Department of Health Care Services
Division of Behavioral Health Services
1212 North California St
Stockton CA 95202

MENTAL HEALTH SERVICES ACT

PREVENTION AND EARLY INTERVENTION
THREE–YEAR PROGRAM AND EXPENDITURE PLAN

IN ACCORDANCE WITH THE
DMH PROPOSED GUIDELINES: ENCLOSURES 1-6
RELEASED SEPTEMBER 2007
REVISED AUGUST 2008

FINAL PLAN

APRIL 7, 2009

ACKNOWLEDGEMENTS

Behavioral Health Services wishes to thank the many consumers and their family members who gave their time and energy to this process. Their words of wisdom and stories of optimism, wellness, resiliency and recovery have shaped every component of this plan.

In addition, BHS wishes to recognize the contributions of the members of the Planning Stakeholder Steering Committee who helped guide the development of the planning process and the creation of this plan.

Prepared by Resource Development Associates

Project Team:

Kayce Garcia Rane, RDA, Project Lead
Jennifer Susskind, RDA
Frances Hutchins, BHS
Becky Gould, BHS
Vic Singh, BHS, Director

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN

Table of Contents:

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN FACE SHEET (FORM # 1)

This page intentionally left blank.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 1

MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2007-08 and 2008-09

County Name: San Joaquin	Date: April 2009

COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	**Project Lead**
Name: Vic Singh, LCSW	Name: Becky Gould
Telephone Number: 209-468-8750	Telephone Number: 209-468-8859
Fax Number: 209-468-2399	Fax Number: 209-468-2399
E-mail: vsingh@sjcbhs.org	E-mail: bgould@sjcbhs.org
Mailing Address: 1212 N. California Street, Stockton CA 95202	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature: _____ April 7, 2009

County Mental Health Director Date

Executed at _____Stockton____, California

PEI COMMUNITY PROGRAM PLANNING PROCESS (FORM # 2)

This page intentionally left blank.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 2

Instructions: Please provide a narrative response and any necessary attachments to address the following questions.

County: San Joaquin Date: April 7, 2009

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

In March 2008, San Joaquin County Behavioral Health Services (BHS) and the MHSA Planning Stakeholder Steering Committee, with assistance from Resource Development Associates, a consulting firm specializing in community-based strategic planning processes, launched the Prevention and Early Intervention (PEI) component of the planning process. This "Planning Team" sought to incorporate stakeholder participation to:

- Identify prevention and early intervention needs;
- Understand existing community assets; and
- Prioritize those strategies which best respond to community needs and most effectively leverage resources.

The Planning Team's objective was to build upon the initial MHSA Community Services and Supports (CSS) planning process by reviewing the CSS plan and supplemental CSS stakeholder participation notes and by drawing on the expertise of the newly-formed MHSA Consortium of community-based organizations. In addition, the Planning Team sought to draw upon the knowledge and expertise of an exceptionally diverse range of stakeholders, including consumers and their families, representatives from underserved ethnic and cultural communities, public and community-based service providers at all occupation levels, and educators. We sought to provide opportunities for intimate, focused discussions and to reach out to the broadest possible number of stakeholders through interactive community meetings.

The PEI planning process occurred simultaneously with the Workforce Education and Training (WET) planning process, which enabled the Planning Team to leverage planning resources and attract an unusually wide range of stakeholders. For example, university professors interested in career pathways participated in a broader discussion about public mental health than they may have otherwise engaged in. We hope that this broadening of the discussion helps reduce stigma and increases understanding of the multi-faceted needs of the community.

The following proposed Prevention and Early Intervention Plan is the result of a planning process that included the following participatory elements:

- Increased membership on the MHSA Planning Stakeholder Steering Committee
- Community education and outreach
- Key informant interviews
- Focused discussion groups
- Community meetings

b. Coordination and management of the Community Program Planning Process

Project Management: Planning Team

Vic Singh, Director of Behavioral Health Services for San Joaquin County, oversaw all planning activities.

Frances Hutchins, Deputy Director of Administration, and Becky Gould, Deputy Director of MHSA, managed the planning effort and ensured the cooperation and coordination of all BHS staff. Ms. Hutchins and Ms. Gould were supported in their efforts by Resource Development Associates (RDA), a consulting firm with 25 years experience planning public mental health systems.

Kayce Rane of RDA, with oversight from Behavioral Health Services, coordinated and led the PEI planning effort. RDA has worked with mental health departments throughout California in efforts ranging from developing permanent supportive housing for mentally ill homeless individuals, treatment planning for co-occurring disorders, and creating data sharing policies and tools between juvenile mental health and probation units. RDA also conducted San Francisco's Community Services and Supports, Merced's Prevention and Early Intervention, and San Joaquin County's Workforce Education and Training planning process. RDA is currently leading the MHSA Capital Facilities and Technological Needs planning process for Merced County.

Using County staff experience and expertise, Ms. Rane developed and implemented a community-wide outreach and engagement strategy that reached across the County and into different cultural population segments. Based on the findings learned through the outreach and engagement portion of the planning process, RDA implemented a community deliberation process designed to get input and buy-in on potential strategies for San Joaquin County.

Oversight and Recommendations: Planning Stakeholder Steering Committee

The MHSA Planning Stakeholder Steering Committee was charged with establishing a shared vision for PEI and WET, overseeing the planning process, ensuring community participation, and approving the draft plan. The Committee was made up of members from the Mental Health Board, many of whom were involved in the CSS Panning Process. BHS and the Mental Health Board also sought to include people with workforce expertise, such as job developers and educators, and people with PEI expertise, such as criminal justice and early childhood experts. Additionally BHS and the Board sought to ensure diverse ethnic and life stages representation and recruited individuals with strong consumer and family member advocacy backgrounds. The intention of BHS and the Board was to include individuals who were not afraid to speak up and advocate for consumers, family members and underserved individuals.

The Stakeholder Steering Committee included the following members:

Cynthia Gustafson	Chair, Mental Health Board, family advocate
Stephanie Bays	Deputy Chief Probation Officer
Ken Cohen	Director, Health Care Services
Mary Ellen Cranston-Bennett	NAMI Representative/Parent Advocate
Mick Founts	Deputy Superintendent, Office of Education
Kathleen Gutierrez	BHS Employee/Labor Representative

Robert Hart	Medical Director, Behavioral Health Services
Monica Madrigal	BHS Outreach Worker Trainee & Recovery Coach
Jennie Montoya	NAMI Representative/ BHS Outreach Worker
Jane Riddle	BHS Outreach Worker/Family Advocate
Chris Rose	Senior Deputy, County Administrator's Office
Daphne Shaw	Older Adult Advocate
Vic Singh	Director, Behavioral Health Services
John Solis	Executive Director, WorkNet
Margaret Szczepaniak	Assistant Director, Health Care Services
Cheryl Torres	BHS Consumer Outreach Coordinator
Curt Willems	Lead Manager, Substance Abuse Services
Stella Williams	Children's Advocate

c. Ensuring that stakeholders had the opportunity to participate in the Community Program Planning Process

General Outreach:

During the initial stage of the PEI planning process, the Planning Team developed an outreach list with phone and email contact information based on sign-in sheets from the earlier CSS planning process, consumer and family member staff and volunteers, staff supervisors and a brainstorm of other PEI stakeholders such as civic leaders, probation and law enforcement personnel, and public education representatives. This list continued to grow during the planning process, and by the end, included over 500 names. Prior to the community meetings, Planning Team members made phone calls and sent email invitations to all on the list.

Additionally, the Planning Team posted notices in libraries, schools, and other public buildings and personally invited stakeholders to participate in focused discussion groups and community meetings. Full-color MHSA newsletters and the County MHSA website announced upcoming meetings and discussion groups as well. Our success in attracting consumers and family members reflected the powerful advocacy and commitment of BHS and CBO Outreach Workers. Our success in attracting participants from underrepresented communities reflected the extensive outreach conducted by the MHSA community-based organizations.

Community Education: MHSA Consortium Meeting & Communitywide WET/PEI Kickoff Meeting

All community meetings and discussion groups included a community education component, specifically a PowerPoint presentation, which explained MHSA goals, principles, activities and findings to date, and opportunities for future involvement. The Planning Team was committed to ensuring all participants understood the PEI component so that they could contribute to the planning process in an informed manner.

On May 7 2008, the Planning Team introduced the PEI and WET planning process to the MHSA Consortium. The Consortium is made up of representatives of the MHSA-funded programs in San Joaquin County. Most of 50-plus attendees at the May 7th meeting were engaged in the initial MHSA-CSS planning process, were invested in programmatic continuity, and wanted to stay involved to ensure a broad-based, community-driven plan.

On May 19, 2008, the Planning Team kicked off the community-wide planning process with a meeting attended by 103 participants. During both the Consortium and the Community Kickoff meetings, participants were informed about the PEI component goals, principles, potential funding opportunities, and plan for involving stakeholders throughout the planning process. During the Kickoff Meeting, the Planning Team distributed commitment forms that asked how participants would be willing to outreach for future meetings. In addition, the Planning Team distributed confidential demographic forms during the Community Kickoff Meeting and all other participatory meetings. Participation rates, based on the demographic forms, are described in the text boxes to the right.

Communitywide PEI/ WET Kickoff Meeting Participation
103 sign-ins; 82 demographic forms submitted
19 consumers of mental health services
23 family members of consumers
6 transitional age youth (18-25 years)
15 older adults (60+)
63 female and 19 male
43 Caucasian/White, 9 African American/Black, 4 Hispanic/Latino, 11 Southeast Asian, 2 other Asian, 1 Native American, 9 mixed-race, and 3 other

Community Needs Assessment Process: Key Informant Interviews & Focused Discussion Groups

The Planning Team conducted a qualitative needs assessment prior to initiating detailed discussions about funding opportunities and strategies. Our objective was to reach the widest range of stakeholders as possible, and also to provide opportunities for meaningful and extended conversations about the County's strengths, challenges and needs *prior* to deeply investigating funding opportunities. To accomplish these objectives, we used two participatory methods: Key Stakeholder Interviews and Focused Discussion Groups.

The Key Informant Interviews, conducted by RDA between April and June 2008, were intended primarily to provide a broad overview of community needs. Interviewees were identified by BHS staff in consultation with the Chair of the Planning Stakeholder Steering Committee early in the planning process. Interviewees were given a brief overview of the PEI component, its goals, MHSA principles and funding opportunities, and were asked to identify and describe:

Key Informant Interview Participation
12 interviews, 7 demographic forms submitted
2 consumers/family members of consumers of mental health services
0 older adults 60+
4 female and 3 male
5 Caucasian/White, and 2 Hispanic/Latino

- Prevention needs that were identified during the CSS planning process.
- Existing mental health prevention and early intervention related activities
- Critical prevention needs, especially those pertaining to different age groups, ethnicities, and geographic places of residence.
- Any special populations for whom there is an acute shortage of mental health services, such as LGBTQ youth or working poor.
- Potential strategies or models that might positively impact San Joaquin County.
- Current opportunities for partnering and leveraging resources.
- Any challenges associated with implementing needed PEI projects.

Formal, confidential interviews were conducted by Resource Development Associates with the following stakeholders:

- Chris Hope, Chief, San Joaquin Juvenile Probation Department
- Dave Erb, Deputy Director, San Joaquin Children's Services
- Wendy Moore, Deputy Director, San Joaquin Human Services
- John Solis, Director, San Joaquin County WorkNet
- Kenneth Cohen, Director and CEO, Health Care Services Agency
- Lani Schiff Ross, Executive Director, First 5 San Joaquin County
- Margaret Szczepaniak, Assistant Director, San Joaquin County Health Care Services Agency
- Phyllis Grupe, Co-chair, San Joaquin A+
- Sheri Coburn, Director of Comprehensive Health Programs, San Joaquin Office of Education
- Sue De Polo, Executive Director, San Joaquin A+
- Ken Vogel, San Joaquin County Board of Supervisors, District 4
- Vic Singh, Director, San Joaquin County Behavioral Health Services

On behalf of the Planning Team, Resource Development Associates facilitated 16 Discussion Groups, (double the number of discussions of groups originally planned) that focused on specific prevention and early intervention needs. The groups were deliberately kept small (between 10 and 20 participants) and focused on specific issues or population concerns identified during the CSS planning process or through the key informant interview process. Every group or person that expressed an interest in hosting or attending a focus group was accommodated. Requests were solicited during the May 19 Kick-off meeting and as momentum with the planning process spread, additional groups were scheduled.

Discussion Group Participation
234 sign-ins, 232 demographic forms submitted
89 consumers/family members of consumers of mental health services
39 older adults 60+
133 female and 73 male
105 Caucasian/White, 26 African American/Black, 23 Hispanic/Latino, 9 Southeast Asian, 8 Other Asian, 8 Native American, 22 mixed-race, 4 other

During each of the Discussion Groups, participants were asked similar questions as those posed during the key informant interviews. In addition, the discussions also reflected the unique composition of each group--for example, the First 5 contractors Discussion Group focused on the experiences of providers in responding to the social, emotional and cognitive developmental needs of young children in stressed families, and a two-part discussion with BHS contractor groups evolved into an in-depth, and personal discussion on the needs of underserved communities.

The size and composition of the Discussion Groups were designed to promote a safe environment for honest discussion (for example, BHS managers were not invited to participate in the crisis staff discussion group) and to provide enough time for participants to express complex thoughts and experiences. The Planning Team, including Program Supervisors, the MHSA Program Manager and various BHS contractors, conducted targeted and general outreach to ensure that meetings were well-attended.

The Discussion Groups included:

- San Joaquin County School DATE Coordinators, May 22
- School Health Coordinators, June 13
- At-risk TAYS and emancipated foster care youth 18-21, June 23
- Manteca Parents of Adolescents, June 26
- Juvenile Justice Roundtable, July 2
- BHS contractors, General, July 9
- BHS contractors, Underserved populations, July 9
- First 5 contractors for children 0-5, July 16
- Health care providers, July 16
- TAY consumers and case managers, July 23
- Older adult service providers, July 23
- BHS children's services staff, July 23
- Suicide and Trauma, crisis staff, July 29
- NAMI consumer and family member group, July 29
- Probation Staff, August 6
- Consumer group, August 14

Community Strategy Prioritization: Community Meetings

The Planning Team embarked on an extensive outreach campaign to invite community members to attend one of six PEI Community Meetings, which were designed to review the potential strategies. The team posted meeting logistics on the County MHSA website and emailed invitations and flyers to all previous participants and to representatives from community-based organizations. Mental Health Outreach Workers posted notices and encouraged peers to attend community meetings. Flyers were posted in most prominent civic places including county libraries, civic buildings and health facilities. BHS staff and consultants made over 450 phone calls to an ever-expanding MHSA contact list. In order to ensure maximum attendance, meetings were planned during business hours, on a Saturday and on a weekday evening. Meetings were held throughout the County, in Stockton, Lodi, Manteca and Tracy. Each of the PEI meetings was three hours in length. The PEI Community Meetings were held in the afternoon, following a three-hour WET Community Meeting. Some participants attended for the whole day, while others participated in only the PEI portion.

Community Meeting Participation
125 sign-ins, 118 demographic forms submitted
55 consumers/family members of consumers of mental health services
17 older adults 60+
83 female and 35 male
49 Caucasian/White, 16 African American/Black, 31 Hispanic/Latino, 5 Southeast Asian, 4 Other Asian, 3 Native American, 7 mixed-race, 3 other

Each of the six PEI Community Meetings began with an overview of MHSA principles, PEI goals, and a summary of the needs assessment. Participants were asked to respond to the needs assessment and add additional input. After completing the Needs Assessment portion of the meeting, the facilitator described each of the potential evidence based best practices that matched community needs. Best practices were

compiled from the Resource Guide (Enclosure 6 of the DMH PEI Guidelines) and from SAMHSA and other mental health organizations. In addition, participants were given a narrative description of each of the strategies to review.

Participants broke into groups of 4 – 6 persons and were given a response sheet to collectively and by consensus answer a series of questions:

- What are your top two strategies?
- Why did you select these strategies?
- What needs do the strategies address?
- Is there anything else you would like us to consider about these strategies?

See Appendix 4: page 134 for an example of a response sheet. This process repeated for each of the four sets of strategies: 1) Public Awareness and Education; 2) Prevention; 3) Assessment; and 4) Early Interventions. At the end of each of the six meetings, each of the participant groups reported their prioritized strategies in each of the categories and why they were chosen.

The Planning Team chose to utilize this community prioritization activity, anticipating that small group discussions would allow for a greater degree of participation, dialogue, and consensus-building. Discussions proved to be very deep, with many participants initially advocating for their own interests, but through dialogue, recognizing the needs of other stakeholders and the community as a whole. During these meetings, as well as all discussion groups and community meetings, the planning team distributed feedback cards to solicit confidential and/or anonymous feedback and suggestions.

After collecting input from the group discussions held during each of the six Community Meetings and tallying results, the Planning Team compiled a list of *prioritized* PEI strategies. The prioritized strategies are listed in the box on the right. Strategies with the highest level of support are listed at the top.

Strategy
Mental Health 101/Crisis Intervention Training
Comprehensive Family Supports
School Age Programs
Youth Empowerment Programs
School-based mental health curriculums
Integrated primary care and mental health care services
School-based mental health screening
Life Skills Classes and Support Groups
Court ordered juvenile and family assessments
Mentoring Programs
Short-Term Therapies
Parenting Programs
Home Delivered Meals Prevention and Screening
Anti-Stigma Campaign
Life Skills for Young Children (0-5)
Consumer Speakers' Bureau

Following the Community Meetings, the Planning Team presented the prioritized strategies to an open meeting of the Mental Health Board, and again at a Stakeholder Steering Committee. RDA then researched the feasibility and costs associated with each of the strategies.

The top eight of the sixteen strategies recommended by the community meeting process were developed into implementable project strategies and are described further in this plan.

In addition, Resource Development Associates broadened the strategies to reflect additional comments from participants and incorporated some of the good ideas that were not prioritized, but nonetheless supported by the community. For example parenting programs were included as a component of comprehensive family supports.

The final plan reflects the prioritized strategies as well as the in-depth analysis of financial feasibility and institutional capacity.

Community Review: Strategy Feasibility

Between September and October of 2008, the Planning Team reviewed the prioritized strategies and researched their feasibility. . This process involved a public meeting of the Mental Health Board on September 17th to review potential strategies and solicit input on feasibility, as well as individual interviews and meetings with key stakeholders to ensure strategies could leverage existing resources and assets. For example, a number the prioritized strategies required providing services in public school settings to better reach children and youth. Discussions with the Office of Education and various school personnel helped clarify the best approach for implementing mental health prevention and early intervention strategies within and in collaboration with existing programs. These conversations were used to verify feasibility of strategy ideas and to refine them to better leverage existing resources. During the feasibility phase, the Planning Team formally and informally communicated with a number of key stakeholders, including:

- Patricia Mazzilli, Assistant Chief Probation Officer
- Stephanie Bays, Deputy Chief Probation Officer
- Sheri Coburn, Director of Comprehensive Health Programs, San Joaquin Office of Education
- Wendy Frink, County Operated Schools Program
- Richard Vlavianos, Superior Court Judge, San Joaquin County
- Anthony Lucaccini, Superior Court Judge, San Joaquin County
- Barbara Kronlund, Superior Court Judge, San Joaquin County
- Lani Schiff Ross, Executive Director, First 5 San Joaquin County
- Kay Ruhstaller, Executive Director, Family Resource and Referral Center
- David Love, Executive Director, Valley Community Counseling Services
- Monica Gutierrez, City of Tracy, Mayor's Community Youth Services Network
- Ralph Womack, Mayor's Office City of Stockton
- Wendy Moore, Deputy Director, San Joaquin Human Services Agency
- Michele Rowland-Bird, Manager, Children and Youth Services
- Curt Williams, Lead Manager, Substance Abuse Services

In addition, a site visit was conducted at the San Francisco Juvenile Detention Center to learn more about the Youth Justice Institute's mental health, case management, and court advocacy program.

Public Meetings: Community Involvement in Decision Making

Between September 2008 and March 2009 three public hearings were conducted to review the progress in developing the PEI Plan. All participants in the planning process were invited to attend the public hearings and to provide input and suggestions in refining the PEI Plan drafts. Additionally core components were reviewed by the Planning Stakeholder Steering Committee at nearly every meeting (with the exception of the November meeting). These meetings are open to the public and are well-attended by the community-based agencies that contract with BHS. These meetings included open discussions on the crafting of the PEI plan and consensus was achieved on the components included. Decision-making was an open, transparent, and public process; any who attended the public meetings were part of the decision-making team. The final Public Hearing was held in April, 2009.

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations

Careful attention was paid to ensuring that the planning process included representatives of unserved and/or underserved populations. Undertaken in conjunction with the PEI planning process, the WET needs assessment included a systematic accounting of how well public mental health services reach into disparate population groups. The WET findings revealed that despite initial efforts through the CSS project begun in 2008 to address the cultural, ethnic, and linguistic service imbalance between the County general population and the public mental health workforce, great disparities still exist in San Joaquin County. The biggest racial/ethnic disparities in access occur among Latinos and Native Americans. Latinos are underrepresented as clients (19% of clients vs. 38% of eligible populations) and underrepresented as staff (23% of staff). Native Americans represent only 2% of the eligible population, while they represent 8% of the 2006 BHS clients. However, only 1% of the public mental health workforce identifies as Native American.[1]

With these findings in mind, the Planning Team made a special effort to talk with Latino and Native American-serving organizations to request their assistance in reaching out to these communities. In addition, translation assistance was available by request for every meeting or discussion group, and a Spanish speaking member of the Planning Team attended four of the six community meetings in the event that translation assistance was requested.

Special effort was also made to reach out to other population groups that the planning team identified as at-risk for not being heard. Outreach efforts were made to include the voices of transitional age youth and older adults. The planning team worked with the Department of Aging and Community Services to help disseminate meeting information. The Planning team also worked with schools and youth serving organizations to reach out to the TAY population. However, due to concerns about the sensitive nature of the research questions, minor children under 18 were not spoken to without a parent or guardian in attendance.

[1] San Joaquin County MHSA Workforce Education and Training Plan, DRAFT, December 2008.

Efforts were also made to hear from the Lesbian, Gay, Bisexual, and Transgender (LGBT) community. Representatives from the San Joaquin AIDS Foundation participated in discussions and during interviews and discussions, specific questions were asked regarding the needs of LGBT community members.

Community meeting at the Gipson Center (a community drop-in program for individuals with mental health issues) drew individuals who have experienced housing instability/homelessness. Out of respect for varying abilities to participate in a formal meeting participants were welcome to come and go from the discussion and were encouraged to talk about what they thought was important to include in the plan, even if topics crossed into treatment services or workforce development issues. All comments were carefully recorded and any feedback not applicable to the PEI planning process was distributed to project leads for other MHSA components.

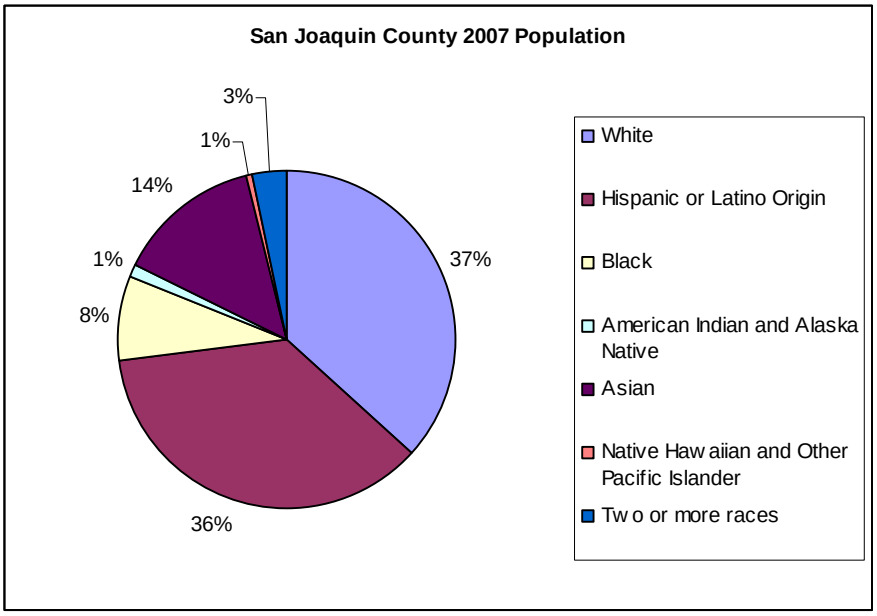
Recovery Coaches and Outreach Workers also played an important role in working with fragile mental health consumers. These community leaders took an active role in acting as peer mentors and trainers during the meetings for consumers who needed a little extra time and information before contributing to the public discussion.

While food and beverages were provided for all meetings a special effort was made to provide "hearty" meal like refreshments at meetings where we anticipated a high consumer or family member turn-out. In particular meetings held at the Gipson Center, with NAMI members, and at evening and Saturday meetings included entrée like provisions, typically meat and/or cheeses, fresh fruit or vegetables, bread or crackers, and a variety of beverages. Any "left-over" portions of food were sent home with consumers and community members in grateful appreciation of their time and participation.

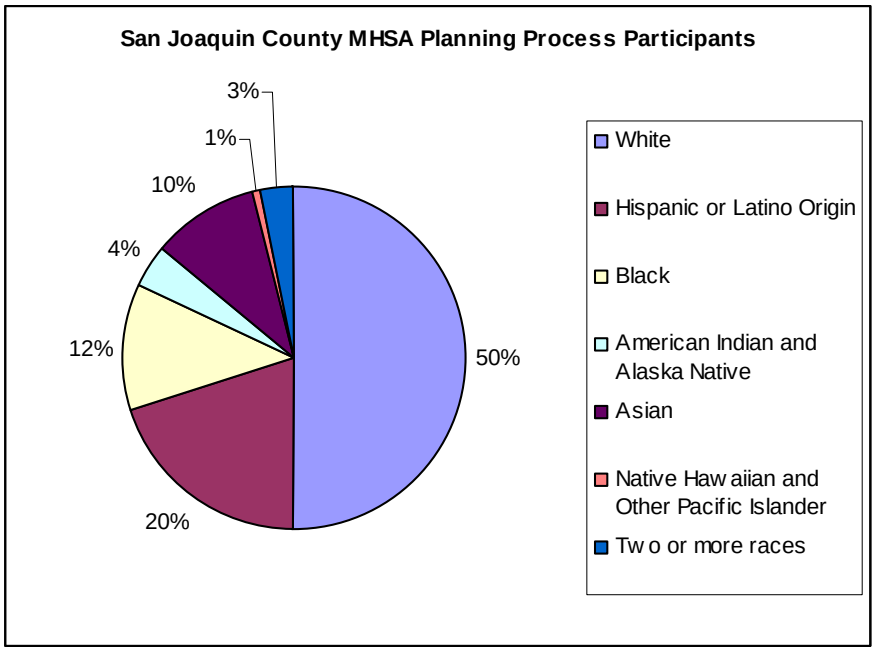
The Saturday meeting was held at a community center which had a separate room with children's activities available. One participant brought her 14 year old son who varied his time between personal activities and contributing a youth perspective to the group discussion.

