they can individually and cumulatively make a difference. While collaborations will be required across the program initiatives, this plan does not require the endorsement or commitment of any other individual or entity. It is believed

that the efforts represented in this plan of work will spur the cooperation of others on an ad hoc basis.

What should the **Priorities** for attention, effort, and investment be? What are the most important things that that need to be done to address the situation?

1st: Local mental health coalition formation. This is a state-wide initiative undertaken as an extension outreach initiative.

Riley County, KS, has a community mental health coalition, the Riley County Mental Health Task Force (RCMHTF). It has been meeting for approximately five years, and includes representation from mental health, private health, public health, law enforcement, the judicial system, city and county government, and others. After a slow start, it is making notable progress on multiple fronts in relation to community mental health concerns. This is a model of a community mental health coalition that is believed to be beneficial in partially responding to regional mental health and substance abuse needs.

Kansas is divided into 26 regions to provide mental health assistance to the state's population. It is uncertain what the status of mental health coalition formation is across the regions. It is likely that other communities have coalitions similar to RCMHTF, and that others do not. This initiative is intended to determine the status of regional coalition formation, and to encourage coalition formation in those regions lacking such a collaborative. State-wide coverage of mental health coalitions is deemed as fostering the community institutional infrastructure needed of collaborative action is addressing complex problems such as opioid abuse.

2nd: Reducing the stigma of mental health and substance abuse. The One Meeting Movement. This is a community initiative with the potential of replication.

One of the major obstacles to addressing problems of mental health and substance abuse is community stigma. Stigma exists at all levels from the sufferer, family unit, medical establishment, community, and society at large. Such stigma hinders help-seeking and the establishment of community support systems and programs. Reducing mental health/substance abuse stigma is a difficult challenge insofar as it tends to be a deep-seated prejudice. This initiative is intended to reduce mental health stigma through "story-telling."

The premise of this initiative is that the general lack of exposure to, and willingness to discuss, behavioral health issues, fosters community stigma. That stigma could be reduced if people better understood the ubiquity of behavioral health challenges and the human stories associated with them. If people understood that sufferers of behavioral health challenges are little different from themselves, they might be more open and accepting of those with such challenges.

This initiative is called the One Meeting Movement. The notion is to create a team to visit with groups and organizations to tell them the story of behavioral health challenges. Most community mental health service providers have one or more people who are skilled in community outreach and education. All these organizations also know of "success stories" wherein a person has come to deal with their problems without shame. Many of the people are successful community and business leaders who may be willing to talk about their challenge without shame, and may

see the opportunity as part of their own recovery or as a way of fostering community awareness of mental health challenges.

The notion is to create a “traveling road-show” to meet with civic and service organizations, local government bodies, business groups, churches, and any other entity that has a regular gathering of some membership. The request of these groups is to dedicate just one meeting per year to discuss behavioral health. A two-person team consisting of a mental health services representative and a person successfully recovering from a behavioral health challenge would spend 30-45 minutes making a presentation to that group. The mental health services person provides an overview of behavioral health challenges and what is known about the situation in the local community. Then, a person who has successfully coped with a behavioral health challenge would spend a few moments to tell their story of how they came to be challenged, the struggles of that challenge, how they got help, and how they continue to function as a successful and contributing member of the community. Upon conclusion, the mental health services representative reminds people that the service agency is an approved United Way provider and would ask for consideration of a directed contribution.

3rd: Employer employee assistance programs. This is a community-based initiative with potential for replication.

Most community mental health service providers offer employee assistance programs (EAP) to area businesses. Private providers also exist for the purpose. However, all but the largest businesses do not offer any such assistance to their employees. The reality is that employers are on the “front line” in the identification of individuals who they know to have behavioral health problems. Many of these business owners/managers do not have the wherewithal to deal with such individuals. Their response when a problem is observed is to fire the problem employee and hope for better results with the next hire. This is costly to the business in terms of wasted resources for recruiting and training, as well as lost productivity. This is costly to the individual who may be experiencing a downward spiral when there might have been an intervention at an early stage. The goal of this initiative is to encourage the business community to become an engaged ally at the front lines of combating behavioral health problems.

Manhattan, KS, has a strong and effective chamber of commerce. The chamber leadership has a generally open and progressive view of its role in the community. Some within its leadership ranks will openly admit to some of their own behavioral health challenges and endorse the notion that behavioral health issues are important. The objective of this initiative is to engage the chamber to identify behavioral health as a business priority, to work within the chamber to identify the most important services businesses need and the barriers they face to participation in an employee assistance program. The community mental health services agency would revamp their existing services and begin a renewed marketing effort in partnership with the chamber.

What are the **Intended Outcomes** you would like to see achieved? What will be the situation or condition when the goal has been achieved?

1) Local Coalitions. All CMHS hub cities will have a mental health task force providing the essential institutional infrastructure for collaborative action to address community mental health

and substance abuse concerns. Given the geographic service coverage of the CMHS's, this provides some level of coverage and assistance to all 105 Kansas Counties.

2) One Meeting. Overall personal, family, and community mental health stigma is reduced. More preventive programs have been established. A greater proportion of behavioral health sufferers are receiving early intervention.

3) The business community becomes a partner in encouraging early intervention, and the chamber of commerce becomes an influential advocate on behalf of mental health challenges.

Filling in the Plan

Now that we've established what we would like to achieve, we need to figure out how to do it. We can create an effective action plan by carefully considering what resources we **need to invest** into the effort, what **activities** we need to do to make progress, **who** we need to reach and involve, identify the **milestones** we'll need to see in order to know we're making progress, and, finally, the **ultimate impact** we would like to see achieved.

What **Resources** are needed to take action? Who is available to work on the problem? How much time will it take? Are money or other resources needed? Who can we partner with to make progress?

1) Local Coalitions. All of the resources needed to create and sustain community mental health coalitions have been identified in the companion CAPE community action plan. In those communities that do not currently have such a coalition, a local champion will need to be recruited. It is presumed this is most likely the Community Mental Health Service (CMHS) executive director (ED), but may be the public health director, hospital, or some other entity.

The statewide outreach to determine the status of coalition building in these communities, and the coaching required to initiate such organization requires the programmatic effort of the extension outreach specialist. He has access to any financial resources that may be required for travel, communication, or other necessary expenses.

The extension specialist will offer the CAPE community development curriculum for interested EDs, extension educators, and other community leaders. The extent to which it makes sense to incorporate the Mental Health First Aid (MHFA) training in the program, this will be self-funded at the local level. There are a sufficient number of MHFA trainers in KS to provide state-wide coverage.

2) One Meeting. The One Meeting initiative will require minimal financial resources but does require collaboration. The logical partner for this initiative is the local CMHS center. The CMHS ED will need to be recruited. An individual from within the CMHS will need to be designated as a community educator within the scope of existing duties. This will require identifying an appropriate person designated as community educator such that it fits with existing responsibilities. The designated person will need to accept the challenge with enthusiasm.

The CMHS center will need to identify potential collaborators from the ranks of former clientele. Perhaps six to 10 individuals might be recruited so not to burden too few. The behavioral health

challenges of the collaborators are secondary to their appearance, standing, and capacity to tell their story. The objective is to communicate that people with behavioral health challenges are regular community members living and working among us every day without incident.

The extension outreach specialist can work with the CMHS outreach provider in the development of a compelling presentation that shows the scope of behavioral health challenges and what is known about the local situation.

Thereafter, the challenge is to create a marketing and outreach initiative targeting local groups and organizations. Thought will be needed to create the target list, sequence scheduling to fit into other responsibilities, and to execute the outreach. Most of this would fall to the CMHS outreach person.

3) Employer EAP. The CMHS ED will be an essential partner. The financial resources required are minimal, but the time commitment is more substantial.

The first step will be to recruit the chamber ED. In this regard, one or more members of the chamber board of directors may be recruited to help endorse the initiative. Assuming the cooperation of the chamber ED, meetings and presentations to one or more chamber committees will be required. A chamber committee or work group will have to be formed. The CMHS organization will need to evaluate recommendations and the extent to which they can be fulfilled. Thereafter, marketing would begin through chamber general meetings and communication tools. Some financial resources will be required to create effective marketing materials.

What **Activities** need to take place to achieve the goals? Do we need to conduct regular meetings? Do we need to have special public meetings or events to inform the community about goals and activities and/or gather feedback? Do products or information resources need to be developed? How should the media be involved? How do we foster needed partnerships and alliances?

1) Local Coalitions. The logical place to start would be an in-person visit with the ED of the state CMHS association. The local ED of the Riley County CMHS could provide introduction. Perhaps as an initial step, a presentation might be made at their annual conference to introduce the idea and gauge interest. The presentation might feature the successes of the Riley County Mental Health Task Force, and an overview of the CAPE community development training.

The extension outreach specialist could then make an initial contact with CMHS EDs via phone. The initial contact would determine whether any community coalition exists and what types of involvement and activities were underway. It would need to be established that the objective was to establish this type of community infrastructure. To the extent there was interest and the lack of any such entity, there would be benefit to an in-person discussion about how to motivate local action.

As a final offering, the extension specialist can gauge interest in CAPE program training. Its execution would require minimal resources.

The extension specialist will have to be prepared and available to assist with any community organizational initiatives if requested.

2) One Meeting. This will require recruitment and buy-in of the local CMHS ED. An in-person meeting with the ED will first be required, followed by an in-person meeting with the ED and the CMHS development officer or other person designated as educational outreach coordinator. An initial determination would assess the feasibility of recruiting former clients to volunteer to be story-tellers on behalf of the initiative.

If all seems feasible at that point, the extension specialist would work with the CMHS outreach person to develop both presentation and marketing materials. The CMHS ED, outreach coordinator, or other person would need to initiate contact with potential client volunteers. If a sufficient number agree, outreach marketing can begin. Scheduling of presentations would be coordinated by the CMHS agency to fit within existing work-related responsibilities.