Transportation was also a critical concern. Meetings were held in central locations easily accessible by public transit. Most meetings were held at public libraries. The evening meeting and the September public hearing was held at the Stockton Transit Center to ensure access by public transit from all areas of the County. Subsequent public meetings were held at BHS, based on consumer input that the location was more comfortable and accessible to them.

Demographic information demonstrating the effectiveness of the outreach efforts in reaching unserved and/or underserved populations is included in the sections below.



Source: US Census Bureau, County Quick Facts



Source: MHSA Planning Process Demographic Forms

Intense outreach efforts resulted in a very diverse mix of planning participants. Of the 770 individuals who answered the demographic question, one half of participants reported that they were from ethnically diverse populations. African Americans and Native Americans were slightly over-represented in the planning process. Hispanic/Latinos and Asian Americans were slightly underrepresented. Six percent of "Asians" were from Southeast Asia. Seventy percent of planning participants were female and 78% were adults 26-59. Seniors accounted for 17% of the meeting participants and TAYs 5%.

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

Throughout the initial design phase of the planning process the Planning Team and the Stakeholder Steering Committee talked about the need for the planning process to be open and inviting to the existing stakeholders and advocates that had emerged during the CSS plan and to new voices who were learning about MHSA for the first time. The Planning Team began by identifying those cultural/ethnic groups that had been actively involved in the CSS planning process and then, identified *who else* should be targeted for inclusion in the planning process.

The following community voices were heard during the CSS planning process:

- Vietnamese community – Vietnamese Voluntary Organization
- Cambodian community – Asian Pacific Self-development and Residential Association, Inc.
- Laotian community – Lao Khmu Association
- Hmong community – Lao Family Community
- Native American community – Native Directions
- Muslim/Middle Eastern community –Community Partnership for Families
- Latino community – El Concilio, Council for the Spanish Speaking
- African American community – Mary Magdalene Community Services
- LGBT community – San Joaquin AIDS Foundation

Representatives from these groups continued to provide input during the PEI planning process. Staff and volunteers participated in many of the discussion groups, community meetings, and public hearings.

In addition, the PEI Planning Team identified several additional stakeholder groups representing diverse demographics. In particular, the Planning Team worked with Wendy Moore, Deputy Director of Human Services, and the Department of Aging and Community Services to get a better understanding of mental health prevention in older adults. The Planning Team convened a discussion group of older adult stakeholders and service providers to hear their perspectives on the links between depression, isolation, co-occurring substance use and the aging process. And, during the discussion group with primary care providers, questions were specifically asked about the needs of older adults.

Transitional age youth and their families were also targeted for outreach. These efforts met with mixed results; three discussion groups aimed at youth were less well attended than we had hoped. Due to the sensitive nature of the questions, we felt it was inappropriate to conduct discussion groups with participants under age 18.

Parents, educators, case managers and other school staff were involved in this planning process to talk about the needs of young children and school age children. Although many of the individuals had

participated in the CSS planning process through the Children and Youth Services Workgroup, other voices were new. In particular, the discussion group for teens in Manteca ended up drawing a number of Manteca parents who had many stories to share about their children's social and emotional development.

The Planning Team made an effort to host meetings throughout the county in order to ensure that more participants could be involved. Community meetings were held in the four large population centers of Lodi, Manteca, Stockton, and Tracy. The three Stockton meetings were held at diverse locations including a downtown library, a transit center, and a neighborhood community center in a predominantly African American neighborhood. Discussion groups were also held throughout the County.

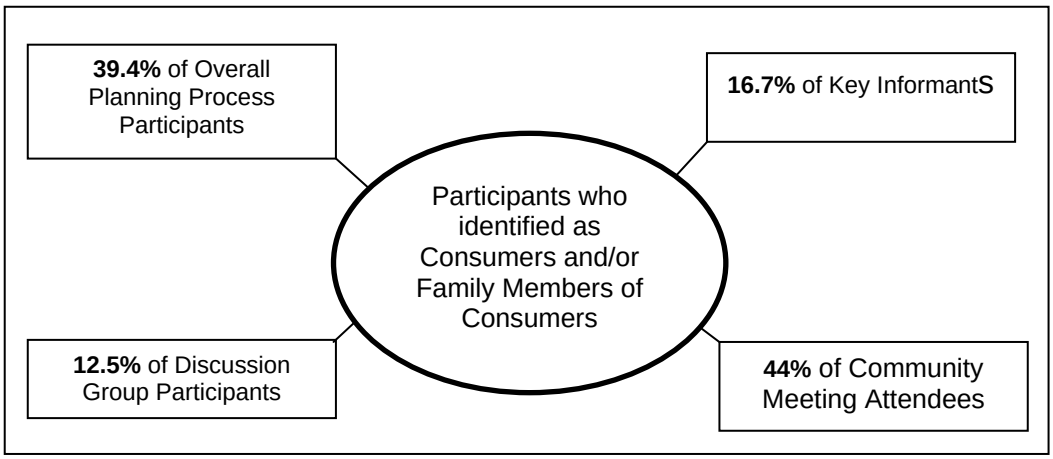
c. *Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure opportunity to participate.*

The enormous involvement of individuals with serious mental illness or serious emotional disturbance and their families cannot be overstated. Consumers and family members were actively engaged during all phases of the PEI plan, attending Planning Stakeholder Steering Committee meetings to give public comment and insight; encouraging friends and peers to attend community meetings; and exhaustively supporting planning, preparation and transportation to meetings to ensure that more reticent consumers felt safe attending. In particular, the Recovery Coaches, funded through the CSS Full Service Partnerships, were an enormous asset to the recruitment and participation of consumers in the PEI planning process.

Three discussion groups were convened to ensure that clients with serious mental illnesses and/or serious emotional disturbance and their family members had confidential and welcoming opportunities to facilitate.

- TAY consumers and case managers, hosted by Human Services Agency
- NAMI consumer and family member group, hosted by NAMI
- Consumer group, hosted by the Martin Gipson Socialization Center

The chart below summarizes consumer and family member participation:



The Planning Stakeholder Steering Committee also includes five members who represent clients with serious mental illnesses and/or serious emotional disturbance and their family members.

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. *Participation of stakeholders, as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:*

Key Informant Interviews and or Discussion Groups were held with representatives from each of the required stakeholder groups including:

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families;
  - At-risk TAYS and emancipated foster care youth 18-21, June 23
  - Manteca Parents of Adolescents, June 26
  - TAY consumers and case managers, July 2
  - NAMI consumer and family member group, July 29
  - Consumer group, August 14
  - In addition private, conversations were held with numerous consumers and or family members whom, for confidentiality purposes, are not listed individually in this document. Special thanks are due in particular to the consumer peer advocates who worked tirelessly during this planning process to engage consumers in the public discussions.
- Providers of mental health and/or related services such as physical health care and/or social services:
  - Health care providers, July 16
  - Older adult service providers, July 23
  - BHS children's services staff, July 23
  - Suicide and Trauma, crisis staff, July 29
  - Michele Rowland-Bird, Manager for Children and Youth Services
  - Curt Williams, Substance Abuse Services Manager
  - Kenneth Cohen, Director and CEO, Health Care Services Agency
  - Margaret Szczepaniak, Assistant Director, San Joaquin County Health Care Services Agency
  - In addition, nearly 100% of BHS contractor organizations participated in at least one discussion group and attended at least one community meetings. Many BHS contractors generously gave their time and wisdom by attending numerous meetings.
- Educators and/or representatives of education:
  - San Joaquin County School Drug, Alcohol, & Tobacco Prevention Education Coordinators, May 22 (DATE)
  - School Health Coordinators, June 13
  - First 5 contractors for children 0-5, July 16
  - Sheri Coburn, Director of Comprehensive Health Programs, San Joaquin Office of Education
  - Wendy Frink, County Operated Schools Program
  - Lani Schiff Ross, Executive Director, First 5 San Joaquin County
  - Kay Ruhstaller, Executive Director, Family Resource and Referral Center

- In addition, numerous school educators participated in community meetings. After mental health service providers (including consumer groups), educators were the second largest profession participating in the PEI planning process.

- Representatives of law enforcement:
  - Juvenile Justice Roundtable, July 2
  - Probation Staff, August 6
  - Richard Vlavianos, Superior Court Judge, San Joaquin County
  - Anthony Lucaccini, Superior Court Judge, San Joaquin County
  - Barbara Kronlund, Superior Court Judge, San Joaquin County
  - Chris Hope, Chief, San Joaquin Juvenile Probation
  - Patricia Mazzilli, Assistant Chief Probation Officer
  - Stephanie Bays, Deputy Chief Probation Officer
  - In addition members of local law enforcement, the judiciary, the public defender's office and other members of the justice community also participated in community meetings or submitted comments for consideration.
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families:
  - BHS contractors, General, July 9
  - BHS contractors, Underserved populations, July 9
  - David Love, Executive Director, Valley Community Counseling Services
  - Monica Gutierrez, City of Tracy, Mayor's Community Youth Services Network
  - Ralph Womack, Mayor's Office City of Stockton
  - Wendy Moore, Deputy Director, San Joaquin Human Services Agency (older adults)

b. Training for county staff and stakeholders participating in the Community Program Planning Process.

Training for county staff and stakeholders started early and continued throughout the planning process. The Kick-off Meeting held May 19th was the first opportunity to provide training on the nature of the prevention and early intervention components in MHSA. At this meeting over 100 staff, community service providers, consumers, and family members received an orientation on the PEI planning requirements, the nature of prevention and early intervention services compared to treatment, the intention of MHSA in creating a PEI component, and an overview of the anticipated planning activities in the months to come.

This information was briefly reviewed during all interviews, discussion groups, and community meetings for the first five months of the planning process to ensure that everyone understood how the different community outreach components related to each other, regardless of what stage their input was heard in the planning process. This was done in part to ensure that all participants understood the PEI goals and activities, but also to help ensure that conversations stayed focused on PEI topics and did not stray into treatment or community services and supports.

Finally, to ensure consistency of messaging across all public outreach and planning activities the following message was either read to or given to all participants.

The Prevention Element of the PEI program is meant to reduce risk factors and stressors that can lead to an initial onset of a mental health problem. The Prevention Element is also intended to promote, support the well-being, and reduce the suffering of "at risk" individuals who are experiencing challenging life circumstances.

The Early Intervention Element of the PEI program is designed to prevent a mental health problem from getting worse. These programs are directed toward people for whom a short-term (less than one year), relatively low-intensity intervention is appropriate to measurably improve their mental health, avoid the need for more extensive mental health treatment or services, or prevent a mental health problem from getting worse.

In the latter half of the planning process the training message shifted to focus more on the PEI plan requirements so that community members and participants would be better informed during the decision making process. In particular key messages such as the required allocation of at least 51% of funds to children and youth, and a focus on how suggested plan components would address disparities in access were reiterated at each meeting to help ensure that the final plan met state guidelines and MHSA goals.

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how these were applied in the PEI process.

The PEI planning process relied heavily on findings from the CSS and WET processes. By conducting WET planning concurrent with the PEI planning process, findings from the WET needs assessment were incorporated into the PEI plan. Two PEI programs described in this plan are joint programs supported in part with WET funding.

Additionally, the PEI plan relied heavily on CSS findings underscoring the importance of accessible, community-based services that ensure earlier identification, better responsiveness, and cultural appropriateness[2]. For example:

Children and Youth CSS workgroups identified the following PEI-related priorities:

- Prevention/Early intervention services
- Increasing school-based counseling services with mental health professionals for early identification
- Transitional case management for incarcerated youth
- Services on school sites
- Building on what exists

[2] San Joaquin county MHSA Three-Year Program and Expenditure Plan, Community Services and Supports, June 2006.

- Advocacy programs to improve access to services that are sensitive to culture and language
- Training/outreach to child care providers serving children 0-12 years old
- Training for law enforcement agencies regarding mental health services

Consumer CSS Workgroups identified the following PEI-related priorities:

- Community mental health awareness and more outreach and education to law enforcement, faith-based organizations and ethnic/cultural community groups.

Adult CSS Workgroups identified the following PEI-related priorities:

- Integrated physical and mental health services
- Geographic services in community-based neighborhoods
- Job and vocational training

b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

The final arbiters of the success of the PEI planning process are the consumers, family members, and community stakeholders who invested their time and energy in developing the PEI plan. The incredible turnout for discussion groups, community meetings, and Stakeholder Steering Committee meetings attests to the community outreach and involvement. The following quotes come from comment cards that were distributed to participants at each meeting:

> *The workshop was very informative and the group discussion was a great opportunity to discuss and share ideas. – Lodi Community Meeting*
>
> *A very interesting and useful process to address the pressing needs of providing mental health prevention and intervention – Tracy Community Meeting*

5. Provide the following information about the required county public hearing:

a. The date of the public hearing:

Date	***Time***	***Hearing***
September 17, 2008	6:00 pm	San Joaquin County Mental Health Board
February 18, 2009	6:00 pm	San Joaquin County Mental Health Board
March 18, 2009	6:00 pm	San Joaquin County Mental Health Board
April 6, 2009	6:00 pm	PEI Public Hearing
April 7, 2009	9:00 am	San Joaquin County Board of Supervisors

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

The PEI Component of the Three-Year Program and Expenditure Plan was posted for review on the County MHSA website on February 25, 2009. A brief executive summary was posted as well to provide an overview of the plan contents for all interested parties.

E-mail notification was sent to all stakeholders involved in the planning process letting them know that the plan was available for review on the website. Additionally notices were posted at the Gipson Center and the Wellness Center that the PEI plan was available for review. Hard copies of the draft plan were distributed to The Gipson Center, the Wellness Center, NAMI, and other key stakeholders to be available for public review.

c. A summary and analysis of any substantive recommendations for revisions.

Public Comments were received between February 24 and March 26 during the 30 day public review period. All written comments are included in the Appendix for review. Behavioral Health Services reviewed these comments and prepared a document summarizing the comments with recommended responses (see page 138).

This plan has been modified from initial drafts reviewed by some stakeholders in the following places:

- Project 1: Reducing Disparities in Access contains a stronger emphasis on the importance of addressing stigma associated with mental health issues.
- Project 2: School-based Prevention Efforts includes specific funding for programs targeting young children 0-5 who may have social/emotional delays and do not qualify for other interventions.
- Project 3: Connections for Seniors and Adults allocates resources to work with the home-delivered meals program for homebound seniors to provide mental health depression screenings.
- Section J, with attachments for additional PEI funding requests including the 2009/2010 funding request and the Training Technical Assistance and Capacity Building Request for PEI statewide projects. Funding for 2009/10 includes an expansion of funding for:
    - School Based Prevention Programs
    - Mental Health for Youth at Risk of Juvenile Justice Involvement
    - Comprehensive Family Support Programs
    - NAMI Peer Advocates

  Startup costs for one new program are recommended with a portion of the anticipated Supplemental funds:
    - Co-occurring Disorders for TAYS 16-21

  Additional funding is also allocated for:
    - Establishing an operating reserves fund at 10% of the 09/10 PEI allocation
    - Sustaining 15% of funding for Administrative costs

d. The estimated number of participants:

Eighteen members of the public attended a meeting of the Mental Health Board on September 17, 2008 to review the draft findings from the community outreach process. Members of the public were given the opportunities to ask questions and provide input into the next phase of the planning process. All feedback and suggestions were incorporated into draft plans as appropriate.

Two members of the public attended the Mental Health Board meeting on February 18. Also in attendance were BHS staff and Kayce Rane, of Resource Development Associates. Kayce Rane presented an overview of the draft plan and accepted comments and suggestions from the Mental Health Board members on how to strengthen it. Their suggestions are incorporated into this plan document for public review. Demographic forms were collected from nine of the twenty individuals present at the meeting. Of those who turned in forms, two-thirds self-identified as a consumer and/or a family member of a consumer.

Five members of the public attended the Mental Health Board meeting on March 18, which included on the agenda public time to discuss the Final Draft of the PEI plan. No public comments were received.

A Public Hearing was held April 6th. The following e-mail notice was sent to all Consortium members as well as individuals who had participated in the planning process. Notices were posted in public spaces.

Notice of Public Hearing

San Joaquin County Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Recommended Plan

On April 6, 2009 at 6:00 p.m. at the Mental Health Center, 1212 N. California St., Stockton, under auspice of the San Joaquin County Mental Health Board, a public hearing will be held on the Prevention and Early Intervention (PEI) Recommended Plan.

Additionally a public notice was printed in the Stockton Record, the primary newspaper for San Joaquin County on April 2nd and April 3rd. The public notice is included in the Appendix.

No members of the public attended the public hearing. We believe that this is due to the due diligence to inform and involve planning participants in the decision-making processes through the series of prior public meetings discussed above. These meetings resulted in a series of micro adjustments in the Final Drafts to make sure that the Plan reflected all community input. Simply put, by the time the Public Hearing was held, people felt heard and considered the work was done.

The San Joaquin County Board of Supervisors reviewed the Final PEI Plan on April 7th. The Plan was passed unanimously. The brief remarks by the Supervisors are included in the Appendix, on page 139.

PEI PROJECT SUMMARY (FORM # 3)

This page intentionally left blank.

Note:

All projects are expected to begin July 2009, or as soon as prudently possible following receipt of PEI funding and/or the commencement of the 2009-2010 school year.

For planning purposes the first year of operations will be July 2009 – 2010.

All estimates of numbers served reflect this time period.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 3

County: San Joaquin **PEI Project Name:** 1. Reducing Disparities in Access **4/7/2009**

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X	X	X	X
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☐	☐	☐	☐
4. Stigma and Discrimination	X	X	X	X
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	X	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	X	X
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	X	X	X	X

Project 1: Reducing Disparities in Access

Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

During both the CSS and PEI planning processes, community stakeholders talked about the importance of increasing mental health awareness in the community. All groups called for increased outreach and information and especially bilingual/culturally competent information. Asian/Pacific Islander stakeholders in particular called for culturally specific information in multiple languages. Numerous groups noted the need to provide more public education to "reduce the stigma". Groups recommended outreach in schools, workplaces, fields (for migrant workers), and shelters.

Summary of Findings

A Mental Health 101 training series was one of the most commonly supported programs among community meeting participants, with near unanimous support. Participants identified a great need for more community professionals to understand mental health in order to help identify issues as they emerge and serve as brokers to additional mental health services. Others talked about the need for broad public outreach and information campaigns, using celebrities or community leaders, to make deep changes in community perceptions around mental health.

> *We need better training for professionals on mental health. This will enhance our "seek and find" activities. – Community meeting participant*
>
> *People may be more apt to be open to input from community people who can help them rather than a "mental health professional". – Community meeting participant*

3. PEI Project Description:

San Joaquin's Community Services and Supports Plan established the framework for community-based, culturally specific mental health services. The Full Service Partnerships provide culturally and linguistically appropriate mental health services in community settings. Specially, trained outreach workers work with individuals (and their family members) that may have serious emotional disturbances or serious mental illnesses in order to encourage them to seek assessment and treatment. However, their efforts continue to be challenged by prevailing community attitudes, norms, and beliefs about mental illness.

Project 1: *Reducing Disparities in Access Project* seeks to change public perceptions and knowledge about mental health services. This multi-pronged approach provides education and training to community professionals and engages cultural brokers to spread information about mental health throughout San Joaquin's diverse cultural communities. It is a joint strategy offered with support from Workforce, Education and Training (WET) funding.

Program Summaries

Project 1: *Reducing Disparities in Access* consists of two program components:

1. Cultural Brokers

2. Mental Health 101

1. Volunteer Cultural Brokers

> *Cultural brokering is defined as the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change. Cultural brokers are knowledgeable in two realms: (1) the health values, beliefs, and practices within their cultural group or community and (2) the system that they have learned to navigate effectively for themselves and their community. They can also serve as communicators and liaisons between the patients/consumers and the providers[3].*

As part of the Reducing Disparities in Access Project, the Cultural Brokers Program will address cultural norms and perceptions around mental health issues. Funding will be allocated to up to four community based organizations, which are full service partnership contract providers, to train volunteer cultural brokers to discuss mental health issues, including co-occurring disorders, in an informative and non-threatening manner in order to reduce the stigma associated with mental illness and mental health services.

Potential cultural brokers include ministers, shamans, elders, medicine men and women, and other community leaders who can influence cultural norms and perceptions around mental health. Special care will be taken to identify cultural brokers who can reach out to different segments of their communities, understanding that gender, age, and acculturation differences may require specific approaches. Important assets that will be identified in potential cultural brokers include individuals who have:

- the trust and respect of the community;
- knowledge of values, beliefs, and health practices of cultural groups;
- an understanding of traditional and indigenous wellness and healing networks within diverse communities; and
- experience navigating care delivery and supportive systems.

Cultural Brokers will be expected to receive on-going training to learn about mental health and co-occurring disorders and will be asked to meet periodically to help develop shared, culturally appropriate messages.

The role of the Cultural Brokers is specifically one of reducing stigma and discrimination towards mental health issues. It is anticipated that through their words at the pulpit, as speakers at community functions, or at clan gatherings these community leaders will help influence the attitudes and perceptions of their communities on issues of mental health.

Additional funding will pay for refreshments, transportation, or recreation costs associated with hosting community events or celebrations where mental health information can be disseminated informally to community members.

2. Mental Health 101

BHS will provide basic training in mental health signs and symptoms, crisis intervention and de-escalation, and available mental health services and supports to partner organizations, agencies, and schools that may have first or ongoing contact with individuals experiencing the onset of severe emotional disturbances (SED) or with serious mental illness (SMI). Trainings may be developed specifically for San Joaquin County or may include existing trainings or presentations, such as the NAMI Anti-Stigma Campaign. All trainings will emphasize the role stigma

[3] US Department of Health and Human Services "Bridging the Cultural Guide in Health Care Settings: The Essential Role of Cultural Broker Programs." Prepared by Georgetown University, Spring 2004.

and discrimination has in preventing individuals or families from seeking help, and ultimately escalating the nature of the crisis. Trainings will also include information on co-occurring disorders, recognizing that recent studies by the California Department of Alcohol and Drug Programs suggest that the percentage of mental health clients with a co-occurring disorder ranges from 50-80%.

Community stakeholders repeatedly brought up the need to train first-responders, particularly County law enforcement officers, citing recent tragedies which may have been prevented had officers been trained to recognize mental illness, de-escalate emotional crises and understand the range of emergency mental health services.

> *When mental health workers are not on duty, law enforcement officers are the first responders to a crisis. They are not trained to meet the need. – Focus Group Participant*

Law enforcement and probation officers, who participated in the planning process, demonstrated enthusiasm for Mental Health 101 trainings.

Mental Health 101 training opportunities will also target educators and schools. Trainings targeting teachers and administrators will emphasize signs and symptoms, crisis intervention, and the assessment and referral process. A more general training may be developed for entire school community targeting parents, teachers, and students that is intended to provide information on the nature and prevalence of mental health issues and to reduce stigma and discrimination towards those who have or are perceived to have mental health issues.

In this joint PEI/WET strategy, the WET Coordinator will be responsible for continuing to develop and maintain relationships with first responders and other community partners, including cultural brokers. Such collaborative relationships will ensure requisite leadership buy-in, because, without high-level commitment, such trainings will not be integrated into coordinated programmatic and policy changes.

A Mental Health 101 Training Team, of a professional trainer and Speakers Bureau, will convene approximately 20 half-day trainings annually. The professional trainer will be widely familiar with available supports and services and will have credentials in Crisis Intervention Training (CIT). The Speakers Bureau will include individuals with consumer and family member experience, and come from underserved or inappropriately served communities (e.g. Middle Eastern/Muslim, African American, Latino, Southeast Asian, Native American, LGBT, non-native English Speakers, transitional age youth, etc.) Consumer and family members who participate in the Speakers Bureau will receive a stipend in appreciation for their participation. Consumers and family member participation will help reduce stigma and provide vital insight into the experiences of people living with mental illness. A culturally diverse Speakers Bureau will articulate how communities experience and respond to psychological crises in unique ways, and will illustrate how cultural biases and misunderstandings affect how first responders and other community partners treat those they perceive as “different”. Culturally competent Mental Health 101 trainings will be critical to ensuring that prevention and early intervention activities by first responders are successful.

The Speakers Bureau will periodically partner with the cultural brokers as requested in order to bring culturally appropriate consumer voices to target communities. We believe that this combined strategy of trainings, using cultural brokers to provide a liaison or entre into the community, and consumer and family member voices will be the most effective means of reducing stigma and discrimination that serves as a barrier to accessing services in a timely manner.

Addressing Disparities in Access

This PEI project will reduce disparities in access by increasing the knowledge and understanding of mental health by diverse communities and stakeholders. By working closely with community leaders in linguistically and culturally isolated communities, this project helps to solicit their support in breaking down cultural barriers to mental health services. Through the Mental Health 101 trainings, more teachers and other potential "first-break responders" will have a better understanding of the sign and symptoms of mental health illnesses and how to respond if an episode happens. These trainings will help ensure an earlier recognition of symptoms and a warmer response from those closest to the individual and family.

Transition to Existing Mental Health Services

A core component of this project is ensuring that more community leaders, teachers, ministers, etc. have enough information about mental health and mental health services to help individuals and families transition safely and securely to existing mental health services.

4. Programs

Program Title Reducing Disparities in Access	Proposed number of individuals or families to be served in first year.		Number of months in operation through June 2009
	Prevention	Early Intervention	
1. Cultural Brokers	300	84	0
2. Mental Health 101	400		0
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 700	Individuals: 84	

Estimating Numbers Served

It is anticipated that the four programs funded by BHS to develop cultural brokers will each recruit and train 4 volunteers to the program. Each individual cultural broker will reach out to and engage an average of 2 individuals per month (4 agencies x 4 cultural brokers x 2 contacts x 12 months = 384). Based on prior experience we anticipate that most their conversations will be preventative in nature, however it is likely that a smaller portion will include early intervention activities.