3) Employer EAP. This will require effort to secure the cooperation of the chamber of commerce. There are camber board members who also have served as local elected officials. These persons would be recruited to help provide entry to the chamber ED. A presentation and discussion would need to proceed among one or more chamber committees. Assuming support, a committee or task force would be designated to meet with the CMHS ED to talk about business needs and structuring service provision that can accommodate different types of businesses. The CMHS ED will need to determine whether they can fulfill the outline of services requested. If so, a presentation would be made at a general meeting of chamber membership and marketing materials developed. The chamber thereafter would help market and promote the available services, as well as agree to participate in the One Meeting initiative. The CMHS agency also would independently market the service.

Who needs to **Participate** in order to make progress? Who are we trying to reach and influence? Who are the targets of our effort? Who needs to be involved?

1) Local Coalitions. At a minimum, the extension specialist will need to spearhead the effort. The Eds of the 26 service areas in Kansas will need to participate.

Thereafter, a host of local institutional representative in each of the CMHS hub communities will need to be recruited and agree to participate. This includes mental health private health, public health law enforcement, local judiciary, local elective bodies, and others identified as key local allies.

The ultimate target of the local initiative is the population of the local service area. Depending on the focus of the local effort, it would by up to the local groups to identify other needed participants.

2) One Meeting. Essential are the extension specialist, the CMHS ED, and a CMHS outreach person. Essential are a sufficient quantity of suitable behavioral health volunteers (likely six to 10).

The target audience are organizations, community institutions, business entities, the faith community, local government, and others.

3) Employer EAP. Essential are the extension specialist, the CMHS ED, one-two chamber board directors, and the chamber ED. Secondarily are chamber committee members who must endorse the effort.

The target of the initiative are business owners, both large and small. who might facilitate employee help-seeking behavior.

The CMHS agency needs to ensure it can provide advertised and requested assistance that may follow.

What are the **Short-Term Results** (6-12 months) you would like to see? What would we like people to learn? What are the changes in awareness, knowledge, attitudes, or skills we would like to see people exhibit? *How will we measure this?*

1.) Local Coalitions. Within this timeframe, contacts will have been made with the state organization and with the Eds representing the 26 service areas in Kansas. The objective will be to secure their endorsement and cooperation.

A simple count and status report can be made to determine the interest and need for any ongoing effort.

2.) One Meeting. Within this timeframe, contacts will have been made with the CNHS agency, a person identified for educational outreach, and behavioral health volunteers recruited. Presentations will have been developed and everyone will understand both their roles and how to make a successful presentation. Marketing will have begun.

Whether anything comes together will be the metric of success.

3.) Employer EAP. The need is to secure the cooperation of the chamber of commerce. This will likely take the full year. A go or no go will become evident.

What are the **Intermediate-Term Results** (1-2-3 years) you would like to see? What are the behaviors, actions, decisions, or policies we would like to see in place? *How will we measure this?*

1.) Local Coalitions. Within this timeframe, local coalitions will form and begin meeting regularly. At a minimum, they are sharing information and beginning to work jointly on community issues. A count and status report can be made of any existing or new collaborative initiatives undertaken. The primary interest is simply organizational activity and longevity. Some programmatic initiative may have begun.

2.) One Meeting. By this time, there should have been at least one presentation made to any interested group or organization.

Simple presentation counts participant surveys will be developed to gauge any change in participant attitudes and level of stigma.

3.) Employer EAP. At this point, business round tables will have occurred and the CMHS agency can determine the extent to which it can offer assistance and the terms of assistance. Marketing to employers begins, and an approximate estimate of businesses with EAPs has been established.

What is the desired **Ultimate Impact** (long-term) on the community? What are the social, economic, or other conditions we'd like to see in place in order to effect the kind of change the would be desired? *How will we measure this?*

1.) Local Coalitions. In this timeframe, all 26 CMHS areas are active and engaged in multiple programmatic activities. The focus of local activities will be locally determined. It would be envisioned that tangible progress would be seen and that ongoing efforts are likely to continue.

2.) One Meeting. At this point, local ongoing activity continues and sufficient data has been collected to reference the initiative as an evidence-based approach to reducing community behavioral heath stigma. The program is being replicated in other communities in Kansas and elsewhere.

3.) Employer EAP. Surveys of community businesses show the number of businesses with EAPs by industry and size. Regular monitoring shows increasing business participation and counts of employees utilizing the service by type of assistance received. While any reasonable thresholds must yet be determined, it might be expected surveys would show 80% of large employers, 50% of medium employers, and 30% of small employers have EAPs. There may be a small business exchange to pool contracts that help preserve employee anonymity and reduce any stigma associated with identification of help-seeking behavior.

Reference

[1] Chen, Q., Larochelle, M.R., Weaver, D.T., Lietz, A.P., Mueller, P.P., Mercaldo, S., Wakeman, S.E.,Freeberg, K.A., Raphel, T.J., Knudsen, A.B., Pandharipande, P.B., and J. Chhatwal. 2019. “Prevention of Prescription Opioid Misuse and Projected Overdose Deaths in the United States.” JAMA Network Open. 2(2):e187621. doi:10.1001/jamanetworkopen,2018.7621.