Funding is available for 20 Mental Health 101 trainings. It is estimated that on average 20 individuals will attend each workshop (20 trainings x 20 attendees = 400).

5. Linkages to County Mental Health and Providers of Other Needed Services

All trainings and education sessions through this PEI project will include information on accessing mental health services. In particular this strategy is enhanced by the intention of having the Full Service Partnership providers facilitate the recruitment and training of the volunteer cultural brokers.

The Mental Health 101 project has been developed in close collaboration with the WET planning process, per the requirement of MHSA to create seamless projects. This project will receive guidance and oversight from the WET coordinator. WET funding will also contribute $5,000 annually for ongoing community training activities over the next ten years. PEI funding will contribute $14,000 annually for ongoing community training activities, for a total budget of $20,000 annually for project oversight and community trainings. Additionally PEI funding will provide $20,000 in one time funding to purchase a Crisis Intervention Training (CIT) curriculum for non-professional mental health workers (e.g. teachers, law enforcement, etc), a train the trainer workshop series, and CIT technical assistance to implement the county-wide training strategy.

6. Collaboration and System Enhancements

This project offers a foundation for several of the other PEI projects by providing important information about mental health to community leaders and potential first identifiers of mental health. It will also support the work of outreach workers by encouraging more people to seek mental health services and by ensuring that pastors, shamans, and other community leaders understand mental health and how services and supports can aid individuals and their families.

7. Intended Outcomes

The principal outcomes for Reducing Disparities in Access will be to reduce stigma and discrimination and reduce disparities in access for underserved cultural populations. The logic model below illustrates the theory of change and the rationale for selecting these projects to meet the intended outcomes.

Focus Area	Resources	Activities	Outputs	Outcomes	Measures	Impact
List the most important things the program will accomplish	*Describe the resources that will support the program activities*	*Describe and define the program activities*	*For each activity identify ways to demonstrate that services have been delivered*	*Identify what changes you expect each activity to effect*	*Specify the ways that these outcomes will be measured*	*Describe the impact that the community will feel in 1-2 years as a result of the program*
Reduce disparities in access to mental health services. Reduce stigma and discrimination towards people who need mental health services.	Funding to develop and purchase materials. Staff time to distribute materials and conduct trainings. Cultural brokers to bring information to culturally and linguistically isolated communities. CBOs, churches and schools that are deeply connected to target populations.	Distribute flyers. Create billboards. Present to groups. Train cultural brokers. Training first responders, teachers, and others	Count of materials distributed. Count of presentations and trainings conducted. Count of participants by key characteristics.	Informed public re: mental health issues. Informed on how to seek help. Knowledge of special issues for different populations.	Change in knowledge of training and presentation participants. Analysis of activities by key characteristics.	More knowledge of mental health, generally. More knowledge of available services. More knowledge of how to seek help. Increase in requests for assistance from culturally and linguistically isolated populations. Earlier requests for assistance.

8. Coordination with Other MHSA Components

This PEI project has strong ties to both CSS and WET projects. WET dollars will fund a portion of this project (Mental Health 101) and the cultural brokers component will teach community leaders how to best utilize the CSS funded recovery coaches and outreach workers. It is anticipated that the Cultural Brokers will help pave the way for outreach workers and recovery coaches to do their jobs within communities where there may have been confusion or resistance in regards to mental health services.

9. Additional Comments (optional)

All of the Prevention and Early Intervention projects in this plan are linked and are designed to support different components along a spectrum of prevention. In this way, San Joaquin County hopes to build momentum for prevention and create a seamless system that supports individuals and their families regardless of where they are at. Each project provides a framework of knowledge, experience, and support that other projects can leverage in their efforts.

San Joaquin County Prevention and Early Intervention Spectrum of Project Activities	
Public Awareness and Education	Reducing Disparities in Access
Prevention	School-based Prevention Efforts
Assessment	Connections for Senior and Adults
Early Intervention	Empowering Youth and Families
Transition to Treatment	Suicide Prevention and Supports

In this first project, *Reducing Disparities in Access*, our intent is to increase knowledge and change perceptions of mental health issues throughout the County. This project lays the foundation for all other projects. Through these efforts, community leaders, ministers and pastors, shamans and elders, teachers and case managers, nurses and doctors will all learn basic information about mental health issues, prevalence, signs and symptoms and where to go for help. These initial trainings will help pave the way as these individuals are asked to incorporate mental health prevention activities within their classrooms, clinics, and community-based programs.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 3

County: San Joaquin **PEI Project Name:** 2. School-based Prevention Efforts **4/7/2009**

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☐
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	X	X	☐	☐
4. Stigma and Discrimination	☐	☐	☐	☐
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	☐	☐
3. Children and Youth in Stressed Families	X	X	☐	☐
4. Children and Youth at Risk for School Failure	X	X	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X	X	☐	☐
6. Underserved Cultural Populations	X	X		

Project 2: School-based Prevention Efforts

Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

School-based prevention programs were some of the highest ranked strategies to arise from the public community meetings. Meeting participants recommended developing classroom-based interventions designed to reduce impulsive and aggressive behaviors and increase protective factors and social-emotional competence. Participants recommended expanding or starting programs that teach children empathy, problem-solving skills, risk assessment, decision making, and goal-setting skills. They recommended programs that are multi-faceted and developmentally-focused, that enhance the competencies of children and youth, and that include special tracks for students who are at-risk for developing conduct problems, including substance use.

> *Reaching kids early on, give them skills, problem solving--these skills can be used for years. – Community meeting participant*
>
> *This age range [children and youth] is underserved. Problem-solving skills and empathy are not always available at home. At school children are a captive audience. – Community meeting participant*
>
> *Comprehensive interventions, focused on at-risk youths to prevent future drop-outs, problem-solving skills, goal-setting skills, and aggressive behavior are addressed by grade level and developmental stages. – Community meeting participant*

Summary of Findings

According to SAMHSA, mental health issues in children and youth are a serious concern that when left untreated can lead to school failure, family conflicts, drug abuse, violence, and even suicide. Studies show that at least 1 in 5 children and adolescents have a mental health disorder and at least 1 in 10, or about 6 million children, have a serious emotional disturbance[4]. These statistics reflect the fact that half of all mental health disorders emerge by age 14 and 75% by age 24.[5]

Mental health disorders in children and youth mimic those seen in adults, ranging from mild depression and anxiety to more serious illnesses such as schizophrenia. In young children mental health disorders may manifest themselves as aggressive or violent behavior towards themselves or others. Though some disorders have biological roots, many environmental factors also put young people at risk for developing mental health disorders. Examples include[6]:

- Exposure to environmental toxins, such as high levels of lead;

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) www.mentalhealth.samhsa.gov
[5] Mental Health America, Conference presentation by CEO Dr. David Shern
[6] Substance Abuse and Mental Health Services Administration (SAMHSA) www.mentalhealth.samhsa.gov

- Exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings, muggings, or other disasters;
- Stress related to chronic poverty, discrimination, or other serious hardships; and
- The loss of important people through death, divorce, or broken relationships.

The risk factors for environmentally related mental health disorders in children suggest that, for some, mental health issues are preventable.

In children and youth, mental health issues are causally related to witnessing, experiencing or committing violence; witnessing family addiction; or substance use[7]. Further, a review of evidence-based, best practices suggests that there is very little program variation between violence prevention, substance use prevention and mental health prevention programs. In general most programs seek to develop life skills such as anger management and decision-making to help children respond appropriately to trauma. Programs also seek to support children's environmental or developmental assets (e.g. a caring adult, extra-curricular activities) so that they have the resources they can call on for support.

Research also suggests that early success in school is a critical component in developing the resilience to avoid problem behaviors later in adolescence. For example, a study of 808 students in Seattle identified school failure as a large risk factor in future depression, particularly for girls[8]. A review of the literature supports this:

> *Conduct disorder symptoms during childhood predicted subsequent depression symptoms[9].*
>
> *Externalizing problems in childhood undermined academic competence in adolescence, creating vulnerability to internalizing problems in young adulthood[10].*

School failure is also linked to juvenile delinquency and violence problems, with juvenile court justices and probation officers identifying school truancy as the biggest predictor of future juvenile justice involvement[11]. In a discussion with county probation officers, discussion group participants recommended programs targeting school-age children prior to juvenile justice involvement as the most important preventative measure.

> *The focus needs to be at the elementary school level. Those youth who are disruptive in the classrooms, get into fights on the school yard, and skip school are the ones who are developing the mental health issues, and the ones we see later. – Discussion Group Participant*

In developing a school-based mental health prevention response, school administrators, substance abuse counselors and parents talked about the overlap between mental health risk factors and risk factors for violence prevention, substance abuse, and school failure. As is embedded in the spirit of MHSA, San Joaquin County stakeholders came to agree that a variety of programs (including substance use and violence prevention programs) can support mental health prevention, given that those administering the

---

[7] Morbidity and Mortality Weekly Report, August 10, 2007, Vol. 56.

[8] McCarty, C. "Adolescent School Failure Predicts Depression in Girls," Journal of Adolescent Health 2008 August; 43(2) 180-187.

9 Ibid. Quoting Burke, JD et al. "Developmental transitions among affective and behavioral disorders in adolescent boys," Journal of Child Psychiatry. 2005;46:1200–10. [PubMed].

[10] Ibid, Quoting Masten, AS; et al. Developmental cascades: linking academic achievement and externalizing and internalizing symptoms over 20 years. *Dev Psychol.* 2005;41:733–46.

[11] Comments during the Juvenile Justice Roundtable.

programs, teachers, and other staff understand enough about mental health to put prevention program activities into an appropriate context.

The school-based prevention program described below focuses on children and youth ages at three different stages: early development, elementary school, and middle school. (School-based early intervention activities focusing on older youth are described in subsequent sections.) The following activities reflect a two-fold approach towards school-based prevention: training and direct services. The first three programs (described below) will train teachers and school staff about mental health issues. The fourth, and largest, funding component will provide grants to school districts to expand and enhance applicable prevention programs within their districts. This funding strategy will build upon the good efforts already undertaken by San Joaquin County schools, will avoid unnecessary duplication of prevention efforts, and will minimize implementation time by supporting what is already well-known and understood. School districts that do not have a school-based prevention program will also have the option of applying for funding to launch a new effort.

> *We have several Early Intervention Mental Health programs in place in Tracy schools, however funding is limited. We have many students, and whole schools that need services, but funding does not allow for it at this point. We would love to have services available to all in need. – Community Comment*

> *We are seeing a lot more bipolar and depression. Depression is the big issue this year. Several years ago, no one had bipolar, now they all do. – Focus Group Participant*

This project builds upon the recommendations from the 2007 Strategic Plan for Substance Abuse Prevention, which identifies school age children as the most important targets for prevention efforts. According to the Plan:

> *The elementary school age (5-11) was found to be the top concern as it is at this age that the prevention message is most crucial. Moreover, it is during these years that there is a chance for considerable impact. Youth at this age can be equipped with resiliency, decision making, and coping skills*[12]*.*

3. PEI Project Description:

Community members, consumers, and professionals all identified schools as the most important venue for early mental health prevention programs. During the CSS planning process the Children and Youth Workgroup identified school-based prevention programs as one of its top priorities. The following project is intended to transform schools into centers of early mental health prevention through a concerted effort to train child educators on signs and symptoms of mental illness and emotional disturbance and to develop programs that will help children develop resiliency and coping skills

Program Summaries

Project 2: *School-based Prevention Efforts* consists of four program components:

1. Mental Health in Young Children 0-5 Education Campaign

[12] San Joaquin County Substance Abuse Services, *Strategic Plan for Substance Abuse Prevention,* July 2007.

2. Emergence of Serious Mental Illness in Adolescents Training
3. Co-Occurring Disorders Training for School Districts
4. Expanding School-based Prevention Programs

1. Mental Health in Young Children 0-5 Education Campaign

Professional child care providers care for over half (54%) of San Joaquin County's young children. However, a survey of San Joaquin's CalWORKs population revealed that 85% of those using child care used (exempt) family child care providers[13, 14]. These findings suggest that some of the most vulnerable children in San Joaquin are being cared for by family care providers with limited child development training.

> *Very young (age 2-5 years) children's emotional development …can impact development and challenge odds of healthy outcomes. Preschool teachers/child care providers need ongoing training and support in recognizing vulnerability/protective factors and in ways to strengthen children's emotional development. – Community Comment*

San Joaquin's Family Resource and Referral Center (FRRC) is uniquely positioned to advance an understanding of early childhood mental health issues amongst both exempt and licensed child care providers. The FRRC offers on-going child care provider workshops and trainings on a variety of topics, including child development, nutrition and behavior. They also have a bi-monthly newsletter that is sent to all childcare providers, including exempt family care providers receiving Cal Works reimbursements.

The Mental Health in Young Children 0-5 program will utilize the capacity of FRRC to reach deep into the provider community. FRRC will convene at least 10 workshops and trainings on mental health issues in young children in multiple languages including Spanish and other threshold languages. The workshops will include the following topics:

- Mental Health concerns in young children
- Recognizing signs and symptoms of mental health issues or concerns
- Talking to parents about mental health concerns
- Where to go for additional help
- Others, as determined

Themes will be echoed in the FRRC newsletter, each month featuring a new mental health-related topic.

Activities will culminate in autumn with the hosting of the annual conference. The annual conference will feature an emphasis on mental health in young children.

FRRC will partner with San Joaquin Behavioral Health to conduct this education campaign. FRRC child development trainers will participate in the mental health 101 workshops to familiarize themselves with mental health topics, and Behavioral Health staff will be available to review newsletter articles for accuracy

[13] Children Now 2005 Databook.
[14] San Joaquin County Cal Works Needs Assessment and Outcomes Study in 2004 by the National Center for Children in Poverty and the San Joaquin Human Services Agency.

and to present at the conference and provide electronic copies of appropriate children's mental health materials.

2. Emergence of Serious Mental Illness in Adolescents Training

With half of all serious mental illnesses emerging by age 14 and 75% by age 25, adolescence is a critical period for early identification and intervention. This program component will provide training to middle school and high school educators to help them understand the signs and symptoms of mental health issues. The training will also help train teachers in how to talk with parents about mental health concerns in a manner that is non-stigmatizing and that encourages early identification and follow-up. The primary purposes of this program activity will be to help train educators in mental health issues in order to:

- Promote earlier identification and intervention
- Develop a school-based plan for responding to mental illnesses in students, and
- Reduce stigma and discrimination associated with mental health issues.

> *At the first signs of symptoms related to mental illness, there must be a plan in place to address these issues in the schools. There are research-based programs that have proven successful in the schools. - Community Comment*

Funding will be allocated to the Office of Education to develop this training series.

3. Co-Occurring Disorders Training for School Districts

For children and youth, aggressive behaviors, acting out, and experimenting or using alcohol and drugs are often linked to a mental health issue. The co-occurrence of mental illness and substance abuse is so common that many clinicians now expect to find it. Studies show that more than half of young persons with a substance abuse diagnosis also have a diagnosable mental illness[15]. When these behaviors manifest themselves on school grounds, school policies usually result in disciplinary actions including suspension or expulsion. While disciplinary actions may be an appropriate deterrent some of the time, it is also important for schools to understand the relationship between mental health and alcohol and drug use.

According to recent research, adolescents with complex problems like concurrent mental health and alcohol and drug addictions will not respond to simplistic advice such as "just say no," and will respond poorly to confrontational or discouragement techniques developed for substance users alone. (Such interventions may in fact increase stress levels, subsequently exacerbating mental health conditions). Rather, evidence suggests that substance use has to be addressed within the context of the mental health issues and both disorders must be treated at the same time[16].

This program will help school counselors and administrators understand how co-occurring disorders manifest in children and adolescents and which types of interventions are most useful for different age groups. The training will also provide samples of school policies and procedures that contain appropriate disciplinary techniques but are broad enough to incorporate recommended adolescent AOD and co-occurring treatment practices, such as skill building programs and support groups that involve family and friends.

Funding will be allocated to the Office of Education to develop this training series.

---

[15] www.nami.org: "Dual Diagnosis in Adolescents," NAMI HelpLine Factsheet.
[16] www.nami.org: "Dual Diagnosis in Adolescents," NAMI HelpLine Factsheet.

4. Expanding School-based Prevention Programs

Based on input from focus groups, community meetings and intensive interviews with school administrators it was clear that school districts throughout the county are grappling with how to respond to the growing number of students who are fighting, acting out and doing poorly in school. School personnel eloquently expressed the relationship between family stresses, neighborhood violence, poverty, and their students' capacity to learn. Teachers talked about kids coming into the classroom too tired, too hungry, and too depressed to learn. Teachers also talked about the increasingly stringent requirements to "teach to the test" and the difficulty with program mandates that start with a bang, only to disappear in a few years. Despite the frustration and anxiety expressed by teachers and other school personnel they also showed a deep passion for the children and youth that they work with and a willingness to explore creative solutions to help the students in their classrooms. Teachers and school personnel made up the biggest contingent of non-mental health professionals participating in the PEI planning process.

Nearly all school personnel agreed with community sentiment that mental health prevention activities should be focused within schools, and most school districts have already taken steps in that direction. A variety of research validated programs ranging from Second Step, Too Good for Violence, Reconnecting Youth, and Project Alert are already embedded within school systems. Additionally, an Asset Development Model that focuses on school and community connectedness serves as the focus of school prevention efforts.

These programs rely on school site case-managers, non-clinical counselors, credentialed school nurses or parent advocates to work with students and families who are identified as at risk. Programs teach life skills, decision making and goal setting, interpersonal communication, anger management, peer conflict mediation, and coping skills. They provide a positive, welcoming place for children and youth to talk about their feelings and experiences and provide a caring adult to help when things are difficult. Staff typically work within the schools and in conjunction with the teachers, counselors and school administrators. Program activities may be concurrent with classroom activities, held in small break-out sessions, or provided through one-on-one sessions with students and/or parents. Many programs combine all three strategies with staff doing "whatever it takes" to support the students' emotional and academic success.

This PEI project will release funding to school districts through grants administered by the County Office of Education. Funding will be available to all school districts to *expand* or *enhance* existing prevention programs. This funding will allow school districts to expand successful prevention programs to additional school sites. It will also help schools enhance their prevention curriculum and training to better include children's mental health issues or to develop in-school mental health assessment procedures where none are in place. Award amounts are anticipated to be $100,000 to $200,000 annually for each school district. Additionally, funding will be awarded to school districts to attend professional institutes or development for curriculum implementation; purchase research validated training materials and curriculum, recreation or computer equipment, student incentives, or other supplies necessary to foster asset development activities and encourage student participation and engagement of children and youth.

Additionally $360,000 will be available to the fund early intervention programs for children 0-5. Similar to the nationally recognized *Incredible Years* model, the Early Childhood Education Program works with young children who are displaying unusually aggressive or anti-social behavior and provides supports for teachers, parents, and child care providers to give them the necessary skills and strategies to 1) assess a child's current and on-going social behaviors, 2) teach the child new socially acceptable skills, 3) ensure that the resources and services necessary for appropriate social and emotional development of the child

are available and implemented, and 4) include parents and child care providers as partners in the intervention process. Direct work with the child in their home or child care center is a core component of the program expansion funding.

Funding will support work with providers of care for infants, toddlers, and preschoolers throughout the County in family child care homes, preschools, subsidized child care programs (including Head Start), and other child care settings. The funding will be available for a one time award for a three-year demonstration project and is intended to highlight the importance of the very earliest interventions. Families with, or at-risk of, child welfare involvement will be a high priority for services, although the program will be open to all children and families in need of this support.

Addressing Disparities in Access

This project was identified by community stakeholders as one of the most important ways to reduce disparities in access. School-based prevention programs were identified as a way to ensure more children throughout the county were served by mental health prevention programs. Furthermore, community participants expressed confidence in the schools' ability to work with parents from many different cultural and linguistic backgrounds, emphasizing that "they are already establishing relationships with the parents and families anyway." Oversight by the Office of Education will ensure that programs are implemented broadly throughout the County and that program staff hired are culturally responsive to the needs of the local school communities.

Transition to Existing Mental Health Services

This project is intended to act in coordination and collaboration with other school-based mental health efforts funded through MHSA and other public mental health dollars; particularly programs that fund school psychologists and other mental health professionals. The expansion of school-based prevention efforts will help provide earlier identification of children who would benefit from more extensive mental health services. Program staff will be expected to refer all children who require more extensive mental health screening to appropriate school- or county-based mental health services.

4. Programs

Program Title	Proposed number of individuals or families to be served in first year		Number of months in operation through June 2009
	Prevention	Early Intervention	
Training Programs: • Mental Health in Young Children 0-5 Education Campaign • Emergence of Serious Mental Illness in Adolescents Training • Co-Occurring Disorders Training for School Districts	50,000 (indirectly impacted)		0
School-based Prevention Programs	700	150	Program expansion
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 700	Individuals: 150	

Estimating Numbers Served

Adding one to two staff to each district's prevention program effort will expand services to 4-8 schools, depending on the number of schools targeted through the expansion and the number of students at each school. For example, a middle school expansion might require a full-time staff member, compared to an elementary school expansion, which might allow a staff person to split his or her time between two or more schools. $615,000 is allocated for up to 10 new positions. At a minimum this program hopes to target approximately 600 - 800 additional children through group services and 150 - 200 children and families with more direct interventions annually.

Funding covers 6 - 8 new staff positions, with each staff person working with approximately 100 kids through group activities in the classrooms (5 classes of 20) and working in direct one-on-one or small group sessions with 25 kids that need more individualized attention. Funding extends existing Early Childhood Education program to include home and child care center visits, impacting approximately 100 children 0-5.

Additionally, it is anticipated that up to 50,000 children will be indirectly affected through the training efforts, understanding that trainings will target approximately 1,000 child care providers, teachers, and school administrators throughout the county. Trainings will have a lasting impact on teachers, with knowledge impacting care and education practices for years to come.

5. Linkages to County Mental Health and Providers of Other Needed Services

The School-based Prevention project provides an important link between educators and mental health services by ensuring that child care providers, school teachers, and school administrators understand better the prevalence of mental illness and the signs and symptoms of mental health issues. In addition to building a better understanding of mental health issues, trainings will provide educators with a trusted person they can talk with if questions or concerns arise. All trainings will include appropriate BHS contact information as well as information on how to contact the trainer. Further, a BHS staff member will oversee the development of mental health content information to ensure the accuracy of the training and outreach activities.

6. Collaboration and System Enhancements

During the PEI planning process community members and stakeholders strongly encouraged "working with what exists and with what works", rather than "building something new". *Leveraging existing programs* received resounding support from school personnel, community members and parents, who were all proud of the work already accomplished within their communities. Expanding existing prevention programs within the schools will improve capacity and enhance programs as school districts incorporate more mental health curricula into their prevention efforts.

The early childhood component provides school systems, child welfare services, and the dependency court with another resource to support children who are impacted by family violence, substance use and mental health issues. It also expands home based supports at a time when more and more San Joaquin families are in crisis due to the worsening financial crisis.

This PEI project is also intended to enhance the overall prevention system by creating a Countywide framework for mental health prevention for children and adolescents, which is steeped in current research linking mental health, substance use, and violence prevention.

7. Intended Outcomes

The principal outcomes for School-based Prevention Efforts will be to:

- Reduce the psycho social impact of trauma;
- Improve the lives of at risk children;
- Reduce stigma and discrimination by talking more openly about mental health issues; and
- Increase protective factors.

The logic model below illustrate the theory of change and the rationale for selecting these projects to meet the intended outcomes.

Focus Area	**Resources**	**Activities**	**Outputs**	**Outcomes**	**Measures**	**Impact**
List the most important things the program will accomplish	*Describe the resources that will support the program activities*	*Describe and define the program activities*	*For each activity identify ways to demonstrate that services have been delivered*	*Identify what changes you expect each activity to effect*	*Specify the ways that these outcomes will be measured*	*Describe the impact that the community will feel in 1-2 years as a result of the program*
Increase resiliency: Children will develop a skill set for responding to difficult situations Reduce stigma: Teachers and children have better understanding of mental health Improve early identification and referral to appropriate services Improved parenting skills	Community-based trainers to provide training and ongoing consultation Knowledgeable teachers/ child care providers to identify and support at risk children Support for co-occurring disorders treatments amongst school administrators Existing First 5 and County Office of Education collaborations will underpin the early childhood program	Teacher training Prevention programs linking mental health, alcohol and other drugs and violence prevention efforts. Counseling/case management for vulnerable children and youth Home visiting and one-on-one sessions with parent and child for emotionally disturbed young children 0-5	Count of trainings Count of child participants in prevention activities Count of children intensely served Count of home or child care visits Count of parents receiving one-on-one child development advice	Positive behaviors in children Knowledgeable teachers Supportive school environments More confident and competent parents	Knowledge change pre and post test in trainings Reduce incidence of school based violence/conflict Teacher reports, school engagement Parent and child surveys	Reduced violence by children e.g. (bullying, hitting) Reduce incidents of children hurting themselves (e.g. cutting) More appropriate referrals to services Children will enter kindergarten with behavior skills that support their learning readiness

8. Coordination with Other MHSA Components

Providing aggressive training to school personnel will help reinforce the philosophy and tenets of MHSA throughout County schools. It is anticipated that the combination of training and enhanced program activities will help build a mental health culture within San Joaquin County that will support earlier identification and intervention.

This program is intended to further strengthen the communication between BHS and local schools, and it is also hoped that school staff will create stronger linkages to mental health providers within their local communities through participation in trainings and other mental health related activities. These endeavors are intended to strengthen overall neighborhood approaches to mental health by ensuring that school personnel understand the broad range of services and supports available to the community.

9. Additional Comments (optional)

All of the Prevention and Early Intervention projects in this plan are linked and are designed to support different components along a spectrum of prevention. In this way, San Joaquin County hopes to build momentum for prevention and create a seamless system that supports individuals and their families regardless of where they are at. Each project provides a framework of knowledge, experience, and support that other projects can leverage in their efforts.

San Joaquin County Prevention and Early Intervention Spectrum of Project Activities	
Public Awareness and Education	Reducing Disparities in Access
Prevention	School-based Prevention Efforts
Assessment	Connections for Seniors and Adults
Early Intervention	Empowering Youth and Families
Transition to Treatment	Suicide Prevention and Supports

The *School-based Prevention Efforts* project is based in the belief that the most effective mental health prevention strategies target children at a very young age. This program is intended to foster the skills and resiliency in children and youth to help them cope with traumatic situations. It is based on current research that links mental health prevention with violence and substance abuse prevention and responds to community interests in building on what works within neighborhoods by working with school districts to expand and enhance their current prevention efforts. It is dependent upon previous PEI efforts to instill an understanding of mental health issues in school leaders. Such efforts generate support for the more specific metal health trainings provided through this project. School-based Prevention Efforts also serve as a precursor to the remaining PEI projects by providing initial skills should the need for more extensive interventions become necessary for at-risk children and youth.

Looking Forward

As additional funding is identified in future fiscal years the following program is identified as “high priority” and eligible for additional funding:

- Expanding School-based Prevention Programs

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 3

County: San Joaquin **PEI Project Name:** 3. Connections for Seniors and Adults 4/7/2009

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	X	X
2. Psycho-Social Impact of Trauma	☐	☐	X	X
3. At-Risk Children, Youth and Young Adult Populations	☐	☐	☐	☐
4. Stigma and Discrimination	☐	☐	X	X
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☐	X	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	X	X
3. Children and Youth in Stressed Families	☐	☐	☐	☐
4. Children and Youth at Risk for School Failure	☐	☐	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐	☐	☐
6. Underserved Populations	☐	☐	X	X

Project 3: Connections for Seniors and Adults

Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Throughout one's lifespan attention must be paid to preserve, protect, and support mental health. As adults age there are more opportunities to witness or experience traumas that can result in mental health issues such as depression, anxiety, or anger. Mental health issues in adulthood can have profound consequences on an individual and their family including job loss, substance use, family violence, or neglecting children or other responsibilities.

Though services for children and youth were some of the highest priorities expressed by community stakeholders, their was also a unanimous recognition that the plan needed to: 1) address the needs of children and youth holistically, understanding that the mental health of parents and adults plays a large role in the mental development of children; and 2) that the mental health needs of seniors is of a critical importance and specific strategies needed to be developed to address mental health assessment and early intervention for seniors.

> *Elder services seem to be underestimated. PEI is needed, as this population is growing more than any other minority class. – Community meeting participant*

In particular community stakeholders pointed to the connection between depression and suicide. Project 3: *Connections for Seniors and Adults* has been conceived as the prevention component of a broad suicide prevention effort. All programs listed below are intended to provide early prevention and intervention activities and help link seniors and adults with profound depression and grief to the suicide prevention services funded through Project 5, as appropriate.

Summary of Findings

Stigma is perhaps the largest barrier towards getting adults and older adults involved with mental health services in San Joaquin County[17]. According to numerous planning participants, including consumers, service providers and BHS employees, County Mental Health Services is perceived as a place where "crazy people" go, and individuals with mental health concerns are reluctant to seek services through the public mental health system.

> *Stigma is perhaps the largest barrier towards getting older adults involved with the Mental Health services in San Joaquin County. First of all, the term itself ("mental illness") is, in many people's minds, viewed as synonymous to "crazy." This perception is rooted in reality. As soon as you identify yourself as being mentally ill…you get treated in a different way. – Discussion Group Participant*

> *My clients don't want to go there [Behavioral Health Services Crisis Unit]. They have to wait for hours to be seen…and meanwhile they are in a waiting room with "really crazy people" and they come back and tell me that it made them more anxious to even go there. – Discussion Group Participant*

PEI planning participants expressed a concern that adults and older adults ignore or misinterpret signs of persistent depression in themselves or their loved ones. For example, participants talked about the experience of those Latino immigrant women who are extremely isolated from their family, language and culture. Amongst these Latinas, a

[17] Community Discussion Group.

condition referred to as *nervios* is so common it can be dismissed by family members despite the persistent headaches, stomachaches, sleep problems and crying that often accompany it.

Cultural beliefs also lead to misunderstandings between mental health professionals and individuals who may need support. Many Southeast Asian immigrants have endured horrific experiences fleeing from the ravages of war and continue to struggle with these past traumas as well as their current challenge of trying to make a home and raise a family in a new environment. For many, particularly the elderly, there are cultural norms and beliefs about the body, mind, and spirit that need to be understood by mental health professionals so that they can appropriately discuss treatment plans with clients and their loved ones.

Many of those we spoke with talked about the link between depression and the aging process. But experts emphasize that depression is not a normal part of aging.

> *Emotional experiences of sadness, grief, response to loss, and temporary "blue" moods are normal. Persistent depression that interferes significantly with ability to function is not*[18].

The problem expressed in San Joaquin County, and echoed in national research, is a persistent belief amongst health care professionals, family members, and older adults themselves that "*depression is an acceptable response to other serious illnesses and the social and financial hardships that often accompany aging.*[19]"

Poverty is also a barrier for those who may need support to overcome depression, anxiety or anger. Adults and older adults experiencing hard financial times can little afford to seek private mental health care. With unemployment rates approaching 12% in San Joaquin County (compared to 7.5 in 2006)[20] more and more families are losing their health insurance benefits along with their monthly salary.

The final barrier expressed by planning participants is persistent difficulty in finding appropriate, accessible, and affordable mental health care. Chronic staffing shortages have made it difficult for mental health professionals to respond to all mental health needs. Individuals with mild to moderate depression or anxiety often have difficulty finding care until their symptoms escalate.

> *Some days there are so many people in the crisis unit waiting room that it takes a very long time to see people. We are very short staffed, with half of our doctors leaving in the past two years. That was a case load of 1,000 patients. I am not saying you have to be suicidal to get attention, but patients are seen on a triage basis and depression and anxiety are lower priorities. – Discussion Group Participant*

For older adults, difficulties in finding appropriate mental health support are compounded by increasing mobility limitations that make it difficult for them to access services, especially in places that are remote or unfamiliar.

> *On the older adult side, there should be a focus on taking services to the community versus having people come to the services. Major barriers to accessing mental health services are mobility, transportation, and overcoming stigma. – Key Informant Interview*

Community meeting participants expressed a strong interest in developing an integrated primary care and mental health system. According to participants, an integrated system will help increase utilization by co-locating health and wellness services, thus overcoming both transportation and stigma barriers.

---

[18] www.nimh.nih.gov: *Older Adults: Depression and Suicide Facts.*
[19] www.nimh.nih.gov: *Older Adults: Depression and Suicide Facts.*
[20] www.labormarketinfo.edd.ca.gov.

There is less stigma when addressing mental health needs at a doctor's office, and also a trust factor with a physician. – Community meeting participant

Screening of mental health symptoms would be beneficial in primary care settings. Multi-disciplinary approach allows cross training and appreciation of mental health and physical heath to provide comprehensive care for the whole person. – Community meeting participant

We supported integrated primary care as a strategy because the Doctor is the first place most people go, and also it addresses all ages and all populations. – Community meeting participant

Participants also expressed strong support for any programs that supported seniors, particularly programs with home visiting components.

3. PEI Project Description:

During the PEI planning process consumers and family members discussed the profound stressors and traumas that led to mental health issues. Experiences included economic stressors such as losing a job or experiencing a foreclosure; environmental and family stressors such as family violence or substance use; and traumatic experiences such as losing a child or experiencing war. For many, a combination of events precluded a final tipping point. *Connections for Adults and Older Adults* is designed to help identify adults and older adults with mental health concerns and connect them to appropriate support services to overcome moderate mental health concerns or to transition to more extensive mental health services. This project is intended to work in tandem with the subsequent PEI project, *Empowering Youth and Families*, which offers ongoing supports for families experiencing acute stress related to economic, environmental, or family concerns.

As with other PEI projects described in this plan, this project takes a multi-pronged approach to ensure better assessment and support for adults and older adults with mental health issues. A portion of the project is designated for public education and professional training. Direct services are provided for adults and older adults through a senior peer counseling program and through better integration of mental health services within the county primary care health center. This project also builds upon the work of the Cultural Brokers, discussed previously, to ensure better outreach and education within San Joaquin County's diverse ethnic communities.

Program Summaries

Project 3: *Connections for Seniors and Adults* consists of four program components:

1. Mental Health in Older Adults Education Campaign
2. Connections for Homebound Seniors
3. Senior Peer Counseling
4. Mental Health at the Family Practice Clinic

1. Mental Health in Older Adults Education Campaign

We need more outreach and education to identify risk factors and reduce the stigma of having a mental health diagnosis. – Key Informant Interview

San Joaquin County Department of Aging and Community Services will be funded to conduct a one-year outreach and education campaign to older adults in San Joaquin County on mental health issues. Outreach efforts will target older adults, older adult paraprofessionals such as home care workers, and volunteers working with senior programs. Outreach efforts will include trainings and discussions on mental health issues including:

- Mental Health concerns in older adults
- Recognizing signs and symptoms of mental health
- Talking to families and caregivers about mental health concerns
- Where to go for additional help
- Others, as determined

A major emphasis of the outreach effort will be to bring information to where older adults already congregate. Speakers will conduct information sessions at senior centers, group homes, places of worship, and other locations throughout the county. A portion of the funding will be used to provide meals and other incentives for participants to attend the discussions.

Trainings for volunteers and paraprofessionals will emphasize how to recognize signs and symptoms of a mental health issue and how to appropriately refer a senior for a follow-up assessment. Trainings and information sessions will be conducted in multiple languages, including Spanish.

Funding will also be used to help strengthen coordination between the Department of Aging and Community Services and Behavioral Health Services to ensure that both organizations are able to leverage existing resources supporting mental health for older adults.

2. Connections for Homebound Seniors

San Joaquin County's home delivered meals program provides nutritious meals to individuals who are homebound by reason of illness, disability, or who are other wise isolated. Home delivered meal providers have unique access to homebound, isolated seniors who may otherwise not receive services. Program staff and volunteers receive special training in first aid and accident prevention and are given resource numbers for other service requests, but have little formal training in mental health prevention or depression screening. This three-year demonstration project is intended to expand the outreach and training potential of Department of Aging and Community Services to recruit more volunteers, identify more seniors in need of services, and ensure that intake and periodic depression screens are conducted on a regular basis with clients.

This program serves as a vital link in screening a vulnerable group of seniors for depression and suicidal tendencies. Most homebound seniors served by the program are truly isolated; with many living far from friends and relations and having few face to face contacts with anyone. Meal delivery staff and volunteers establish regular, consistent contact with the clients, building trusting relationships and providing important social interaction to alleviate loneliness. Delivery staff and volunteers also provide a keen eye on the home environment to watch for signs of depression by assessing the upkeep of the home, physical and mental state of the client, and determining whether there is adequate food and necessary supplies in the house. In particular having established a relationship, delivery staff and volunteers are able to assess changes in mood and mental health status, and can help assess both passive and active suicidal tendencies[21].

[21] Passive suicidal tendencies are often unnoted and occur when there is an active decision to stop eating or to stop taking important medicines. These passive suicide behaviors can be as successful as the active measures more commonly associated with suicide and are as equally important to prevent.

3. Senior Peer Counseling

> *Senior peer counseling--we have and it is great and we would like to see it expanded. – Key Informant Interview*

Seniors assessed with mild to moderate depression or anxiety will be referred to a network of volunteer Senior Peer Counselors. This program matches specially trained peers with adults, age 55 and older, to provide supportive counseling and help engage individuals in social activities. The existing Senior Peer Counseling Program has been enormously popular and additional funding is required to expand and coordinate this volunteer program.

Expansion of the Senior Peer Counseling program will fund a full-time clinician who can oversee the volunteer peer counselors. This will ensure that peer counselors who have concerns about mental health issues beyond their capacity to resolve will be able to easily ask for an assessment or assistance in transitioning that senior to extended mental health care services. Funding will also support a part-time volunteer coordinator who can help coordinate scheduling and ensure that peer counselors have all appropriate training, including LivingWorks Suicide Prevention Training (described in Project 5), cultural competency trainings and PEARLS Training.

The Program to Encourage Active Rewarding Lives for Seniors (PEARLS) is an intervention for older adults who have mild depression. The PEARLS curriculum is designed for trained social workers, but a modified version of the training can be given to trained mental health volunteers. The training emphasizes the importance of social and physical activities to help combat depression that is a result of loneliness, isolation, or a recent loss.

4. Mental Health at the Family Practice Clinic

San Joaquin General Hospital offers comprehensive outpatient services including Primary Care and Specialty Clinics, and a state-of-the-art Emergency Department. The hospital provides more than 200,000 outpatient visits a year. The outpatient Family Practice Clinic provides children and adult primary health care services

The San Joaquin General Hospital is a public institution serving a patient population which receives little or no other medical care besides that provided by its large emergency drop-in services, its formal clinics and its inpatient facilities. The San Joaquin General Hospital has approved post-graduate training programs (residencies) in Internal Medicine, Surgery and Family Medicine plus a Transitional Internship. The teaching and consulting services are provided by full-time and geographical full-time faculty and by an attending staff recruited from the local community and from nearby medical schools (UC Davis).

This project will expand the capacity of the Family Practice Clinic to conduct mental health screenings, care coordination and early intervention mental health services for adults and older adults. It will help ensure that patients with mental health concerns can continue to receive care within the family practice clinic rather than being referred to the acute care clinic at Behavioral Health Services. It will also ensure that family practice residents have better training on mental health services and appropriate mental health interventions for mild to moderate illnesses.

The first component of the project is funding for a psychiatrist one half day each week (200 hours annually). The psychiatrist will be available primarily to support the Family Practice Clinic physicians in providing appropriate care for their patients. The psychiatrist will aid in prescribing and dispensing psychiatric medication and will conduct informal trainings with the physicians (many of whom are in residency) on treating moderate mental health illnesses in a primary care clinic.

The project will also provide funding for 1.5 FTE mental health clinicians at the Family Practice Clinic. Mental health clinicians will be available onsite during clinic hours for all patients with mild to moderate mental health issues for

whom a referral to extended mental health services is not appropriate or for those who are uncomfortable with seeking services from Behavioral Health. Clinical services are anticipated to be short-term in duration, ranging from 12-16 sessions as necessary.

This project aims to provide a combined therapeutic treatment approach of medication management and counseling, which research shows is a very effective method of addressing mild to moderate mental health issues. It is anticipated that full staffing after project start-up will be two full-time positions, as a portion of the patient visits will be reimbursable through MediCal. Subsequent years of the project will require reassessment to determine how much funding is leveraged through MediCal and other insurance billings and to determine if expansion to a third clinician is feasible.

Addressing Disparities in Access

This project focuses on assessments and early interventions for adults and older adults with mild to moderate mental health issues. It works to fill a gap in service for those individuals and families who are unable to seek private mental health care but who are not able (due to income levels, diagnosis, or concerns about stigma) to seek existing public mental health services. The program specifically targets low-income adults and older adults by expanding the capacity of the County-administered health clinic to provide mental health care services where patients are already comfortable seeking care. It also ensures that high quality care is available at this location by including the services of a licensed psychiatrist. It develops a long term strategy to reduce disparities in access by including physician training as part of the psychiatrist's function to ensure that patients at the Family Practice Clinic receive the best mental health care services available.

Expanding the Senior Peer Counselor program is intended to ensure that homebound and geographically isolated older adults throughout the county also receive appropriate assessment and early intervention services. It is anticipated that through the expansion of this program more volunteers can be recruited to reach deeper into the rural and isolated foothill communities. Expanded training will also enhance the cultural competency of the Senior Peer Counselors. The part-time coordinator will also be responsible for ongoing volunteer recruitment with a key goal of expanding the cultural and language capacity of the volunteers to meet the diverse needs of San Joaquin County.

Expanded education and outreach regarding mental health services is intended to ensure that more seniors throughout the county who need mental health assessments are identified.

Transition to Existing Mental Health Services

A focus on assessments in this project ensures that seniors with mental health issues will be referred to these low-level early interventions or ongoing support services funded through CSS. This project develops multiple early intervention strategies: peer counseling, mental health clinical counselors, and prescription medication and medication management through the primary care centers. These interventions are intended to provide early interventions for mild to moderate mental health concerns such as depression or anxiety. Programs include clinical supervision to ensure that referrals to more intensive mental health service can be made as appropriate if symptoms intensify or are not resolved within an appropriate period of time.

4. Programs

Program Title	Proposed number of individuals or families to be served in first year		Number of months in operation through June 2009
	Prevention	Early Intervention	
Mental Health in Older Adults Education Campaign	120 directly 5,000 indirectly		0
Connections for Homebound Seniors	500		
Senior Peer Counseling		45	Program expansion
Mental Health in Family Practice		280	0
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 620 Families: 5,000	Individuals: 325	

Estimating Numbers Served

Funding is available for at least 6 mental health workshops for older adults. On average it is anticipated that 20 individuals attend each workshop. An additional 5,000 older adults and their families will be indirectly impacted by the outreach efforts.

Approximately 500 San Joaquin County seniors will receive mental health assessments and screenings for suicide prevention through the Connections for Homebound Seniors program.

Approximately 7 new volunteer senior peer counselors will be recruited through this expansion funding. Each peer counselor carries an average case load of 2 clients and turnover to new clients is expected every three to four months (7 senior peer counselors x 2 participants x 3 turnovers = a minimum of 42 and an average of 45 clients annually).

Funding (including, leveraged funding from Medi-Cal) will support the hiring of two mental health clinicians in the Family Practice Clinic. These clinicians will provide short term mental health counseling 12-16 sessions and is estimated that new patients will rotate in approximately every three months. (2 clinicians x average case load of 35 x 4 quarters = 280 patients).

5. Linkages to County Mental Health and Providers of Other Needed Services

This project is intended to strengthen the linkages between primary care and mental health and between senior services and mental health. These tighter bonds are intended to ensure that these providers have a better capacity to refer individuals and family members to other needed services. In preparing the education campaign for older adults, Department of Aging and Community Services staff and volunteers will become more familiar with the mental health resources available in the community for seniors and their families. It is anticipated that once the trainings and outreach campaigns are concluded, this knowledge will continue to ensure that appropriate referrals are made to seniors in need of mental health supports.

6. Collaboration and System Enhancements

This project strengthens and builds upon the local community-based senior programs and primary care systems. All new programs leverage existing programs and provide funding to expand both knowledge and training and also service capacity. The project leverages the existing network of home health care providers, meal delivery staff and volunteers, other senior volunteers, and senior programs to spread mental health informational messages to a broad population of seniors in the County. It utilizes the County clinic system to ensure that mental health services are available for the most indigent members of the County and supports the clinic physicians to provide a higher level of care.

Ongoing sustainability will be achieved through continued PEI funding investments, however it is assumed that knowledge gained from trainings will last beyond the scope of the project. Furthermore, it is anticipated that though PEI, funding will support the core costs related to the placement of mental health clinicians within the Family Practice Clinic. MediCal and other reimbursements will be able to help sustain a portion of the project as well. In the first year administrative fees from PEI are earmarked for clinic operations. In ongoing years it is anticipated that the revenue generated from the 1.5 positions will be enough to sustain an additional .5 position (resulting in 2 FT positions) and any necessary overhead or operating costs associated with administering the program within the clinic.

Project 3: *Connections for Seniors and Adults* in combination with Project 5: *Suicide Prevention and Supports* serves as San Joaquin County's response to the statewide suicide prevention initiative. The program activities listed in this section are intended to complement and support the more direct suicide prevention interventions described in Project 5, with the understanding that early screening, identification, and peer support may be the first preventative measures established to prevent or reverse suicide ideation from progressing to suicide planning or attempted suicides.

7. Intended Outcomes

The principal outcomes for Connections for Seniors and Adults will be to reduce disparities in access to mental health care and the psycho social impact of trauma. The logic model below illustrates the theory of change and the rationale for selecting these projects to meet the intended outcomes.

Focus Area	**Resources**	**Activities**	**Outputs**	**Outcomes**	**Measures**	**Impact**
List the most important things the program will accomplish	*Describe the resources that will support the program activities*	*Describe and define the program activities*	*For each activity identify ways to demonstrate that services have been delivered*	*Identify what changes you expect each activity to effect*	*Specify the ways that these outcomes will be measured*	*Describe the impact that the community will feel in 1-2 years as a result of the program*
Primary Care facilities will provide mental health screening and early intervention Primary Care facilities that provide mental health services will have better capacity to serve culturally and linguistically isolated Early interventions will be provided for seniors with mild depression Homebound seniors at risk for chronic depression and suicide will have trained home visitors assessing their mental well-being	Primary care clinics Physicians Existing mental health personnel Senior Peer Counselors Cultural brokers (new resources) Existing senior programs, clubs, nutrition centers, and food bank Meals on Wheels program and volunteer meal delivery staff.	Primary care clinics provide screenings Primary care physicians will be trained in mental health treatment Clinicians will help resolve mild anxieties Enrichment activities will be provided for seniors Food security will be addressed Nutrition intake and "will to live" will be assessed in the home	Physician/ clinician trainings Counts of PHQ-9 screenings administered, positive results, and follow-up activities by race/ethnicity Case load for clinicians by race/ethnicity Counts of meal delivery visits. Number of homebound seniors screened and reassessed.	Change in clinician knowledge Increased # of screenings Increased utilization of existing senior resources and programs Self reported improvements in quality of life Increase depression or suicide prevention referrals	Monthly clinic reports Quarterly case management reports Quality of Life questionnaire Services for culturally and linguistically isolated Optional sources: Annual report by Dept. of Aging Participant focus group Referral counts	Approximately 20% of County residents will have access to early mental health interventions through their primary care providers Linguistically and culturally isolated adults and seniors who have experienced trauma have appropriate interventions Passive suicides amongst older adults will decline More homebound seniors will have better connections to mental health care

8. Coordination with Other MHSA Components

Physicians, senior services staff and others involved in this project will also be eligible to receive the "Mental Health 101Training for Primary Care Physicians" as specified in the San Joaquin Workforce Education and Training Plan. This project will help set the framework for the project and build early buy-in and support for the expanded programs within their respective agencies. The training will provide an overview of the services and supports available through Behavioral Health Services including the Full Service Community Partnerships and others that are available for adults and older adults who may need more extensive support than what is offered through this PEI project scope.

The trainings provided will focus on developing an understanding in the medical community of:

- The values of wellness, recovery and resiliency;
- The provision of prevention, early intervention, psychiatric and psychological services in a culturally competent, welcoming manner;
- The recognition of signs and symptoms of mental illness, including co-occurring disorders;
- Effective early interventions for first break and the onset of SMI and SED;
- The prescription of medications for routine care and the risks associated with over-prescription by multiple providers, misdiagnosis and other improper treatments;
- When it is necessary/appropriate to refer a patient to BHS and other mental health service providers;
- The rights of patients receiving psychological and psychiatric services;
- The proper use of psychiatric telemedicine;
- Effective communication strategies between BHS and primary care medical providers; and
- The relationship between physical and mental health.

Through cross-training and more effective communication methods it will be possible to provide additional quality routine mental health care in primary care settings and reduce overall psychiatric caseloads.

San Joaquin County WET Plan DRAFT February 2009 for Public Review

Workforce Education and Training funds will also be used to support cultural competency trainings for the Senior Peer Counselors. All BHS staff and volunteers will receive training to meet the federally recommended Culturally and Linguistically Appropriate Service (CLAS) Standards.

9. Additional Comments (optional)

All of the Prevention and Early Intervention projects in this plan are intrinsically linked to each other and are designed to support different components along a spectrum of prevention. In this way San Joaquin County hopes to build momentum for prevention and create a seamless system that supports individuals and their families regardless of where they are at. Each project provides a framework of knowledge, experience, and support that other projects can leverage in their efforts.

San Joaquin County Prevention and Early Intervention Spectrum of Project Activities	
Public Awareness and Education	Reducing Disparities in Access
Prevention	School-based Prevention Efforts
Assessment	Connections for Seniors and Adults
Early Intervention	Empowering Youth and Families
Transition to Treatment	Suicide Prevention and Supports

Project 3: C*onnections for Seniors and Adults* is intended to fill in critical gaps in the current public mental health care system for seniors and adults who are experiencing mental health issues such as depression and anxiety or who are at risk for chronic depression or suicide ideation due to grief, loss of mobility, isolation, or other risk-factor. The project serves to increase awareness amongst seniors on mental health issues and provides a series of assessment checkpoints: (1) one year education campaign to older adults on mental health issues; (2) senior peer counselors to help identify seniors for whom mental health issues are not resolved through activity and engagement; and (3) physicians and counselors to help identify seniors and adults who are not responding to short-term counseling and/or medications and who may benefit for more intensive mental health treatments. This program targets low income seniors and adults who are receiving nutritional supplements or supports through the Human Services Agency- Department of Aging or receiving their primary health care from the Family Practice Clinic at San Joaquin General Hospital. It also strengthens the capacity of existing mental health early interventions available for seniors and adults by leveraging the existing Senior Peer Counseling program and the medical expertise of the Family Practice Clinic.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 3

County: San Joaquin PEI Project Name: 4. Empowering Youth and Families 4/7/2009

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X	X	X	☐
2. Psycho-Social Impact of Trauma	X	X	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	X	X	☐	☐
4. Stigma and Discrimination	☐	☐	☐	☐
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	X	X	☐	☐
4. Children and Youth at Risk for School Failure	X	X	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X	X	☐	☐
6. Underserved Communities	X	X	☐	☐

Project 4: Empowering Youth and Families

Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Consumers, parents, adolescents, probation officers, teachers, and many others discussed extensively how difficult it is for many children and youth to transition to adulthood in San Joaquin County. PEI stakeholders identified a number of interrelated risk factors that are linked to the development of mental health issues in adolescents and young adults. These primary risk factors correlate to those identified in the PEI guidelines:

- School Failure
- Stressful Home and Family Environment
- Violence or Juvenile Justice Involvement

Stakeholders identified underlying and unresolved mental health issues amongst adolescents and young adults as the major precipitating factor in becoming involved in substance use, criminal or violent behaviors. County residents talked about the difficulty many youth experience in their home and family life and talked, too, of the inability of teachers and schools to overcome these obstacles, given the number of students that need help overcoming early and persistent trauma associated with parental substance use, family violence and neglect.

> *Unaddressed trauma issues may lead to anxiety disorders, depression, and post-traumatic stress disorders later in life. Addressing trauma with MHSA funds would alleviate a great deal of community suffering, substance abuse, and the perpetuation of violence. – Community Meeting Participant*
>
> *I wish [my community] had some publicly funded 'Healthy Family' workshops for parenting/recognizing struggles of potential problems. – Community Meeting Participant*
>
> *Identify and provide strong coping skills to prevent crisis, neglect and abuse. – Community Meeting Participant*
>
> *Addresses all the people in the family; develop a holistic approach to serving the needs of an individual. – Community Meeting Participant*

Summary of Findings

The following summary of findings describes some of the current research linking violence, school performance and exposure to family violence or substance use to the healthy development of adolescents and young adults. It also describes some of the local studies and assessments that were reviewed during the initial stages of the PEI planning process. Both local and general scientific research were used to develop the selected PEI strategies.

School Failure: Research suggests that youths who persistently and progressively are held back in school for low academic achievement are at much greater risk of truancy, school drop out and expulsion. These behaviors in turn are associated with later serious violent behavior. Conversely, students who experience high academic

achievement and actively engage in and feel attached to their school are less likely to engage in problem behaviors and delinquency[22]. These students are bolstered by various protective factors such as high expectations for youth by the community, positive bonds with parents and family, effective parenting, opportunities for participation in the school and community, and involvement with positive peers and peer-group activities.[23]

School failure is a major issue in San Joaquin County. San Joaquin County dropout rates are significantly higher than Statewide averages, with a four year derived dropout rate of 34% compared to 21% Statewide. Approximately 10% of high school students dropped out in the 2006-2007 academic year[24]. Dropout rates are highest amongst African American, Native American and Latino youth.

San Joaquin County
Drop Out Rates by Ethnicity
2006-2007

Ethnic Category	Grade 9-12 Enrollment	Adjusted Grade 9-12 Dropout Total	Adjusted Grade 9-12 Four-year Derived Dropout Rate	Adjusted Grade 9-12 One-year Dropout Rate
American Indian/Alaska Native	727	89	45.50%	12.20%
Asian	4,964	402	30.50%	8.10%
Pacific Islander	322	32	37.00%	9.90%
Filipino	2,162	92	17.40%	4.30%
Hispanic or Latino	15,910	1,795	41.60%	11.30%
African American (not Hispanic)	4,540	671	49.50%	14.80%
White	13,068	777	21.90%	5.90%
Multiple/No Response	361	50	46.10%	13.90%
County Total	42,054	3,908	34.00%	9.30%
Statewide	1,997,181	109,011	21.10%	5.5

Source: California Department of Education

Although there are multiple factors associated with school failure, research suggests that health-related issues have significant direct and indirect effects on school dropout rates[25]. Student health problems associated with dropping out are substance use, pregnancy, and psychological, emotional, and behavioral problems. Teenage pregnancy is the leading cause of dropping out of school for adolescent women; an estimated 30%–40% of female teenage dropouts are mothers[26]. Given the mental health associations between substance use and other risky behaviors, it was clear to parents and educator participants in the PEI planning process that programs which support youth through counseling, case management, and positive recreation opportunities were important strategies to preventing school failure.

> *Counseling services have to be on school site. Schools are a natural hub. Makes sense to anchor services. We need a multidisciplinary team approach. – Community meeting participant*

[22] Statements summarize numerous studies (cited below) and also the discussion of a meeting of the San Joaquin Juvenile Justice Roundtable participants who met in July 2008 to discuss the mental health prevention needs of at-risk youth.
[23] http://www.dsgonline.com/mpg2.5/academic_skills_enhancement.htm
[24] www.cde.ca.gov/datquest Dropouts by grade and ethnicity for San Joaquin County 2006-2007. Percentages reflect adjusted dropout rates which reflect re-enrollments and lost to transfer.
[25] Freudenberg, N. "Reframing School Dropout as a Public Health Issue," Prevention of Chronic Diseases 4(4) October 2007.
[26] Ibid.

> *Creating a multidisciplinary team to work with the youth will facilitate communication between agencies. Include a mental health counselor, probation staff, social welfare staff, a public health nurse, and other resources. – Key Informant Interview*

Educators, in particular recommended a multi-pronged strategy of enhancing school and community-based programs and providing supportive programs for parents.

> *We have mandated resiliency programs for substance abuse, we have pro-social skill development, but once you take the kids out of school, the system falls apart, because parents become responsible. – Discussion Group Participant*

> *We have plenty of stuff at the school, but it needs to happen at the home, too. – Discussion Group Participant*

> *We can provide all the prevention activities, but when they leave our schools, the children are on their own. Then they are faced with negative stuff in the home and neighborhood. There needs to be stuff afterschool. – Discussion Group Participant*

Family Environment: There is growing awareness of trauma as a key health issue[27, 28]. Mental health providers, substance abuse treatment providers, policy-makers, and funding agencies recognize that:

- a majority of persons served in public mental health and substance abuse systems have experienced repeated trauma since childhood;
- these clients have been severely affected by this trauma; and
- when trauma is not addressed, there is a greater use of services and cost associated with these clients.

A recent San Joaquin County needs assessment developed in partnership between Children's Services and Probation examined challenges and potential support strategies for families struggling to overcome child abuse and neglect. These studies provide key insights into some of the potential factors that can help mitigate family stress and prevent childhood traumas from occurring. Factors identified as related to stressful family conditions in San Joaquin County include[29]:

- Not enough jobs
- Crime and Violence
- Drugs
- Lack of affordable housing

Service providers and community members had differing opinions on the rank order of the problems families faced[30], but they were in strong agreement on the solutions. With slight variations in order and intensity of need, the following strategies were recommended to prevent child abuse and neglect:

---

[27] www.seekingsafety.org.
[28] www.cachildwelfareclearinghouse.org.
[29] From a survey of community members and family service providers for the San Joaquin County California Child and Family Services Review County System Improvement Plan, March 2008.
[30] Community members identified jobs as the biggest problem (55%) and ranked drugs as the fourth biggest concern (34%). Conversely service providers identified drugs as the largest problem (49%) with jobs as a distant fourth (28%).

- Help for parents experiencing stress
- Classes to help parents solve family problems
- Help for parents to deal with crime and drugs in their neighborhoods

For parents who are experiencing stress or anger, community members and providers recommended developing:

- Parent groups or programs offered close to home (at a school or community center)
- Classes for parents (jobs, parenting, money management)

For parents with children in foster care, recommendations included:

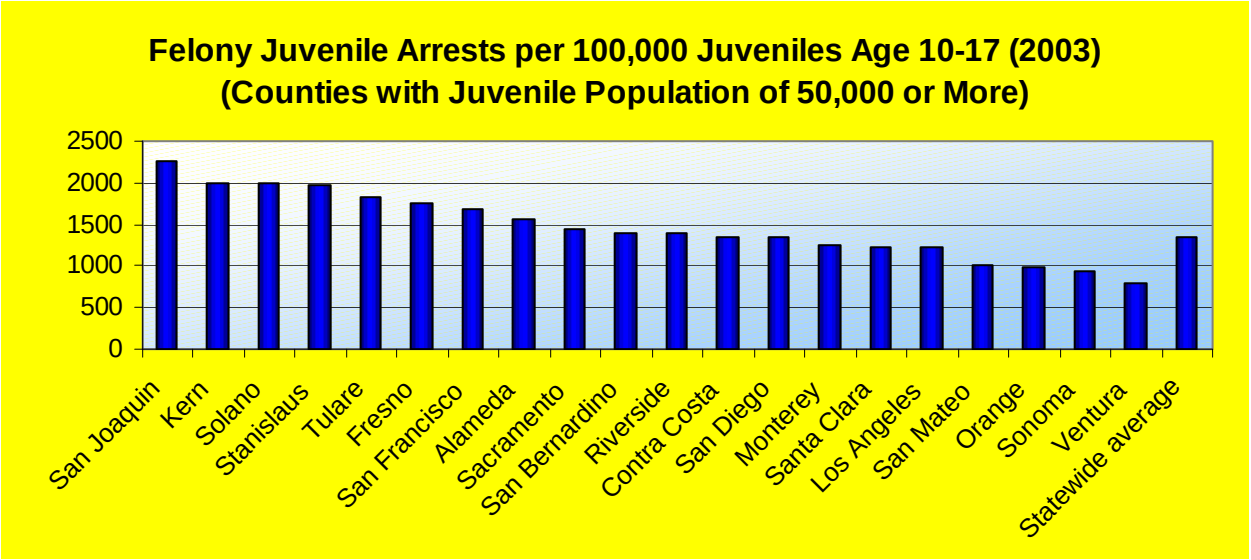
- Treatment programs for abuse, drug addiction, or other problems
- Support to help them follow their case plan
- One-on-one counseling

Impact of Violence: Violence during adolescence can have very serious repercussions. Adolescents who have been violently victimized are more likely to have physical health problems, substance abuse problems, and problems at school[31]. Sexual and physical assault victimization is associated with higher rates of mental health problems during adolescence, including post-traumatic stress disorder[32]. Additionally, adolescents who are the victims of violent crime may be more likely to commit violent criminal offenses in youth or as adults[33]. For example, teenage victims of violent crime are more likely than other teens to be perpetrators or victims of violence as adults and to suffer from post-traumatic stress disorder as adults[34]. Risk factors for youth violence include low socio-economic status, poor parental supervision, harsh and erratic discipline, and delinquent peers. Related issues may include history of or experience with alcohol and drug use, difficulties in school, and mental health problems[35].

San Joaquin County has the highest juvenile arrest rate (for both felonies and misdemeanors) in the State of California for medium to large counties[36] and the rate of violent juvenile crime in San Joaquin County was 81% higher than the state average[37]. Furthermore, County officials estimate that as many as 70% of the youth that cycle in and out of the justice system suffer from mental health disorders, but that only a fraction of those meet the criteria to receive mental health services[38]. The table below illustrates San Joaquin County's juvenile arrest rate compared to other California Counties. With over 2,000 arrests per 100,000 youths, San Joaquin leads the state in juvenile arrest rates.

---

[31] Wordes, M., & Nunez, M. (2002). *Our Vulnerable Teenagers: Their Victimization, Its Consequences, and Directions for Prevention and Intervention*: National Council on Crime and Delinquency: 13. http://www.ncvc.org/ncvc/main.aspx?dbID=DB_Teens453.
[32] National Institute of Justice 2003.
[33] Wordes, M., & Nunez, M. (2002).
[34] www.Childtrendsdatabank.org.
[35] Morbidity and Mortality Weekly Report, August 10, 2007, Vol. 56.
[36] San Joaquin County Probation Department, Mentally Ill Offender Crime Reduction Grant Application, November 2006. Citing Department of Justice Statistics demonstrating San Joaquin County as having the highest juvenile arrest rate in 2003 among comparable counties. Current (2006) arrest rates are higher than those reported in 2003, per current Department of Justice statistics at www.ag.ca.gov.
[37] Community Partnership for Families 2006-2008 Strategic Plan.
[38] San Joaquin County Probation Department, Mentally Ill Offender Crime Reduction Grant Application, November 2006.



Mentally Ill Offenders Crime Reduction Grant Application. Submitted by San Joaquin Probation Department 2006

In an August 2008 discussion group San Joaquin County Probation Officers and staff noted that youth require help managing anger, improving functioning (school and community), and to stop acting out in ways that are detrimental to their health and wellbeing and the safety of the community. In particular, probation officers noted the importance of the Mentally Ill Offender Crime Reduction program for youth on probation and expressed concern that it may be discontinued due to anticipated State Budget revisions.

Participants noted two major barriers to prevention and early intervention efforts for youth in the juvenile justice system and on probation, specifically: transportation and lack of parent support for complying with probation terms.

Participants agreed that parents were often most resistant to youth connecting with mental health services. According to the participants, parents often sabotage the treatment of the youth by not following through with recommendations for treatment, counseling, or prevention. Without the parent's cooperation, youth are severely hamstrung. Probation officers discussed the importance of having additional supports for parents and families in order to be able to make a positive impact on children and youth with juvenile justice involvement.

Another challenge related to accessing services has to do with transportation costs. Many San Joaquin youth come from poor families without cars or money for public transportation. One participant noted that providing transportation vouchers often set youth up for failure as they would eventually claim inability to make appointments due to having "run out of vouchers". Youth seemed to become dependent on vouchers. Probation officers recommended programs be based at schools to eliminate transportation as an excuse for not participating in helpful programs.

Probation officers and staff who participated in the planning efforts recommended three strategies for improving Countywide early mental health interventions for youth with juvenile justice involvement:

- Provide community-based youth outreach, recreation, and early intervention programs, particularly the enhancement of existing programs run separately by the Cities of Stockton and Tracy or other afterschool recreation and mentoring program for high-risk youth;

- Provide short-term mental health counseling and case management support at school for juvenile offenders on probation who do not meet diagnosis criteria; and
- Provide continuation funding for the youth Mentally Ill Offender Crime Reduction Program.

Additional Concerns:

Poverty is also a major risk factor related to mental health issues in adolescents and young adults, with unemployment or unrewarding employment correlated with lower levels of personal satisfaction.

> *Among young adults ages 18 to 24 in 2004, 8 percent of those living below the poverty line reported suffering from two or more symptoms of depression in the past 30 days, compared with 5 percent of those young adults living at or above the poverty line[39].*

Participants in nearly every group identified job skills and employment training as one of the most important strategies to consider for adolescents and young adults ages 16-25, noting that employment is critically linked to youth self-esteem and satisfaction and reduces the time spent in which risky behaviors can be engaged in. The following discussion groups all noted the importance of employment for youth:

- At-risk TAYS and emancipated foster care youth 18-21
- Manteca parents of adolescents
- TAY consumers and case managers
- BHS children's services staff
- Probation staff

Potential Strategies:

A discussion group with children's service providers identified the following strategies as the most critical for high school age youth and youth at risk of juvenile justice involvement. Meeting participants also expressed that some of these programs, particularly ones related to employment and the development of life skills, would be beneficial to transitional age youth as well:

- Job training programs
- Mentoring programs
- Transition programs to help adolescents

Community meeting participants recommended similar strategies identifying the following programs:

- Comprehensive family supports
- Youth empowerment programs
- Life skills classes or support groups

Participants also identified schools or neighborhood or community centers as the best venues to operate programs. There was also strong support for focusing on youth with juvenile justice involvement and/or at risk for school failure.

Participants universally encouraged taking a holistic approach to supporting youth, suggesting that programs need to also be in place for parents, and noting that family stress related to unemployment, substance use, family conflict or other issues may play a large part in the wellbeing of adolescents and young adults. Furthermore, putting community supports in place for parents and families provides a venue for transitional age youth to continue to get

[39] www.Childtrendsdatabank.org.

the supports they need as they age out of the education, probation, and foster care support systems. These programs were particularly noted as useful for transitional age youth looking for employment and for young parents.

3. PEI Project Description:

Planning stakeholders strongly supported mental health prevention and early intervention activities that link to programs which strengthen and empower youth and families. Specifically, they recommended additional job training; parenting classes; recovery groups; other support groups; and life skills classes. Planning participants recommended early intervention activities that target adolescents and adults, with a special emphasis on parents of young children and transitional age youth. Programs described below specifically address the needs of youth at-risk of school failure and/or juvenile justice involvement and adults facing chronic unemployment or under-employment; poverty; witnessing or experiencing violence; or substance use in conjunction with a mild to moderate mental health issue such as depression, anxiety, and anger. Programs 1 and 4 below target youth involved in the juvenile justice system; Program 2 targets a slightly broader age group of high-risk transitional age youth; and Program 3 activities are designed for adults ages 18 and older, including transitional age youth.

Program Summaries

Project 4: *Empowering Youth and Families*

1. Mentally Ill Offender Crime Reduction Grant
2. Mental Health for Youth at Risk of Juvenile Justice Involvement
3. Comprehensive Youth Outreach and Early Intervention Programs
4. Comprehensive Family Support Programs

1. Mentally Ill Offender Crime Reduction (MIOCR) Grant

This program area provides funding for two mental health clinicians in Juvenile Hall to conduct mental health screening and assessments on all juveniles brought into the Hall. These screenings and assessments were identified by local judges and members of the juvenile justice roundtable as critical components of juvenile justice intervention and necessary to identify and provide appropriate early intervention programming to this target population. Furthermore, these screening and assessment activities are critical for successful outcomes in the other high-risk youth related programs that make up Project 4..

> Approximately 70% of the youth that cycle in and out of the state and local juvenile justice systems suffer from mental health disorders "with at least 20% experiencing disorders so severe that their ability to function is significantly impaired[40]." Illnesses that affect these youth include: major depression, bipolar disorder, attention deficit disorder, anxiety disorder, etc. The combination of the exceedingly high juvenile crime rate and corresponding mental health issues pose a serious concern for San Joaquin County. Data from the 2005 calendar year indicates that 2,664 juveniles were booked into San Joaquin County Juvenile

[40] Blueprint for Change – A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System

Hall; of this total, 1,865 would be estimated to be in need of mental health services based on the research cited above. It is critical to note that the current mental health team was only referred 247 juveniles for assessment, after exhibiting symptoms and behaviors of serious emotional disturbance during Fiscal Year 2005/2006. Additionally, only 142 of these met the criteria to receive mental health services; this represents a very small proportion of the juveniles who suffer from some type of mental health diagnosis.

San Joaquin County Probation Department, *Mentally Ill Offender Crime Reduction Grant Application,* November 2006

2. Mental Health for Youth at Risk of Juvenile Justice Involvement

This program is a collaborative effort between Behavioral Health Services, the Probation Department and the Office of Education. It provides funding for mental health clinicians to be placed in high schools to provide counseling and case management for high-risk youth referred by the school, courts, or the probation department. Program participants will be identified based on screening and assessments conducted by education and juvenile justice partners.

Clinicians will work in partnership with school-based probation officers to help support the youth to comply with the terms of the probation and stay enrolled in school. Primary objectives for this project will be to: 1) ensure youth complete the terms of the probation; 2) reduce recidivism amongst participating youth; 3) decrease truancy; and 4) increase school participation and involvement. These objectives are expected to be met through one-on-one case management and counseling. Mental health clinicians are expected to help youth identify their own barriers to school success and develop internal resources and assets to meet personal development plan goals. A long term outcome of this project will be to help give youth the supports and skills that they need to avoid further mental health concerns and to reduce harmful or risky behaviors related to substance use, acceptance of violence, and expectations of failure.

Mental health clinicians are expected to support and collaborate with the probation officers to help ensure compliance with probation terms and to give (non-confidential) updates to the court regarding participants' progress. School-based probation officers will also receive training in mental health issues for adolescents so that they can have a better understanding to the underlying mental health issues that may impact the juveniles on their case load. This training (requested by the Probation Department) will also help ensure that clinicians and probation officers can reach stronger consensus on the areas to emphasize in their respective encounters with youth participants.

Mental health clinicians will also work in partnership with substance recovery programs and will help school administrators and probation officers better understand how to work with adolescents struggling with co-occurring disorders.

Mental health clinicians will be selected based on a broad hiring rubric that takes into consideration recommendations from the Federal Culturally and Linguistically Appropriate Services (CLAS) Standards. Because family support and responsiveness was identified as a large barrier to working with at-risk youth, special consideration will be placed on recruiting mental health clinicians that can demonstrate the cultural competence to work with adolescents and their families from the African-American, Latino, and Native American Cultures, because it is these communities that are experiencing the largest drop out and juvenile justice involvement rates. School sites and the probation department will also collaborate to determine if the needs of other special populations should be considered.

The County Office of Education, in collaboration with the Probation Department and Behavioral Health Services, will take the lead role in this project. The County Office of Education will distribute funding to County ONE schools and continuing education high schools operated by local school districts. School site selections will be determined in

collaboration with the Probation Department and will be based on the number of students with juvenile justice involvement and the need for additional interventions at the school site. Clinicians will also have the support of a Mental Health Clinician III staff person within Behavioral Health Services. Funding will be available for at least five schools, although additional school sites may be added depending on the level of EPSDT billing generated by the school site counselors. Additional funding ($15,000) will be available for each school for equipment and supplies for program administration and start-up costs. (Please see the budget narrative for additional details.)

A potential model for this program is the Youth Justice Institute which provides similar services for girls in coordination with San Francisco and Alameda Probation Departments. Other potential program models are East Bay Agency for Children and East Bay Asian Youth Center, both of which receive funding from the City of Oakland Measure Y Violence Prevention Initiative. It is important to note that all services under this program are voluntary.

3. Comprehensive Youth Outreach and Early Intervention Programs

This program provides funding for two existing programs and makes available funding for a third program to be identified by RFP. The Cities of Stockton and Tracy have both initiated comprehensive programs to reach out to area youth who are on the streets, disengaged from school or community activities, and may be involved with gangs, substance use, or violent or criminal behaviors. This program seeks to expand on and replicate these existing efforts.

Funding will be provided for the following three activities:

- Outreach: Relationship-building
- Engagement: Classes and Recreation
- Mentoring: Case Management and Support Groups

Outreach activities include ongoing efforts to build relationships with youth and to encourage youth to become involved in program activities. Referrals from schools, police, or community members may also help identify youth.

Programs are expected to develop recreation opportunities and classes that will help build interest among youth in participating in program activities that strengthen the relationship between youth participants and program staff. The provision of day-to-day recreation activities is intended to give youth opportunities to engage in positive activities and to spend more time in a supervised environment with a caring adult. Examples of recreation activities and classes include camping trips, digital photography classes, multi-media projects, and other activities designed for youth participants. Funding is available to each program to purchase necessary equipment and supplies to help ensure that classes, recreation activities, and facilities are attractive and engaging to target youth.

Programs will be led by case mangers and other outreach staff that can serve as mentors for youth. A strong emphasis is placed on hiring staff that youth will trust and respect. Cultural competence and life experiences, as well as education, training, and experience, are important qualifications. All programs will include a case management component and will provide gender-specific support groups for youth participants to talk about major issues and to learn new skills and approaches for resolving conflicts and achieving their goals.

Program staff will be aided by mediation training that will help staff learn appropriate communication strategies and approaches for working with youth who have a history of disruptive behavior or anger management issues; who are participating from different neighborhoods or “turf” affiliations; or who have conflicts with each other or with each others’ friends or family members.

Primary objectives for this project will be to: 1) reduce recidivism amongst participating youth; 2) decrease truancy or re-engage youth in school/education opportunities; and 3) increase job readiness skills. These objectives are expected to be met through classes and one-on-one case management. Participants are also expected to learn positive ways to interact with peers, to control anger or disruptive behavior, and to develop positive interests and expectations for the future. The mentoring component is also intended to help youth to develop positive, trusting relationships with a caring adult. A long term outcome of this project will be to help give youth the supports and skills that they need to avoid further mental health concerns and to reduce harmful or risky behaviors related to substance use, acceptance of violence, and expectations of failure.

Potential models for this program include Youth Uprising and Leadership Excellence, both of which receive funding from the City of Oakland Measure Y Violence Prevention Initiative for recreation, case management, and mentoring for high-risk youth. It is also important to note that all services under this program are voluntary.

4. Comprehensive Family Support Programs

For the Comprehensive Family Support Programs, RFPs will be released to non-profits, educational entities, or faith-based institutions to provide adult-oriented case management, groups, classes, and other family supports in Stockton, Tracy, Lodi, Manteca, and other areas of the County. This program provides tangible strategies for high-risk adults to improve functioning and reduce anxiety, anger, and depression. It is anticipated that most referrals for program participation will come from the justice system. Referrals will also come from school districts, primary care physicians, and BHS.

In particular, Comprehensive Family Support Programs responds to the critical need for support services to parents ages 18 and over in order to divert non-felony offenders from jail. This is a key system enhancement designed to prevent inter-generational mental health needs. By providing services and supports *for adults* this program helps prevent the difficulties and trauma parental incarceration brings *children*.

A variety of studies have shown that the challenges faced by young people with incarcerated parents are numerous and formidable, and that these young people are at high risk for delinquent behaviors themselves, including incarceration. According to a 1991 study, the children of offenders are five times more likely than their peers to end up in prison themselves, and one in ten are incarcerated as juveniles[41]. A more recent study shows children with parents in prison are up to six times more likely to become involved in the criminal justice system than children without parents in custody[42]. Another study says that as many as 70 percent of children who have parents in jail might "follow in their parents' footsteps"[43].

Children and youth struggling with parental incarceration describe feelings of anger, alienation, depression, and fear, and are at elevated risk for early pregnancy, poor relationships, gang activity, and crime and delinquency. Keva Miller's study corroborates these personal accounts, saying: "*the short- and long-term effects [of parental incarceration] are difficult to quantify; however, the most commonly cited adverse reactions include internalizing behaviors such as depression and difficulty forming attachments*"[44]. Charlene Wear Simmons' report, "Children of

[41] Johnston, Denise. 1991. *Jailed Mothers*, Pasadena, California, Pacific Oaks Center for Children of Incarcerated Parents, 1991. p. 75; Seymour, C. (1998). "Children with parents in prison: Child welfare policy, program, and practice issues." *Child Welfare*, 77, 469– 493.
[42] Miller, Keva. 2006. "The Impact of Parental Incarceration on Children: An Emerging Need for Effective Interventions." *Child and Adolescent Social Work Journal*, Volume 23, Number 4, August 2006, pp. 472-486(15)
[43] Goode, W. Wilson, Sr. and Thomas Smith. 2006. *Building from the Ground Up: Creating Effective Programs to Mentor Children of Prisoners: The Amachi model*. Philadelphia, PA: Public/Private Ventures.
[44] Miller, Keva. 2006.

Incarcerated Parents," says of children of incarcerated parents that "their lack of visibility in the criminal justice and child welfare systems can inhibit positive intervention and may led to neglect"[45].

Effects of Parental Incarceration on Children at Different Developmental Stages[46]

Developmental Stage	Age	Effect of Parental Incarceration
Infancy	0-2 years	Impaired parent child bonding
Early childhood	2-6 years	Anxiety, developmental regression, acute traumatic stress, survivor guilt
Middle childhood	7-10 years	Acute traumatic stress and reactive behaviors
Early adolescence	11-14 years	Rejection of limits on behavior, trauma-reactive behaviors
Late adolescence	15-18 years	Premature termination of parent child relationship; intergenerational crime and incarceration

This approach recognizes that one way to target mental health prevention for children is to stabilize their families. Programs providing these components have been specifically requested by the presiding judge in San Joaquin County's Family Violence Court.

Programs responding to the RFP are expected to demonstrate their capacity to provide a range of services and supports to respond to the needs within their local communities. Potential services and supports include:

- Case management and family counseling;
- Anger management, support groups, coping skills, budgeting/money management; and
- Alcoholics anonymous, narcotics anonymous, and other 12 step or harm reduction models for substance recovery;
- Parenting classes, child development classes, supports for parents with developmentally challenged children;
- Job readiness, job training, and other employment related classes;
- GED preparation, computer classes, English as a second language, and other educational classes;
- Tai-chi, yoga, twilight basketball, parent/child activities, and other recreation programs; and
- Other services and supports identified by the local community.

Additionally applicants will be encouraged to consider the following, in describing the programs and supports that they can provide to the community:

- Programs that provide case management, alcohol and drug recovery groups, domestic violence counseling, and employment training in accordance to the needs of the mental health court, family violence court and the drug court are strongly encouraged.
- Classes and supports should be developed to be gender, age, and language/culture-appropriate.

[45] Simmons, Charlene Wear. 2000. "Children of Incarcerated Parents". A California Research Bureau Report. (CRB-v7-n2), March 2000.
[46] Johnston, Denise. 1995. "Effects of Parental Incarceration," in *Children of Incarcerated Parents*, edited by Katherine Gabel and Denise Johnston, M.D., Lexington Books, New York.

- Programs are encouraged to develop specific responses to common community stresses for particular cultural groups that are language and gender-specific.
- Programs are encouraged to ensure that at least 30% of the programming targets transitional age youth.
- Program participation records will be expected quarterly and programs are expected to demonstrate community interest and need for funded services and supports with ongoing attendance of 8-12 participants.
- Programs that have more than one community location may submit requests for multiple locations under one application.
- Collaborative proposals or proposals that share resources across community locations are also strongly encouraged to apply.

Awards will be distributed to programs throughout the County, with average awards amounting to $50,000 annually. Up to $200,000 will be available for programs in Stockton; up to $100,000 will be available for programs in each of the three remaining cities (Tracy, Manteca, and Lodi); and $100,000 will be available for programs that provide services in other rural and underserved communities of the County. Program awards are expected to expand existing program capacity to provide support services that reduce harmful behavioral patterns and improve the well-being of youth and families.

Potential models for this program include the Beacon Centers, which receive funding from the San Francisco Department of Children Youth and Families for recreation, case management, and support groups within community centers, schools, and other community hubs. Seeking Safety, an evidence-based approach in comprehensive wrap around supports for women with co-occurring disorders also provides helpful information on the level and intensity of supports recommended. See www.seekingsafety.org for more information. It is also important to note that all services under this program are voluntary.

Addressing Disparities in Access

A major barrier identified by stakeholder participants in providing services to youth was failure to gain family trust and participation. This project addresses this barrier with a clear mandate to hire culturally competent staff and to provide culturally competent programming. Programs are also encouraged to develop gender and age-specific programming, in recognition that, for example, parenting classes for mothers and fathers may require very different approaches.

This project also gives a clear mandate to be responsive to existing community needs. Reflecting higher drop-out rates and juvenile justice incarceration, youth programs are specifically targeted to the African American, Latino, and Native American populations. Recognizing that trends can shift and reported statistics lag behind field experience, this project also specifies a joint review by schools and the probation department to ensure that services continue to target the most critically impacted population groups.

Transition to Existing Mental Health Services

A Mental Health Clinician III, positioned within the Children's Services Division of BHS, will be funded by this project. This clinician will provide consultation and clinical support to the youth-serving clinicians and case managers, also funded through this project, to ensure that as more intensive mental health needs emerge, youth can be appropriately transitioned to ongoing intensive treatment options through BHS.

4. Programs

Program Title	Proposed number of individuals or families to be served in first year		Number of months in operation through June 2009
	Prevention	Early Intervention	
Mentally Ill Offender Crime Reduction		1920 –Youth	Program continuation
Mental Health for Youth at Risk of Juvenile Justice Involvement		420 – Youth	0
Comprehensive Youth Outreach and Early Intervention		675 - TAYS	0
Comprehensive Family Support Programs		475 TAYS 475 families	0
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: 3,490 Families: 475	

Estimating Numbers Served

Estimates of participants served by the programs is based on the following calculations:

Currently the youth MIOCR program completes screenings and assessments on approximately 8 youth per day and 160 youth per month (160 youth screened x 12 months = 1920).

Mental Health for Youth at Risk of Juvenile Justice Involvement will fund clinicians in six schools. Each clinician will carry a case load of 35 students receiving mental health services each semester (6 schools x 35 students x 2 semesters = 420).

Comprehensive Youth Outreach and Early Intervention will fund three programs to hire new recreation and support staff and case mangers. Each staff person will see an average of 75 additional kids (3 programs x 3 staff x 75 participants = 675 youth).

Comprehensive Family Support Programs will fund multiple programs, and an estimated additional 9.5 staff county wide to provide support groups and other activities (9.5 staff x 5 regular groups x 20 participants = 950 adults/TAYS/ families).

5. Linkages to County Mental Health and Providers of Other Needed Services

This project is intended to strengthen the capacity of existing community services, schools, and youth-serving programs to provide early interventions and referrals to additional mental health services.

For example, the Comprehensive Family Support component was strongly championed by primary care physicians who urgently identified the importance of being able to refer patients to support groups, anger management classes, and other activities to help them manage the overwhelming stress in their lives. Community based-agencies also expressed a need for a place to refer clients for non-intensive mental health treatments, such as will be provided by the Family Practice Clinic. This project is intended to forge a tighter connection between community based agencies who will provide these services. and primary care physicians to provide early intervention mental health supports for individuals with mild to moderate mental health issues without requiring the involvement of BHS.

6. Collaboration and System Enhancements

This project builds upon and strengthens the partnership between County schools, Probation, and Mental Health Services. Three of the four programs identified for this project were developed with strong collaborative input from schools, probation and behavioral health. Responding to their mutual interest in serving a population of children and youth identified as being of "mutual concern", helps strengthen the ongoing ability of these three agencies to work together for the well-being of San Joaquin's children and youth.

This project also sustains a critical mental health component of the juvenile justice system of care by providing continuing support for mental health screening and assessment. The loss of this program to the entire juvenile justice system would be incredibly detrimental to the wellbeing and recovery of youth involved in the justice system by limiting the capacity of the courts, public defender, district attorney, and probation officers to make appropriate recommendations regarding the dispensation of the youth. Furthermore, it was necessary to continue the screenings and assessments in order to implement the proposed PEI projects as intended.

7. Intended Outcomes

The principal outcomes for the Empowering Youth and Families will be to reduce the psycho social impact of trauma, and improve the lives of at risk youth and families, with a special focus on youth with juvenile justice involvement and supporting underserved communities. The logic model below illustrates the theory of change and the rationale for selecting these projects to meet the intended outcomes.

Focus Area	**Resources**	**Activities**	**Outputs**	**Outcomes**	**Measures**	**Impact**
List the most important things the program will accomplish	*Describe the resources that will support the program activities*	*Describe and define the program activities*	*For each activity identify ways to demonstrate that services have been delivered*	*Identify what changes you expect each activity to effect*	*Specify the ways that these outcomes will be measured*	*Describe the impact that the community will feel in 1-2 years as a result of the program*
Provide counseling and support to reduce recidivism Create stronger families Support school completion, job training, and the development of critical life skills	Juvenile justice system / courts Linkages with local police and gang prevention programs Community based organizations Mediation Training Office of Education	Family and individual counseling Mentoring Positive peer interactions Coordination between mental health, schools, and probation Life skills and supports Case management Conflict resolution	Quarterly reports Counts of participants intensely served through counseling or case management Counts of participants in classes, support groups and recreation activities Duration of participation	Reduced violence Increase school participation, engagement Employment Reduced Mental Health impact (fear, anxiety, anger, depression)	Reduced recidivism Reduce truancy, suspension, expulsion Improve school participation, grades, standardized tests, completion Employment Participant self reports of mental health and quality of life	Stronger collaborations between the courts, juvenile probation, mental health and schools to provide earlier and more effective interventions for at-risk youth More youth and families will make positive changes in their lives related to managing conflict/anger, overcoming addiction, finding employment, completing school, and developing a sense of meaning and belonging.

8. Coordination with Other MHSA Components

This project has strong ties with Project 2: School-based Prevention Efforts. The Office of Education will oversee both school-based projects and will help ensure continuity between program components. Furthermore, the Mental Health Clinician III supporting school- and community-based clinicians and case managers for this project will also provide supports for the school-based case managers in Project 2. It is hoped that these shared oversight responsibilities will improve coordination and collaboration between school-based and youth-serving program activities.

Programs are expected to look to the WET Coordinator, along with the BHS Ethnic Service Manager, for guidance and direction on the CLAS standards, as they look to develop culturally competent staffs. It is anticipated that as a MHSA team member, the WET coordinator will help ensure that these values and expectations are shared with funded programs as they train staff and develop new program components.

9. Additional Comments (optional)

All of the Prevention and Early Intervention projects in this plan are intrinsically linked to each other and are designed to support different components along a spectrum of prevention. In this way San Joaquin County hopes to build momentum for prevention and create a seamless system that supports individuals and their families regardless of where they are at. Each project provides a framework of knowledge, experience, and support that other projects can leverage in their efforts.

San Joaquin County Prevention and Early Intervention Spectrum of Project Activities	
Public Awareness and Education	Reducing Disparities in Access
Prevention	School-based Prevention Efforts
Assessment	Connections for Seniors and Adults
Early Intervention	Empowering Youth and Families
Transition to Treatment	Suicide Prevention and Supports

Project 4: *Empowering Youth and Adults* recognizes the critical need to establish a holistic response to mental health prevention and early intervention activities by providing services and supports that: 1) recognize and respond to the considerable stressors experienced by individuals and 2) are community based and culturally appropriate. This component of the PEI plan is intended to provide early interventions for youth and adults for whom a purely prevention approach is no longer appropriate and for whom full scale mental health treatments are not clinically necessary. It serves to "fill in the gaps" of the existing mental health service delivery system by providing low level interventions for youth and adults with mild to moderate mental health issues for whom non-clinical interventions, such as case management, support groups, mentoring, or recreation opportunities, will reduce stress, teach skills, and improve self-esteem and wellbeing. It also provides mental health screening and counseling for youth in the juvenile justice system, of which approximately 70% are estimated to have ongoing mental health issues.

Looking Forward

As additional funding is identified in future fiscal years the following programs are identified as "high priority" and eligible for additional funding:

- Mental Health for Youth at Risk of Juvenile Justice Involvement
- Comprehensive Family Support Programs

An additional project desired, but not funded in this 08/09 fiscal year funding request, is to develop or expand a program specially designed for TAYS to provide counseling, case management, AA &r NA groups, recreation, life skills, and enrichment activities for youth at risk of co-occurring disorders ages 16-21. The program will specifically target emancipating foster care youth, teen parents, and other high risk youth identified through the funded PEI programs described above that could benefit from additional supports responsive to co-occurring disorders. Although significant start-up costs are associated with the project, long term sustainability is anticipated through EPSDT funding.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 3

County: San Joaquin **PEI Project Name: 5. Suicide Prevention and Supports** **4/7/2009**

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☐
2. Psycho-Social Impact of Trauma	X	X	X	X
3. At-Risk Children, Youth and Young Adult Populations	☐	☐	☐	☐
4. Stigma and Discrimination	☐	☐	☐	☐
5. Suicide Risk	X	X	X	X

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	X	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☐	☐	☐	☐
4. Children and Youth at Risk for School Failure	☐	☐	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X	X	☐	☐
6. Underserved Communities	☐	☐	☐	☐

Project 5: Suicide Prevention and Supports

Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Strategies aimed at preventing suicide emerged during many of the Community Meetings' public comment and group discussion sessions.

> *PEI for suicide prevention is needed especially considering the psychosocial impact of trauma – Community meeting participant*

After the meetings, the Planning Team conducted additional key informant interviews to learn more about the suicide risk in the County and to develop the Suicide Prevention and Supports project.

Summary of Findings

Suicide is a complex behavior that has been related to multiple risk factors, which vary with age, gender, and race/ethnicity. A majority of persons (90%) who commit suicide often suffered from depression or another diagnosable mental or substance abuse disorder. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses[47]. SAMHSA, the National Institute of Health, and the California Department of Health Services all recognize suicide as preventable.

Suicide rates in San Joaquin County are comparable to California overall. Suicide rates are higher amongst males compared to females and amongst non-Hispanic Whites. Just over 70% of all suicides in California are committed by non-Hispanic Whites. A multi-year study of suicide rates in San Joaquin County found that the number of suicide deaths in the County fluctuated each year, from a low of 45 in 1980 to a high of 71 in 1989. Between 1979 and 1996, the number of suicide deaths were highest amongst young adults, 25-44, although the rate of suicides increased with age. A report by the California Health Services Agency shows that these trends continue to hold true, with 2002-2004 suicide deaths averaging 61.7 per year,[48].

San Joaquin County 1979-1996		
Age Range	% of total suicides	Rate per 100,000
14 and younger	1%	not reliable
15-24	15%	12.185
25-34	23%	17.65
35-44	17%	15.95
45-54	12%	15.92
55-64	11%	18.29
65-74	11%	20.92
75 and older	10%	30.22

Source: www.injuryprevention.org

[47] National Institute of Mental Health, "Suicide in the United States," www.nimh.nih.gov.
[48] State of California, Department of Health Services, "Suicide Deaths California, 2004," Data Summary No. DS06-060003, June 2006.

3. PEI Project Description:

The San Joaquin County's Suicide Prevention project will administer a multi-pronged approach to suicide prevention by providing direct services to at-risk youth experiencing juvenile justice involvement and by improving the capacity of professionals to identify suicide ideation and mitigate actual suicide risk. The final component of this project is peer support for individuals and families to help navigate the service delivery system. The Healthy People 2010 objective for suicide rates is less than 11.4 suicide deaths per 100,000 people. This project aims to help San Joaquin better meet that goal by ensuring that interventions happen earlier and mental health resources are available for individuals in crisis.

This project will fund a mental health clinician to work in the juvenile detention center with youth who may be suicidal. Trainings will be provided to physicians, home health workers, cultural brokers, teachers, family support case managers and others for whom research indicates have the earliest opportunity to identify suicide ideation and observe suicidal behaviors. A peer advocate program will be supported to help individuals in crisis navigate the unfamiliar public mental health system.

Project 5: *Suicide Prevention and Supports* consists of four program components:

1. Mental Health Clinician II in Juvenile Hall
2. PROSPECT Training
3. LivingWorks Suicide Prevention Train the Trainer
4. NAMI Peer Advocates

Program Summaries

1. Mental Health Clinician II in Juvenile Hall

Suicidal behaviors are elevated for youth involved in the juvenile justice system. According to recent research--and corroborated by interviews with San Joaquin County Probation staff--suicide behaviors (including suicide ideation, verbal suicide threats, and suicide attempts) are very common in the detention center.

> *While incapacitation may explain the low rate of completed suicides in secure justice settings, both attempts and ideation are high relative to the general population. [Estimates suggest] that 2–3% of incarcerated youths will attempt suicide every 4 weeks, relative to an estimated yearly rate of 9% in the general adolescent population[49].*
>
> *Pretty much everyday we have a young person who is on a 24-hour suicide watch because of something they have done or said. We put them in isolation and monitor them, but it feels ineffectual. We really need a mental health clinician who can be available for these kids. (Probation staff interview, September 2008).*

[49] Wasserman, G & McReynolds, L: "Suicide Risk at Juvenile Intake" Suicide and Life-Threatening Behavior 36(2) April 2006.

Ongoing funding through PEI will be used to pay for a mental health clinician II position within BHS that is based at the San Joaquin County Juvenile Detention Center. The clinician will work primarily with youth who have a history of prior suicide attempts or who are exhibiting suicidal behaviors.

An estimated 60 youth will be served annually by the clinician.

2. PROSPECT

Suicide in older adults is a serious public health problem[50]. According to SAMHSA:

- Older adults (age 65+) represent 13% of the U.S. population, yet account for nearly one-fifth of U.S. suicides.
- Older adults are less likely to report suicidal ideation compared to younger adults.
- Suicide attempts among older adults are more likely to be deliberate and lethal.
- More than half (58%) of older adults (age 55+) contact their primary care provider 1 month before completing suicide.

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) is a SAMHSA-recognized evidence based practice that has shown to reduce suicides in older adults by working with primary care physicians to help train them on the signs and symptoms of suicide ideation and depression. The intervention components are: 1) recognition of depression and suicide ideation by primary care physicians; 2) application of appropriate treatments and 3) ongoing follow-up with an appropriate clinician (e.g., nurses, social workers, and psychologists).

PROSPECT has been implemented in over 20 primary care practices in the United States. In a randomized, controlled trial comparing the PROSPECT intervention with "treatment as usual," patients with major depression experienced greater decreases in depression with the PROSPECT intervention. Further research using the Scale for Suicidal Ideation (SSI) found that rates of suicidal ideation decreased 12.9% among patients receiving PROSPECT (from 29.4% to 16.5%), compared with a 3.0% decrease (from 20.1% to 17.1%) among patients receiving "treatment as usual"[51].

Implementation of the program relies on educating primary care physicians to recognize symptoms and apply a clinical algorithm based on depression treatment guidelines for older patients from the American Psychiatric Association, the Agency for Healthcare Research and Quality, and the Texas Department of Mental Health. County-employed primary care physicians, clinicians, and home health workers will receive PROSPECT training. Other physicians providing primary patient care to older adults will also be notified of the training series and invited to attend.

Working with Dr. Martha Bruce, the developer of PROSPECT, San Joaquin Health Care Services will train the physicians and nurse practitioners working in the Family Clinic on how to implement PROSPECT in a clinical setting.

It is anticipated that through this enhanced training an estimated 40 additional older adults will be identified, and linked to appropriate services, annually. PEI funding will support the PROSPECT suicide prevention training. Ongoing funding for health care services will continue to account for patient care and treatment expenses.

[50] www.samhsa.gov/OlderAdultsTAC/docs/Suicide_Booklet.pdf

[51] www.nrepp.samhsa.gov SAMHSA's National Registry of Evidence Based Programs and Practices, PROSPECT Review March 2007

3. LivingWorks Suicide Prevention "Train-the-Trainer"

LivingWorks is a comprehensive, coordinated, and integrated approach to suicide prevention. In the Train-the-Trainer workshop, potential trainers learn how to give a two-day Applied Suicide Intervention Skills Training (ASIST). The ASIST workshop prepares teachers, probation staff, and other caregivers to provide suicide "first aid" interventions to help persons with thoughts of suicide in ways that increase their suicide safety. For example, trainees learn to:

- identify people who have thoughts of suicide;
- understand how beliefs and attitudes can affect suicide interventions;
- seek a shared understanding of the reasons for thoughts of suicide and the reasons for living;
- review current risk and develop a plan to increase safety from suicidal behavior for an agreed amount of time; and
- follow up on all safety commitments, accessing further help as needed.

Trainer candidates are taught the basic way of presenting ASIST, which ensures standardization, fidelity and training quality. Once taught the basic tools, trainers are encouraged to customize the training to suite a particular population, culture or organization. In San Joaquin County particular interest has been expressed regarding the needs of Southeast Asians, LGBTQ youth, Native Americans, and incarcerated youth and adults.

The Train-the-Trainer workshop is expected to be provided to individuals in a variety of service sectors throughout the county in order to ensure that a cadre of trainers is developed who will deliver the 2-day suicide prevention trainings to diverse audience types, including educators, corrections officers, health professionals, social workers and others who are likely to be first responders for a suicide threat or attempt. The LivingWorks training has been identified by San Joaquin County Office of Education DATE Coordinators as their first choice in suicide prevention training.

It is also anticipated that once ASIST trainers are developed, professionals working on MHSA-related projects, including the cultural brokers identified in Project 1 and the Family Support Program staff identified in Project 4, will receive the 2-day ASIST training as part of their core start-up training for other PEI project components.

The 2-day ASIST training will given to teachers, school counselors, public safety and corrections officers, cultural brokers, family support case managers, and other professionals. These newly trained suicide prevention leaders will act as service brokers, helping identify and transition individuals to more intensive support services. Approximately 40 individuals are expected to be supported or referred to BHS each year for suicide interventions (based on an average of 60 suicide deaths per year).

4. NAMI Peer Advocates

The local chapter of National Alliance on Mental Illness (NAMI) coordinates grassroots volunteers to offer information and assistance to consumers and family members of consumers. NAMI regularly sponsors talks and other informational events, such as screening the documentary *Out of the Shadow*, offers support groups for family members on how to negotiate the mental health system, and sponsors the Family to Family Series in both English and Spanish.

A major concern expressed by community members and stakeholders during the planning process is how "ordinary" individuals and families who are not connected to community services or public supports can access

support. For individuals and families experiencing a crisis event such as first break or suicide attempt, NAMI offers a friendly, trained cadre of peer advisors to help navigate system supports and services. These peer advocates are critically important during a first break or suicide attempt where frustration with "the system" can lead some individuals or families to give up seeking services, thus precipitating another, more serious crisis.

Prevention and Early Intervention funding will expand NAMI's ability to help encourage individuals and families who are experiencing first break and/or who have expressed suicide ideation/suicidal behaviors to continue to utilize appropriate services, thereby reducing the likelihood of experiencing another crisis. The funding will pay for a part-time volunteer coordinator to organize and expand existing volunteer efforts. Additional one-time funding will also be granted to help expand organizational capacity.

Eligible participants will not be limited to those who have expressed suicidal tendencies, but will be open to all individuals and families experiencing a first-time mental health crisis, recognizing that first break occurrences are traumatic and may themselves precipitate suicidal thoughts.

Addressing Disparities in Access

San Joaquin's Suicide Prevention Project works to aggressively reduce disparities in access to early mental health interventions by ensuring that trained "first responders" are in the community. The training efforts outlined above are intended to work most closely with primary care physicians, teachers, and other community leaders so that those professionals who have the closest relationships with individuals who are depressed or considering suicide have the skills to identify suicide risk and the knowledge of how to appropriately intervene.

Transition to Existing Mental Health Services

The Suicide Prevention Project provides training to professionals about how to respond to suicidal behaviors. All trainings will include information about how to access an immediate mental health intervention through Behavioral Health Services.

4. Programs

Program Title Suicide Prevention	Proposed number of individuals or families to be served in first year		Number of months in operation through June 2009
	Prevention	Early Intervention	
1. Mental Health Clinician II in Juvenile Hall		60	0
2. PROSPECT		40	0
3. LivingWorks Suicide Prevention "Train the Trainer"		40	0
4. Family Linkages Peer Advocates		60	0
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: 200 Families:	

Estimating Numbers Served

Efforts are conservatively estimated to directly impact approximately 200 individuals each year. The broader goal is to create a culture of suicide awareness and understanding amongst professional caregivers to help ensure that even the mildest suicide ideation can be addressed prior to it becoming a major threat to the individual's well-being.

It is also important to note that intervention activities associated with suicide prevention are also intended to reach approximately 620 at-risk older adults through Project 3, described previously.

5. Linkages to County Mental Health and Providers of Other Needed Services

County mental health providers and other health providers shall all be eligible for suicide prevention trainings. It is anticipated that following the LivingWorks train-the-trainer series, newly certified trainers will train others within BHS, the full service partnership's county and contract providers, primary care clinics, school counselors and others. PROSPECT suicide prevention training will specifically ensure that the County's primary care center, serving the most indigent members of the community, can respond more effectively to serious depression and suicide ideation amongst older adults.

6. Collaboration and System Enhancements

This project significantly enhances the entire county's suicide prevention efforts, consisting of focused efforts targeting high risk youth in probation, high risk older adults, and the general population. It creates long-term lasting change by emphasizing training and knowledge gain within existing programs where the suicide ideation is most likely to be observed.

7. Intended Outcomes

The principal outcomes for the Suicide Prevention and Supports will be to reduce suicide risk in children and youth experiencing juvenile justice involvement and others who have been exposed to trauma or are experiencing the onset of serious psychiatric illnesses. The logic model below illustrates the theory of change and the rationale for selecting these projects to meet the intended outcomes.

Focus Area	**Resources**	**Activities**	**Outputs**	**Outcomes**	**Measures**	**Impact**
List the most important things the program will accomplish	*Describe the resources that will support the program activities*	*Describe and define the program activities*	*For each activity identify ways to demonstrate that services have been delivered*	*Identify what changes you expect each activity to effect*	*Specify the ways that these outcomes will be measured*	*Describe the impact that the community will feel in 1-2 years as a result of the program*
Develop suicide prevention program for juvenile hall Provide suicide prevention training to likely first responders and develop a cadre of trained trainers for the county Increase access to and awareness of suicide prevention for older adults Provide caring peer advocates to link individuals and families to extended supports	Juvenile probation Dept of Aging NAMI San Joaquin General Hospital Office of Education	Clinician will be placed in juvenile hall Teachers and other community members will become suicide prevention trainers Clinicians will be trained in suicide risk and prevention for older adults Peer advocates will link families to services	Count of suicide attempts, or expressions of suicide ideation made by individual in juvenile hall Prospect referrals made Number of San Joaquin County suicide prevention trainers	Fewer juveniles placed in solitary isolation without a clinical response	Clinical response time in juvenile hall Suicide rates by age NAMI quarterly reports	Decrease in rates of suicide and suicide attempts Improved linkages of individuals and families in crisis to extended mental health services

8. Coordination with Other MHSA Components

The Suicide Prevention project is strongly linked to the third PEI project described in this plan, *Connections for Adults and Older Adults* (described in pages 47-58). Together these projects comprise San Joaquin County's response to the statewide suicide prevention initiative. In this project the suicide prevention efforts for older adults are complimented with a senior peer counseling program within BHS, and with integrated mental health within primary care settings. Department of Aging and Community Services staff and volunteers will also be provided with training to help ensure their understanding of mental health issues in older adults. Older adults identified with suicide ideation within the primary care settings will have ample resources through this and other PEI-related projects to address their needs both within the primary care offices, at BHS, and through the Department of Aging and Community Services.

9. Additional Comments (optional)

All of the Prevention and Early Intervention projects in this plan are intrinsically linked to each other and are designed to support different components along a spectrum of prevention. In this way San Joaquin County hopes to build momentum for prevention and create a seamless system that supports individuals and their families regardless of where they are at. Each project provides a framework of knowledge, experience, and support that other projects can leverage in their efforts.

San Joaquin County Prevention and Early Intervention Spectrum of Project Activities	
Public Awareness and Education	Reducing Disparities in Access
Prevention	School-based Prevention Efforts
Assessment	Connections for Seniors and Adults
Early Intervention	Empowering Youth and Families
Transition to Treatment	Suicide Prevention and Supports

In this last project, *Suicide Prevention and Supports*, efforts are intended to provide a final series of services and supports to help appropriately transition those who may need extended mental health services to the supports that they require. The success of this advanced suicide prevention training is dependent upon more basic mental health trainings, which are also funded through the PEI component. This project also serves as a final safety net for adults and adolescents for whom previous mental health prevention, assessment, and early intervention activities failed to support.

Looking Forward

As additional funding is identified in future fiscal years the following program is identified as "high priority" and eligible for additional funding:

- NAMI Peer Advocates

PEI REVENUE AND EXPENDITURE BUDGET WORKSHEET (FORM # 4)

This page intentionally left blank.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 4

Form
No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: San Joaquin Date: April, 2009

PEI Project Name: 1. Reducing Disparities in Access

Provider Name (if known): Eligible Full Service Partnership Providers
Behavioral Health Services – WET Coordinator

Intended Provider Category: Various Non-profits and a Workforce Training and Education Project

Proposed Total Number of Individuals to be served:	FY 09-10	784	FY 10-11	n/a
Total Number of Individuals currently being served:	FY 09-10	0	FY 10-11	n/a
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	784	FY 10-11	n/a
Months of Operation:	FY 09-10	12	FY 10-11	n/a

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
b. Benefits and Taxes			
c. Total Personnel Expenditures			
2. Operating Expenditures			
a. Facility Cost			
b. Other Operating Expenses:			
c. Total Operating Expenses			
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Eligible FSP Providers – Cultural Brokers Recruitment and Training		180,000	
WET – Mental Health 101		34,000	
a. Total Subcontracts		$214,000	
4. Total Proposed PEI Project Budget		$214,000	
B. Revenues (list/itemize by fund source)			
1. Total Revenue			
5. Total Funding Requested for PEI Project		$214,000	
6. Total In-Kind Contributions		$20,000	

BUDGET NARRATIVE Form No.4
PROJECT 1: Reducing Disparities in Access

Personnel Expenditures: $0

No personnel costs are anticipated through this project.

Operating Expenses: $0

No Operating costs are budgeted through this project. All BHS operating costs are detailed in Form #5.

Subcontracts: $214,000

1. Eligible CBO Providers – Cultural Brokers Recruitment and Training

Funding will be eligible for existing full service partners who wish to augment and expand current outreach efforts with the addition of cultural brokers for mental health services. Cultural brokers will provide information and education regarding mental health services to culturally and linguistically isolated communities where there is evidence of low mental health service utilization. Each organization should plan to recruit between 4 and 6 cultural brokers with diverse representation of age, gender, and acculturation represented amongst the cultural broker team.

Funding is allocated to recruit and train volunteer cultural brokers and develop culturally specific messages. Funding for this project is intended to sustain the cultural brokers and also to provide funding for ongoing social activities, often deemed the best opportunity to convey health and wellbeing messages to diverse population types. Additional funding may be available in 2009/2010 funding cycle.

- $120,000. The $120,000 allocated for program start-up recruitment and training will be allocated in amounts of approximately $30,000 to up to 4 full service partner organizations to develop cultural broker program and recruit and train volunteer cultural brokers. At least one organization must provide cultural broker for Spanish-speaking residents.
- $60,000. The $60,000 allocated for events and activities will be allocated in amounts of approximately $15,000 to each of the 4 full service partner organizations implementing a cultural broker program. Funding is to be used to convene periodic events and activities for community members throughout the year with the understanding that disseminating mental health messages must be a key theme of the event.

2. WET – Mental Health 101

A Mental Health 101 Training Team, made up of a professional trainer and a Speakers Bureau, will convene approximately 20 half-day trainings annually. The professional trainer will be widely familiar with available supports and services and will have credentials in Crisis Intervention Training (CIT). This is a combined Prevention and Early Intervention (PEI) and Workforce Education and Training (WET) strategy because it addresses the PEI goal of reducing stigma and discrimination and the WET goal of providing training not only to County and contracting CBO staff, but also to community partners, such as criminal justice, law enforcement, medical, social services, education, cultural centers, faith-based organizations and other “first responders”.

- A one-time cost of $20,000 from PEI will fund CIT curriculum, train the trainer and technical assistance.

- Ongoing costs: $19,000 annually. The PEI Component will contribute $14,000 annually. The WET component will contribute $5,000 per year. Annual cost is based on:
    - 20 half-day professional stipends @ $750/day = $15,000
    - 20 trainings @ $50 per training for up to four volunteer speakers = $4000

Revenue: $0

This project is not expected to generate any revenue, although reducing disparities in access may prompt individuals to seek services who would not have otherwise.

In Kind Contributions: $ 20,000

San Joaquin Behavior Health Services is also committing to improving its organization in order to reduce disparities in access. To this end BHS is implementing the federally recommended Culturally and Linguistically Appropriate Service (CLAS) Standards throughout all divisions.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 4

Form
No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: San Joaquin Date: April, 2009

PEI Project Name: 2. School-based Prevention Efforts
Family Resource and Referral Center
Office of Education

Provider Name (if known): Contracted Training Partners

Intended Provider Category: County Agency, Non-profits, and

Proposed Total Number of Individuals to be served:	FY 09-10	3350	FY 10-11	n/a
Total Number of Individuals currently being served:	FY 09-10	2500	FY 10-11	n/a
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	850	FY 10-11	n/a
Months of Operation:	FY 09-10	12	FY 10-11	n/a

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs) Management Analyst 1 (0.40 FTE)			
a. Salaries, Wages		21,420	
b. Benefits and Taxes		10,980	
c. Total Personnel Expenditures		32,400	
2. Operating Expenditures			
a. Facility Cost		600	
c. Other Operating Expenses:		2,000	
c. Total Operating Expenses		2,600	
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Mental Health in Young Children 0-5 Educational Campaign		80,000	
Emergence of Serious Mental Illness in Adolescents Training		40,000	
Co-occurring Disorders Training for School Districts		100,000	
Expanding School-based Prevention Programs		1,110,000	
a. Total Subcontracts		1,330,000	
4. Total Proposed PEI Project Budget		$1,365,000	
B. Revenues (list/itemize by fund source)			
1. Total Revenue			
5. Total Funding Requested for PEI Project		$1,365,000	
6. Total In-Kind Contributions			

BUDGET NARRATIVE Form No.4
PROJECT 2: School-based Prevention Efforts

Personnel Expenditures: $32,400

A portion of a Management Analyst I position will be designated to provide information and technical assistance to agencies contracted for School-based Prevention Project.

This position will be responsible for working with the County Office of Education to oversee the expansion of the school-based prevention efforts and to support the FRRC in developing the Mental Health Education Campaign for Child Care providers. Time allocation is anticipated to be:

.20 Staff liaison with Family Resource and Referral Center
.20 Staff liaison with the Office of Education

Additional support and clinical consultation will be provided to staff funded through the Office of Education grant described below through the Mental Health Clinician III funded through Project 4: Empowering Youth and Families.

Additional contract management and training coordination will be supported by the PEI Coordinator and is described in Form 5.

Operating Expenses: $2,600

$2,600 is allocated to provide facilities, supervision support, materials and information to support the School-based Prevention Project Coordinator.

Subcontracts:

1. Family Resource and Referral Center will receive $80,000 to conduct a mental health education campaign with child care providers. Funding is intended to pay for staff time to attend community mental health trainings, develop training materials for the child care community, schedule and plan trainings to diverse child care communities, convene and present trainings, develop monthly newsletter articles and train other FRRC staff on mental health issues to ensure that there is a continual dialogue with child care providers on mental health issues. Specifically funding will pay for:

- 10 community workshops/ trainings for parents, child care providers and other community groups on Mental Health in young children with:
    - half in languages other than English
    - 4 outside the City of Stockton
- Inclusion of children's mental health as a workshop or track in the Annual Conference
- Monthly children's mental health articles or tips in the FRRC newsletter in English and Spanish
- Educational materials will be distributed at 50 exempt provider orientations
- A staff liaison with the Children's Mental Health Division for the duration of the project

2. Behavioral Health Services will fund the Office of Education to develop and conduct trainings with county educators on the signs and symptoms of serious mental illnesses in adolescents. This contract may be outsourced if it is deemed in the best interest of the project by BHS and the Office of Education.

$40,000 is allocated for the training series. The training is expected to reach middle school and high school teachers and staff in every School District.

3. Behavioral Health Services will fund the Office of Education to develop and conduct trainings with School District Staff and Administration on co-occurring disorders in adolescents. This contract may be outsourced if it is deemed in the best interest of the project by BHS and the Office of Education.

$100,000 is allocated for the training series. Trainings are intended to help school personnel develop disciplinary policies, referral policies, and student and family support practices that support best practices in overcoming co-occurring disorders.

4. The Office of Education will receive $600,000 to make available for the four largest school districts (Stockton, Lodi, Tracy and Manteca) to expand prevention programs for children ages 0-13, that aligns with their safe and drug free schools and communities Local Education Agency (LEA) plan. School districts receiving funding are expected to develop expenditure plans that include prevention activities for preschool, elementary and middle school age children. Additionally, $150,000 is available for one-time program enhancement costs, including material and equipment purchases as deemed appropriate for program success. District indirect costs for organization-wide general management costs (accounting, personnel, purchasing) are limited to five percent of the funding requested. If the district has an indirect cost rate less than five percent, the district must use the lower approved rate. County Office of Education indirect costs may not exceed 2%. $360,000 is established as a demonstration grant for the Office of Education's Early Childhood Education program to support home and child care center visits to work directly with parents and teachers. Additionally, there is up to 10% of the one-time funding for materials, equipment, and student incentives may be used for program start-up costs. Specifically funding will pay for:

- $546,000: 6-8 program staff, with a salary range of $45,000 – $60,000 and benefits estimated at 30%.
- $30,000: Minimal indirect costs for school districts to account for the expansion of the personnel or higher salary / benefit costs; may not exceed 5% or their approved indirect costs rate, whichever is less.
- $12,000: 2% indirect costs rate for the Office of Education.
- $12,000: 2% County Office of Education administrative oversight to serve as a liaison to San Joaquin Behavioral Health.
- $135,000: Materials, equipment, and other recreation supplies as deemed necessary for program expansion and enhancement.
- $15,000: for Office of Education program start-up costs.
- This project is identified as a "high priority project." Additional funds received in future fiscal years may be applied to expand this project.

- $360,000: is included in the form of a one-time award for a three year demonstration grant to support the Office of Education and its partners in conducting home or childcare center visits to work with parents and teachers of children 0-5.

Revenue: $0

No revenue is anticipated from the prevention projects as individual districts will determine staffing needs. Depending on staffing categories (e.g. case managers vs. clinicians) EPSDT billing may not be feasible.

In Kind Contributions: $

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 4

Form
No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: San Joaquin Date: April, 2009

PEI Project Name: 3. Connections for Seniors and Adults

Provider Name (if known): Department of Aging and Community Services , Senior Peer Counseling Program, Family Practice Clinic

Intended Provider Category: County Agencies

Proposed Total Number of Individuals to be served:	FY 09-10	925	FY 10-11	n/a
Total Number of Individuals currently being served:	FY 09-10	600	FY 10-11	n/a
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	325	FY 10-11	n/a
Months of Operation:	FY 09-10	12	FY 10-11	n/a

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel: Mental Health Clinician II (1.0 FTE)			
a. Salaries, Wages		69,660	
b. Benefits and Taxes		32,510	
Personnel: Management Analyst (0.40 FTE)			
a. Salaries, Wages		21,420	
b. Benefits and Taxes		10,980	
c. Total Personnel Expenditures		134,570	
2. Operating Expenditures			
a. Facility Cost		685	
Other Operating Expenses:		3,000	
c. Total Operating Expenses		3,685	
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
PEARLS Training		16,845	
Mental Health in Older Adults Education Campaign		75,000	
Connections for Homebound Seniors		309,500	
Mental Health at the Family Practice Clinic		315,000	
a. Total Subcontracts		716,345	
4. Total Proposed PEI Project Budget		854,600	
B. Revenues (list/itemize by fund source)			
1. Total Revenue		75,000	
5. Total Funding Requested for PEI Project		$779,600	
6. Total In-Kind Contributions		0	

BUDGET NARRATIVE Form No.4
PROJECT 3: Connections for Seniors and Adults

Personnel Expenditures: $134,570

Two positions are funded to expand the Senior Peer Counseling Program: a full time mental health clinician and a part time management analyst to help oversee and administer the program. Stable dedicated staffing will help strengthen the program and ensure objectives are met.

- $102,170 is allocated for one Mental Health Clinician II to oversee and supervise all volunteer peer counselors.
- $32,400 is allocated for a part-time (0.40 FTE) Management Analyst to help coordinate training and scheduling of the Senior Peer Counselors. The Management analyst will also act as a liaison for the Department of Aging and Community Services providing technical support and consultation on the development of training materials for older adults. The Management Analyst will operate under the supervision of the Mental Health Clinician II assigned to the Senior Peer Counseling Program.

Operating Expenses: $3,685

Nominal funding is reserved for the operations of the Senior Peer Counselor Program, including $685 for facility costs and $3,000 for equipment, materials, and supplies to operate the program.

Subcontracts: $406,845

1. Funding is reserved for the Mental Health Clinician, the Management Analyst, the Home Delivered Meals supervisor, and 2 senior peer counselors to attend the PEARLS training in Seattle ($16,845). Funding is allocated for airfare, hotel accommodations, and other costs for the weekend training.
   - Round trip airfare for 5: $1500
   - Hotel accommodations for 2 nights for 5 individuals: $1500
   - Per Diem for meals and expenses at $84.50 per day per person: $845
   - Participation in Training at $2,000 each, $10,000
   - Purchase of materials and supplies for staff distribution, $3,000

2. Department of Aging and Community Services will receive $75,000 to conduct a mental health education campaign with home health workers and other senior serving staff. Funding is intended to pay for staff time to attend community mental health trainings, develop training materials for older adults, schedule and plan trainings to diverse communities, convene and present trainings, develop monthly newsletter articles and train other aging services staff on mental health issues to ensure that there is consistent dialogue with older adults on mental health issues. Specifically funding will pay for:
   - 6 community workshops/ trainings on Mental Health in older adults with:
     - 2 in languages other than English
     - 3 outside the City of Stockton
   - Mental health articles or tips in the monthly newsletter in English and Spanish
   - A staff liaison with the Older Adults Mental Health Division for the duration of the project

A portion of the total amount budgeted for this project ($90,000) will be allocated to the Older Adults Mental Health division for a staff liaison to provide technical support and clinical review of the training materials developed (see above).

3. Department of Aging and Community Services will receive $309,500 to enhance the current home delivered meals program to include a mental health depression and suicide prevention component. Funding is a one-time allocation for a three-year demonstration project and is funded through the Suicide Prevention Statewide Project Initiative. Funding will be used in the following manner:
   - Recruit additional home meal volunteers
   - Provide suicide prevention and depression training to all volunteer drivers

- For developing screening and assessment tools and protocols to be used in the home visiting program
- For at least one staff position to help oversee project, coordinate screenings and assessments, and to conduct secondary, or more intensive screenings when indicated
- For transportation, communication or translation costs, incentives, or other materials and supplies necessary to build the rapport and trust between the meal delivery person and the homebound adult

4. Family Practice Clinic at San Joaquin General Hospital will receive funding for operating and staffing mental health services within the Clinic. Funding is allocated for operations and start-up costs in Year 1, however a portion of the revenue generated from patient billing is expected to support operation costs in subsequent years. Funding is also allocated on an on-going basis for a psychiatrist to consult with physicians and mental health staff on cases that may need additional supports or to be transitioned to a higher level of mental health services.

- Psychiatrist: $30,000 at a rate of $150 per hour to provide 200 hours of time (one half day a week for 50 weeks). The Psychiatrist will help train resident physicians on how to integrate mental health care into a clinical practice and provide consultation and medication supervisions on patient care as necessary.
- Mental Health Clinician II: $225,000 provides funding for 2 FTE mental health clinicians and going administrative costs and o to provide short-term counseling for patients with mild to moderate depression or anxiety who are best treated with one-on-one counseling in the Family Practice Clinic. Based on salary range of $100,000 - $105,000 per clinician including benefits. Up to 50% of the clinicians' time is anticipated to be billable through MediCal, generating revenue to support the actual hiring of 2 full time clinicians (see expected Revenue, below).
- Start-up and operating costs are anticipated in the Year 1 of $60,000 to account for the purchase of the necessary tools and equipment and to account to a potential loss of billing hours due to start-up training and the time necessary to get to full scheduling. In Year 2 and subsequent years, revenue are expected to contribute to operating expenses.

Revenue: $75,000

Mental Health Clinicians working with MediCal or other insured patients will be reimbursed for their clinic visits. Approximately $75,000 in revenue is anticipated through MediCal billings. Revenue will be used to partially offset the cost of one clinician's salary and benefits.

In Kind Contributions: $0

Project success is in part dependent on the cooperation of the physicians in the Family Practice Clinic. It is anticipated that with heightened awareness of mental health issues and more readily available resources for their patients that the Family Practice physicians will contribute time to supporting mental health prevention and early intervention activities.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 4

Form
No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: San Joaquin Date: April, 2009

PEI Project Name: 4. Empowering Youth and Families

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals to be served:	FY 09-10	4165	FY 10-11	n/a
Total Number of Individuals currently being served:	FY 09-10	2200	FY 10-11	n/a
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	3965	FY 10-11	n/a
Months of Operation:	FY 09-10	12	FY 10-11	n/a

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs) Mental Health Clinician III (1.0 FTE) Mental Health Clinician II (2.0 FTE) MIOCRG			
a. Salaries, Wages		218,020	
b. Benefits and Taxes		100,403	
c. Total Personnel Expenditures		318,423	
2. Operating Expenditures			
a. Facility Cost		1,597	
d. Other Operating Expenses:		57,000	
c. Total Operating Expenses		58,597	
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Mental Health for Youth at Risk of Juvenile Justice Involvement		780,000	
Comprehensive Youth Outreach and Early Intervention Programs		773,000	
Comprehensive Family Support Programs		650,000	
a. Total Subcontracts		2,203,000	
4. Total Proposed PEI Project Budget		$2,580,000	
B. Revenues (list/itemize by fund source)			
1. Total Revenue		100,000	
5. Total Funding Requested for PEI Project		$2,480,000	
6. Total In-Kind Contributions		0	

BUDGET NARRATIVE Form No.4
PROJECT 4: Empowering Youth and Families

Personnel Expenditures: $114,063

A full time position for a Mental Health Clinician III ($114,063) is funded to provide ongoing mental health clinical support for the community based programs, probation officers, and school based mental health clinicians implementing this project. The Mental Health Clinician III will also be expected to support school based project staff conducting prevention programs for Project 2: School-based Prevention Efforts. The MHC III will work in close coordination with the PEI coordinator to oversee all project operations and ensure overall objectives are being met.

- $114,063 is allocated for one Mental Health Clinician III to oversee and all project activities and to provide clinical supervision and consultation as necessary for project staff. (Salary = $78,700) + (Benefits = $35,363)

The Mentally Ill Offender Crime Reduction grant for juveniles in San Joaquin County was cut from the 2008-2009 State budget. Funding will be allocated to partially offset this funding loss, per legislative notice that MHSA funding could be used to supplant mental health MIOCRG components that had lost funding. This funding provides for the mental health screening and assessment component of the grant which is integral to ongoing and proposed PEI related activities.

- $204,340 is allocated annually to support two (2) Mental Health Clinician II positions to continue to screen and assess all juveniles booked in Juvenile Hall. (Salary = $69,660) + (Benefits = 32,520) x (2 positions) = $204,340

Operating Expenses: $58,597

Ongoing and one-time operating costs related the Empowering Youth and Families project include:

- Nominal funding is reserved for operations, including $1,597 for facility costs and $2,000 for equipment, materials, and supplies to operate the program.
- $25,000 One-time purchases related to travel or vehicle purchases are included under this expense category; however funding is available for only one year to purchase necessary equipment and supplies, not to fund ongoing operations.

Ongoing and one-time operating costs related to the Mentally Ill Offender Crime Reduction program include:

- $5,000 is allocated for ongoing indirect costs, office space and communication (cell phones) of program staff annually. Two phones @ $35/month x 12 months = $840. Two office space at $50/month x 12 months = $1200. Indirect costs at 1.5% = $3,000.
- $25,000 is allocated for computers, supplies, and other expenses. Travel costs or vehicle purchases are included under this expense category; however funding is available for only one year to purchase necessary equipment and supplies, not to fund ongoing operations.

Subcontracts: $2,203,000

1. San Joaquin Office of Education will receive funding to distribute to continuing education high schools and County ONE schools to provide mental health counselors within the schools to provide mental health counseling, group sessions, and case management for youth experiencing or at-risk of juvenile justice involvement. Additional funding is provided to provide mental health training for the probation officers working in the school to improve communication and coordination with mental health counselors. Funding is also provided for computers, equipment, and recreation supplies to encourage program participation.

- $10,000 is allocated for a mental health continuing education conference for School-based Probation Officers. Costs include conference registration, travel, and other expenses.

- $75,000 is allocated for computers, supplies, recreation equipment, and other expenses required to support project start-up. Travel costs or vehicle purchases are included under this expense category; however funding is available for only one year to purchase necessary equipment and supplies, not to fund ongoing operations.
- $50,000 is allocated to provide required 1-to-1 match funding for a selected County ONE school to receive a grant from the Kaiser Foundation to provide a mental health counselor in the school.
- $611,000 is provided to fund 5 - 6 Mental Health Clinician II positions for five schools in San Joaquin County. Mental Health Clinicians will be placed in County ONE schools or continuing education high schools. At least two of the schools funded for placement of the Mental Health Clinician II positions will be continuing education high schools operated by local school districts. Determinations of which schools to provide a mental health counselor at will be made in collaboration with the probation department and will be based on number of juveniles on probation and the need for additional counseling support at the school. A portion of this funding ($100,000) is anticipated to be earned through EPSDT billings (see revenues below).
- $34,000 is allocated for project overhead and supervision (approximately 5% of the total budget). Overhead costs are expected to be used to support Mental Health clinical staff and to include all necessary training, supervision, and regularly scheduled counseling team meetings.
- No indirect costs are allowed on this grant.
- This project is identified as a "high priority project." Additional funds received in future fiscal years may be applied to expand this project.

2. Three Comprehensive Youth Outreach and Early Intervention Programs will be funded to provide case management and counseling support for youth ages 16-24 experiencing or at-risk of homelessness, witnessing or experiencing violence, unplanned parenting, substance use, or gang involvement. Additional funding will be provided for mediation training to provide staff training on working with youth across neighborhood boundaries (turf) or gang affiliations. Funding is provided for one time program start-up costs including computers, recreation equipment (including multi-media equipment, sports equipment, digital arts equipment, etc), vehicles, or other one time purchases to support program start-up.

- $40,000 is provided to conduct mediation workshops on communication, and mediation, and other skills necessary for working with this high-risk population.
- $133,000 is allocated for start-up costs and to purchase recreation equipment for the three comprehensive outreach programs. Each program will be asked to submit a budget of $40,000 for start-up costs and purchases. The remaining $13,000 will be held in reserve for additional costs and expenses as programs are refined.
- $200,000 is allocated for the City of Tracy, Mayor's Community Youth Support Network to conduct community outreach and case management with high-risk youth. This funding matches $200,000 committed by the City of Tracy to support non-profits working in Tracy.
- $200,000 is allocated for the City of Stockton, Operation Peacekeeper Program to conduct community outreach and case management with high risk youth.
- $200,000 will be released through a competitive RFP process to a local community-based non-profit, educational entity, or faith-based institution to provide community outreach and case management.
- All overhead and indirect costs must be included in the grant allocations awarded. Overhead and indirect costs combined should not exceed 7% of the total award amount.

3. For the Comprehensive Family Support Programs, RFPs will be released to non-profits, educational entities, or faith-based institutions to provide case management, groups and classes (employment training, parenting classes, anger management, narcotics anonymous), and other family supports in Stockton, Tracy, Lodi, and Manteca to adults age 18 and older.

- $300,000 will be available for programs in Tracy, Lodi and Manteca.
- $200,000 will be available for programs in Stockton
- $100,000 will be available for programs in other San Joaquin County communities
- $50,000 is allocated for start-up costs and to purchase program equipment (e.g. computers, digital media equipment, or other materials for job training programs). Each program will be asked to submit a budget, not to exceed 8% of their funding award for their start-up costs and purchases.
- All overhead and indirect costs must be included in the grant allocations awarded. Overhead and indirect costs combined should not exceed 7% of the total award amount.
- Residential living programs and urine drug testing are not permitted program costs.
- This project is identified as a "high priority project." Additional funds received in future fiscal years may be applied to expand this project.

Revenue: $100,000

Where applicable, mental health counselors will bill for one-on-one counseling sessions provided to youth in schools. Estimated reimbursements through EPSDT are expected to reach at least $100,000 between the five clinicians. After Year 1 the revenue stream from the clinicians will be reviewed to determine if the project can support an additional Mental Health Clinician II to be placed at a sixth school. If funding is available for a sixth school, funding will be provided to a continuing education high school operated by a local school district.

In Kind Contributions: $0

Prevention and Early Intervention funding provides $250,000 in one-to-one match funding, leveraging greater resources for San Joaquin County. (Please see the match descriptions in the budget details above.)

Additional Comments:

An additional project desired, but not funded in this 08/09 fiscal year funding request, is the development of a program specially designed for TAYS to provide counseling, case management, AA &r NA groups, recreation, life skills, and enrichment activities for youth at risk of co-occurring disorders ages 16-21. The program will specifically target emancipating foster care youth, teen parents, and other high risk youth identified through the funded PEI programs described above that could benefit from additional supports responsive to co-occurring disorders. Although significant start-up costs are associated with the project, long term sustainability is anticipated through EPSDT funding.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 4

Form
No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: San Joaquin Date: April, 2009

PEI Project Name: 5. Suicide Prevention and Supports

Provider Name (if known): Probation department and two suicide prevention trainers

Intended Provider Category: County Agency, Research and Training Organizations

Proposed Total Number of Individuals to be served:	FY 09-10	200	FY 10-11	n/a
Total Number of Individuals currently being served:	FY 09-10	0	FY 10-11	n/a
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	200	FY 10-11	n/a
Months of Operation:	FY 09-10	12	FY 10-11	n/a

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
Probation – Suicide Prevention Counselor in Juvenile Hall			
a. Salaries, Wages		$69,659	
b. Benefits and Taxes		$32,510	
c. Total Personnel Expenditures		$102,169	
2. Operating Expenditures			
a. Facility Cost			
e. Other Operating Expenses:		$231	
c. Total Operating Expenses			
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Prospect – Suicide Prevention in Older Adults		$20,000	
LivingWorks Suicide Prevention, Train the Trainer Series		$35,000	
NAMI –Peer Advocates		$61,000	
a. Total Subcontracts		$116,000	
4. Total Proposed PEI Project Budget		$218,400	
B. Revenues (list/itemize by fund source)			
1. Total Revenue			
5. Total Funding Requested for PEI Project		$218,400	
6. Total In-Kind Contributions		$0	

BUDGET NARRATIVE Form No.4
PROJECT 5: Suicide Prevention and Supports

Personnel Expenditures: $102,169

1. Probation – Suicide Prevention Counselor in Juvenile Hall

Funding is allocated to place one mental health worker (position level Mental Health Clinician II) in juvenile hall to work with youth who have a history of suicide attempts, express suicidal ideation, or display suicidal behaviors.

$69,659 is budgeted for salary of position
$32,510 is budgeted for benefits

Operating Expenses: $231

A nominal sum, $231, is allocated for new office supplies for the position.

Subcontracts: $116,000

2. Prospect Suicide Prevention Training

$20,000 is allocated for county primary care clinical staff, physicians, and home health workers to receive training in recognizing the signs and symptoms of suicide ideation and depression. Cost may be offset by combining training opportunities with neighboring County.

3. LivingWorks Suicide Prevention, Train the Trainer Series

$33,000 is allocated for the cost of the 5-day training. Funding pays for the trainer, related travel costs, and all training materials. Costs require training space being made available through an in-kind donation by the San Joaquin County Office of Education for the 5-day training session. A nominal portion of the budget, $2,000 is anticipated to be spent on food and beverages for the training. Training costs can also be offset by allowing other counties to send staff to the training. A portion of their attendance fees will be reimbursed back to San Joaquin County per LivingWorks training policy to help offset the total cost of the training event.

4. NAMI – Peer Advocates

Funding will be provided to the San Joaquin NAMI chapter to recruit, train, and supervise volunteer peer advocates. The volunteer peer advocates are intended to provide peer support, information about mental health services, and assistance navigating mental health services to individuals and families who are recently learning of a diagnosis of a serious mental health illness.

- Start-up costs are estimated at $37,000 to recruit and train volunteer peer advocates. Additional funding may also be spent on equipment upgrades and other needed supplies to support the peer advocate team.
- Ongoing costs: $24,000 annually. Funding is anticipated to cover the costs of a part time volunteer coordinator. Based on an anticipated annual salary range of $40,000 - $48,000 with benefits.

Revenue: $0

This project will not generate any revenue as youth receiving mental health services are in custodial care of the County.

In Kind Contributions: $0

The Juvenile probation department will contribute office space and other necessary facilities for the Mental Health Clinician.

The Office of Education has agreed to allow the LivingWorks Train the Trainer series be held within the Office of Education workshop rooms at no additional cost to the County.

PEI ADMINISTRATION BUDGET WORKSHEET (FORM # 5)

This page intentionally left blank.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 5

Form No.5

County: San Joaquin Date: April, 2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator Management Analyst III (1.0)				$91,115	
b. PEI Support Management Analyst I (0.5)				$26,770	
c. PEI Evaluation Support Management Analyst I (0.5)				$26,770	
d. Employee Benefits					
PEI Coordinator (1.0)				$30,978	
PEI Support Staff (0.5)				$13,720	
PEI Evaluation and Fidelity Support (0.5)				$13,720	
e. Total Personnel Expenditures				**$203,073**	
2. Operating Expenditures					
a. Facility Costs					
b. Other Operating Expenditures				239,140	
c. Total Operating Expenditures				**239,140**	
3.County Allocated Administration					
a. County Administration				470,387	
b. PEI Evaluation				95,000	
c. PEI Planning Estimate				275,000	
d. Total County Administration Costs				**840,387**	
4. Total PEI Funding Request for County Administration Budget				**1,282,600**	
B. Revenue					
1. Total Revenue			$0	$0	$0
C. Total Funding Requirements			$0	**1,282,600**	$0
D. Total In-Kind Contributions			$0	$0	$0

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 5

BUDGET NARRATIVE Form No.5

- Funding will be used to support two administrative positions:
  - $122,093 is allocated for a management analyst III to serve as the PEI coordinator.
  - $80,980 is allocated for a management analyst I to support the PEI coordinator and to provide contract monitoring and fidelity oversight with the funded programs

Funding is also allocated to operations and administrative costs. Operations costs includes all office supplies, printing and reproduction services, internal and external communication costs including cell phones, and the use of County motor pool vehicles. Administrative costs include PEI Planning and Evaluation. Additionally County Administration costs include all overhead associated with overseeing the PEI projects included share of the County data processing center and IT division, A-87 costs, facilities management, purchasing, legal, human resources, etc.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY (FORM # 6)

This page intentionally left blank.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 6

Funding sources for the San Joaquin County's PEI Budget

- 07/08 allocation: $1,865,100 per DMH info notice 07-17, Aug. 10, 2007
- 08/09 allocation: $3,135,500 per DMH info notice 07-17, Aug. 10, 2007
- 08/09 Statewide Project Allocation: $669,500 per DMH info notice 08-25, 9/11/08
- 08/09 Supplemental: $669,500 per DMH info notice 08-27, 9/24/08
- Total Funding request for 08/09: $6,339,600

- 09/10 Statewide Project Allocation: $669,500 per DMH notice 08-25, 9/11/08
- 09/10 Fiscal Year Planning Estimate: $4,431,500 per DMH notice 08-36, 12/11/08
- 09/10 Supplement: $1,012,500 per DMH notice 08-36, 12/11/08
- Total Funding request for 09/10: $6,113,500

- 08/09 & 09/10 Prevention and Early Intervention Statewide Project for Training, Technical Assistance and Capacity Building: $202,800 per DMH notice 08-25, 9/11/08

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 6

Form No. 6

Instruction: Please provide a listing of all PEI projects submitted for which PEI funding is being requested. This form provides a PEI project number and name that will be used consistently on all related PEI project documents. It identifies the funding being requested for each PEI project from Form No. 4 for each PEI project by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5 (line C).

County:	San Joaquin
Date:	April, 2009

		Fiscal Year			Funds Requested by Age Group			
#	List each PEI Project	FY 07/08	FY 08/09	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Reducing Disparities in Access (3%)	$200,000	$14,000	$214,000	0	0	$214,000	0
2	School-based Prevention Efforts (22%)	$370,000	$995,000	$1,365,000	$1,365,000	0	0	0
3	Connections for Seniors and Adults (12%)	$151,845	$627,755	$779,600	0	0	$240,000	$539,600
4	Empowering Youth and Families (39%)	$358,000	$2,122,000	$2,480,000	$650,000	$1,505,000	$325,000	0
5	Suicide Prevention and Supports (3%)	$92,000	$126,400	$218,400	102,400	$16,000	80,000	$20,000
	Administration (20%)	$693,255	$589,345	$1,282,600	n/a	n/a	n/a	n/a
	Total PEI Funds Requested:	$1,865,100	$4,474,500	$6,339,600	$2,117,400 (33%)	$1,521,000 (24%)	$859,000 (14%)	$559,600 (9%)

*A minimum of 51 percent of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 ("small counties" excluded).

**In San Joaquin County, 57% of the budget is allocated to children and youth 0-25.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 6

Addendum to Form 6 Project	Program	FY 08/09 PEI Request 07/08 funding	 08/09 funding
1. Reducing Disparities in Access: $214,000 (3%)			
	Cultural Brokers Recruitment and Training	$180,000	
	Implementation of CLAS Standards	in-kind	
	Mental Health 101	20,000	$14,000
2. School-based Prevention Efforts: $1,365,000 (22%)			
	Mental Health in Young Children 0-5 Educational Campaign	$80,000	
	Emergence of Serious Mental Illness in Adolescents Training	$40,000	
	Co-occurring Disorders Training for School Districts	$100,000	
	Expanding School-based Prevention Programs	150,000	$600,000
	& w/ Early Childhood Education		$360,000
	School Based Prevention BHS Management Analyst 1 (PT)		35,000
3. Connections for Seniors and Adults: $779,600 (12%)			
	Senior Peer Counseling		$138,255
	& w/ PEARLS training for Senior Peer Counselors	$16,845	
	Signs and Symptoms of older adult depression - 1 year education campaign to Area Agency on Aging	$75,000	
	Connections for Homebound Seniors		309,500
	Mental Health in Primary Care Settings*	$60,000	$180,000
4. Empowering Youth and Families: $2,480,000 (39%)			
	Mental Health Clinician III for project clinical supervision (FT)		$117,000
	Mental Health for Youth at Risk of Juvenile Justice**	$75,000	$595,000
	& w/ Mental Health Continuing Education for School POs	$10,000	
	Comprehensive Youth Outreach and Early Intervention	$133,000	$600,000
	& w/ Mediation Training	$40,000	
	Comprehensive Family Support Programs	$50,000	$600,000
	Mentally Ill Offender Crime Reduction Grant	$50,000	$210,000
5. Suicide Prevention and Supports: $218,400 (3%)			
	Suicide Prevention in Juvenile Hall		$102,400
	Suicide Prevention Train the Trainers	$35,000	
	PROSPECT - Suicide Prevention for older adults	$20,000	
	NAMI - Peer Advocates	$37,000	$24,000
Administration: $1,282,600 (20%)			
	PEI Coordinator		$122,386
	PEI Administration @ 11%	$323,255	$385,979
Required PEI Administrative Expenses			
	PEI Planning	$275,000	
	PEI Evaluation and Fidelity support	$95,000	$80,980
Total: $6,339,600 (100%)		$1,865,100	$4,474,500

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 6

Use of 08/09 Statewide Project Allocation

Statewide Project Allocation: $669,500 for projects addressing Stigma and Discrimination, Suicide Prevention and the Student Mental Health Initiative.

San Joaquin County PEI projects that align with these statewide objectives:

- Reducing Disparities in Access: $214,000
- Connections for Seniors and Adults
    - Senior Peer Counseling: $138,255
    - Pearls Senior Depression Training: $16,845
    - Connections for Homebound Seniors: $309,500
- Suicide Prevention and Supports: $218,400

Total San Joaquin County funding intended to align to statewide project objectives: $897,000.
Total additional PEI funding contributed to statewide project objectives: $227,500

San Joaquin County is also pleased to leverage the program support of the Department of Aging, Juvenile Probation, the Office of Education, San Joaquin General Hospital, and the wealth of community partners and mental health serving organizations to aid in our efforts to promote the statewide initiatives.

LOCAL EVALUATION OF A PEI PROJECT (FORM # 7)

This page intentionally left blank.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Form No. 7

County: San Joaquin Date: April, 2009

☐ Check this box if this is a "very small county" (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name:

1. a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.

Empowering Youth and Families

b. Explain how this PEI project and its programs were selected for local evaluation.

This PEI project was selected for the following reasons:

1. This project accounts for 39% of the PEI funding allocation and represents the largest funded project.
2. The project focuses on children and youth.
3. This project provides direct services to older teens and legal adults making it more appropriate to implement the DRAFT client satisfaction tools and other evaluation tools identified, compared to the younger children served in the next highest funded program (School-based Prevention Efforts).
4. The different programs to be evaluated will all use similar methods to achieve their individual program goals (i.e. a combination of case management, counseling, enrichment and recreation).

2. What are the expected person/family-level and program/system-level outcomes for each program?

The *Empowering Youth and Families* Project has been designed to develop a comprehensive system of mental health interventions, case management, enrichment, and recreation activities to improve the well-being of some of the most vulnerable, at-risk children and youth. The target population identifies youth, TAYS and parents, recognizing that providing supports for high-risk parents may help prevent issues developing in their children. The proposed target population for this project is as follows:

Target Population:

- High-school age youth (eligible ages, 13-22) experiencing juvenile justice involvement &/or school failure.
- Transitional age youth (eligible ages 13- 25) parenting, involved with drugs, &/or at risk of juvenile/justice involvement and not eligible for services through a participating high school.
- TAYS, parenting TAYS, and other parents who are themselves experiencing or at-risk of CWS or justice involvement.
- All youth admitted to juvenile hall.
- All youth and TAYS with current or prior CWS involvement.

The three primary goals address the interventions intended for the target population.

Goal 1: Improve access to short-term mental health counseling and other early intervention supports for children and youth with juvenile justice involvement.

Activity 1.1: Conduct mental health screening and assessment in juvenile hall. Participant Outcome: At-risk youth are screened for mental health issues.

Activity 1.2: Refer children and youth with serious mental health issues to BHS for intensive psychiatric evaluation and treatment supports Participant Outcome: Youth with Serious Mental Illnesses (SMI) or Serious Emotional Disturbances (SED) are referred to extended treatments and supports.

Activity 1.3: Develop collaborative taskforce between probation, office of education and BHS to identify the 5-6 high schools which enroll the most seriously at-risk youth. System Outcome: Strengthened systems collaboration.

Activity 1.4: Hire mental health clinicians to work in selected County ONE and continuation schools. Program Outcome: Mental health staff available at schools for high-risk youth.

Activity 1:5: Provide school-based counseling (12-16 sessions), case management, and other supports to ensure success in school and with terms of probation. (Participant level indicators of success include reduce recidivism, increased school involvement, increased participation in positive activities, and increased sense of personal well-being.) Participant Outcomes: Protective factors for youth well-being and success are developed; and risk factors for SMI and SED are reduced.

Activity 1.6: Establish coordinated case management and communication protocols between probation, school staff, and mental health clinicians in participating high schools. System Outcome: Better protocols and tools to support coordinated case management activities.

Goal 2: Improve access to comprehensive case management and other early intervention supports for high-risk youth and TAYS.

Activity 2.1: Provide mediation and conflict resolution training and mental health 101 to existing youth outreach workers in Stockton and Tracy. Program Outcome: More highly trained staff and staff are more competent to work with youth who may have SED.

Activity 2.2: Hire a mental health clinician III to work with youth outreach programs to ensure youth outreach staff understand next steps when they identify a youth with mental health issues. System Outcome: School site counselors, probation officers, and community program staff working with high risk youth have better linkages with BHS.

Activity 2.3: Refer Youth and TAYS with serious mental health issues to BHS for intensive psychiatric evaluation and treatment supports. Participant Outcome: Youth with Serious Mental Illnesses (SMI) or Serious Emotional Disturbances (SED) are referred to extended treatments and supports.

Activity 2.4: Provide case management, life skills (e.g. anger management), recreation, and other supports to promote resiliency and empower youth to achieve successful outcomes. (Participant level indicators of success include reduce recidivism, increased school /employment, increased participation in positive activities, and increased sense of personal well-being.) Participant Outcomes: Protective factors for youth well-being and success are developed; and risk factors for SMI and SED are reduced.

Activity 2.5: Establish protocols for coordinating referrals between outreach and engagement programs and other services and supports available in the community (e.g. job training, substance use treatment

programs). System Outcome: Better protocols and tools to support coordinated case management activities.

Goal 3: Improve access to comprehensive community-based supports for TAYS, TAY parents, and other high-risk parents (e.g. with experiences of family violence, substance use, etc).

Activity 3:1: Develop appropriate memorandums of understanding between participating PEI funded community based agencies and with other county agencies (e.g. court system, child welfare) regarding client referrals, coordinating case management, and communication protocols. System Outcome: Strengthened systems collaboration.

Activity 3.2: Develop a rich network of comprehensive services and supports available in the community that includes parenting classes, AA/NA or other recovery support groups, anger management or conflict resolution workshops, employment training and job development, and other enrichment and recreation programs. (Participant level indicators of success include participation in positive activities, and increased sense of personal well-being.) Participant Outcomes: Protective factors for well-being and success are developed; and risk factors for SMI and SED are reduced for TAYS, parents, and their children.

Activity 3.3: Hire case managers to work within community based organizations to provide guidance, support, and referrals for TAYS and adults transforming their lives. (Participant level indicators of success include successful compliance with Court/CWS requirements.) Participant Outcomes: Successful completion of diversion, differential response, reunification requirements for high-risk parents.

Activity 3.4: Refer TAYS and adults with serious mental health issues to BHS for intensive psychiatric evaluation and treatment supports. Participant Outcome: TAYS and adults with Serious Mental Illnesses (SMI) or Serious Emotional Disturbances (SED) are referred to extended treatments and supports.

Activity 3.5: Establish coordinated case management protocols between CWS case managers and community based agencies and communication protocols with CWS and justice agencies as applicable. System Outcome: Better protocols and tools to support coordinated case management activities.

Additionally one long-term project goal calls for the development of better interventions and supports for youth who are at-risk of or experiencing co-occurring disorders, with the development of TAY oriented substance use prevention and recovery services, including:

- TAY specific Ala-non/Ala-teen , AA/NA, or other substance related support groups;
- Counseling and case management for TAYS who are involved with substance use;
- Classes and workshops that address the linkages between exposure to trauma or family history with addiction;
- Recreation, physical activities, and other positive enrichment programs to provide safe and fun alternatives to the substance using culture

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For "other", provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American			1500	1500	1500		
Asian Pacific Islander			400	400	400		
Latino			1500	1500	1500		
Native American			65	65	65		
Caucasian			500	500	500		
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)			2340	2340	2340		
Transition Age Youth (16-25)			1150	1150	1150		
Adult (18-59)	475						
Older Adult (>60)							
TOTAL							

Total PEI project estimated ***unduplicated*** count of individuals to be served __3965_____

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

In a multi-faceted project such as this, not only do the outcomes of the various individual programs need to be monitored, a sense of the effectiveness of the project itself must be somehow measured. The programs selected are intended to enhance the existing system of service and supports available for the most high risk youth and families experiencing or at risk of school failure, juvenile justice, or child welfare involvement in the family. Substance use and witnessing or experiencing violence are correlated risk factors.

Evaluation Area	Potential Indicators	Qualitative Methods	Quantitative Methods
Community Level Do probation, justice, and child welfare clients have access to needed early mental health interventions?	Changes in perceptions of school safety Changes in compliance with the terms of: • Juvenile probation • Family violence or drug courts • Child welfare services	Interviews and focus groups with principals, probation officers, judges, and CWS case managers on perception of program impact.	None. Due to the relatively moderate number of youth and family members targeted through this project, quantitative data analysis would be insignificant for this level of analysis.
Systems/ Program Level Are programs and county agencies intensely collaborating?	Effective collaboration among organizations Availability and successful referrals to mental health services	Interviews and Focus Groups with service providers, and personnel at schools, probation	Instruments designed for specific program outcomes. (e.g. are MOUs in place, protocols for collaboration, and reporting, team meeting processes, etc.)
Participant Level Are participants demonstrating changes in behavior?	Changes in truancy/suspension/ achievement Changes in frequency police contact/arrests Participation in substance abuses, anger management and other groups Satisfaction with program and specific interventions	Interviews and Focus groups with participants	School attendance data, Probation data (pre-post), Program attendance data Successful phase completion/graduation from Family violence court or drug court Closed-ended self report survey

Evaluation tools and project reporting forms will be developed upon project implementation. The proposed division of labor will charge the BHS PEI Coordinator and evaluation staff with developing the compliance and reporting processes and the year 1 evaluation team with developing the outcomes portion of the evaluation.

Through the PEI planning process a DRAFT tool has been identified to help measure client satisfaction and measure change within the program. The tool, developed by SAMHSA's Mental Health Statistics Improvement Program Policy Group is publically available and comes with a set of guidelines and instructions for administering it (see: www.mhsip.org).

5. How will data be collected and analyzed?

Data collection will be coordinated by an outside local evaluator. The PEI plan calls for the hiring of the outside evaluator for one year to develop an evaluation plan, create evaluation tools and protocols. Train all applicable staff on data collection and reporting procedures, and train the PEI coordination team on how to administer the evaluation year to year. The intention of contracting with an outside evaluator is to both develop an evaluation plan and also to strengthen the internal capacity of BHS and all community partners to conduct self assessments, honestly share findings, and develop plans for continuous program improvement.

All programs and schools receiving MHSA funding will be contractually required to support all data collection activities including site visits, confidential interviews and the release of student information (as permissible under state and federal statute and with passive parent consent).

All data collected will be kept confidential. Student ID numbers rather than student names are encouraged substitutes. Data from the Office of Education and Probation Department will be used to track student outcomes, although it is recognized that an integrated data system may be required and may not be available until subsequent fiscal years. Reports will be compiled in aggregate format to prevent the identity of any one individual.

6. How will cultural competency be incorporated into the programs and the evaluation?

The evaluation team must demonstrate an ability to develop questionnaires that are suitable for different cultural audiences, language capacities and education levels. Bicultural and/or bilingual staffing that is similar to San Joaquin's population will be considered an asset.

The evaluation will also be guided by an Evaluation Stakeholder Steering Committee. The Evaluation Stakeholder Steering Committee (ESSC) will include representatives of different organizations and agencies that have worked in San Joaquin County that can aid in the evaluation design. The ESSC will be co-coordinated by the local evaluator and the PEI Coordinator and will be composed of representatives from the following groups:

- Mental Health Board
- Education
- Probation / Justice
- Consumers
- Youth / TAYS
- City of Stockton
- City of Tracy
- Consortium member funded through CSS but not through this PEI project
- Additional Stakeholders as necessary

An effort will also be made to consider language and cultural diversity of ESSC members regardless of the organization they represent.

ESSC members will help ensure that some the evaluation questions developed relate to the specific interests of the diverse populations of San Joaquin County, for example "Are there gender and language

specific opportunities for Latinas to talk about parenting concerns?", "Are recreation and enrichment programs responsive to the interests of young African American males?", etc.

Evaluation findings, to the extent possible will be analyzed by race and ethnicity. This will help programs understand if there are language and other cultural factors that impact service effectiveness. It will also help ensure that services are being provided to the most at-risk San Joaquin county youth and families (e.g. African American, Latino, and Native American youth) or emerging high-risk populations (e.g. South East Asian adolescent males) per the risk-factors reported above.

7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

Not Applicable. The project incorporates many of the promising practices identified in a comprehensive review of similar successful projects. However the project is not attempting to 'replicate" any one particular federally recognized evidence based practice for which fidelity standards have been developed.

8. How will the report on the evaluation be disseminated to interested local constituencies?

The evaluation report will be submitted to Behavioral Health Services and to the program directors of the funded programs. Evaluation findings will be presented to the Mental Health Board and at other consumer-driven organizations if desired. Other county-wide organizations such as the Office of Education or the Probation Department, may request periodic briefings or presentations on program success by the MHSA PEI coordinator or the evaluator in order to ensure that the outcomes of the MHSA PEI program efforts are disseminated broadly throughout the county and used to help develop future strategies that can leverage continued project activities.

The report will also be posted on the department website for public review. Additional copies can be requested by the public in writing.

APPENDIX

This page intentionally left blank.

Appendix

1. Contact Information for Purchased Trainings and other Resources
2. Community Meeting Flyer
3. Key Informant Interview Tool
4. Community Meeting Handouts

Contact Information for Purchased Trainings and other Resources

1. LivingWorks Education, USA
Jerry Swanner
P.O. Box 9607, Fayetteville, NC 28311
P (910) 867-8822
F (910) 867-8832
E jerry.swanner@livingworks.net
http://www.livingworks.net

2. PEARLS
University of Washington
School of Public Health
For general PEARLS questions, please contact Sheryl Schwartz at sheryls@u.washington.edu or 206-685-7258.
For questions about trainings, please contact Eddie Edmondson at eedmonds@u.washington.edu or 206-744-1751.

3. PROSPECT
Weill Cornell Medical College
Martha L. Bruce, PhD, MPH
Professor of Sociology in Psychiatry, Department of Psychiatry
888-694-5700
mbruce@med.cornell.edu

Transforming Mental Health Services

Community Meetings

on

Workforce Education & Training (WET)
Prevention & Early Intervention (PEI)

We Need Your Help!

In November 2004 voters passed Proposition 63, the Mental Health Services Act (MHSA), intended to transform public mental health care for children, youth, adults and seniors. MHSA provides funding for improvements in Prevention and Early Intervention (PEI) and Workforce Education and Training (WET). The County's WET plan will focus on developing and maintaining a competent and diverse workforce capable of effectively meeting the mental health needs of the community. The County's PEI plan will focus on reducing risk factors and stressors, preventing mental health issues from emerging, and guiding early intervention efforts to ensure that when a situation arises it will not get worse.

We are in the planning stage of this process and believe you have valuable insight to contribute. Help us create a plan that will respond to the needs of our community.

Community Meetings – Please join us!

Wednesday, August 20
WET 9am-12pm / PEI 2pm-5pm
Chavez Central Library, Stewart Hazelton Room, 605 N. El Dorado St, STOCKTON

Thursday, August 21
5pm- 8pm (Evening Meeting)
San Joaquin Regional Transit District, Downtown Transit Center, 421 E. Weber Ave., STOCKTON

Friday, August 22
WET 9am-12pm / PEI 2pm-5pm
Manteca Branch Library, McFall Room, 320 W. Center, MANTECA

Saturday, August 23
WET 9am-12pm / PEI 2pm-5pm
CUFF Family Resource Center, "Training Area" – 2044 Fair Street, STOCKTON

Monday, August 25
WET 9am-12pm / PEI 2pm-5pm
Tracy Branch Library, The Wadsworth Room, 20 E. Eaton Avenue, TRACY

Tuesday, August 26
WET 9am-12pm / PEI 2pm-5pm
Lodi Public Library, C.M. "Bud" Sullivan Community Room, 201 W. Locust Street, LODI

If you require special accommodations to attend, (interpreters, accessible seating, sign language or documents in alternate formats) please call us at 209-468-8871.

San Joaquin County Mental Health Department
MHSA Prevention and Early Intervention Planning Process

Key Informant Interview Questions

Interview Overview

Name:

Organization (if applicable):

Address:

Date:

Interviewer:

Interview Overview Script

The purpose of our conversation today is to inform the decision-making for the Prevention and Early Intervention component of the Mental Health Services Act Planning Process. Your input will help craft a plan to be submitted to the State of California for review on how San Joaquin County hopes to allocate over $5 million in funding for mental health prevention and early intervention services. This planning process follows an original planning process that occurred several years ago focusing on community services and supports. The first planning process focused on treatment and consumer services. This planning process takes what was learned in the previous planning effort and focuses more closely on how to develop **prevention and early intervention services.**

The Prevention Element of the PEI program is meant to reduce risk factors and stressors that can lead to an initial onset of a mental health problem. The Prevention Element is also intended to promote, support the well-being, and reduce the suffering of "at risk" individuals who are experiencing challenging life circumstances.

The Early Intervention Element of the PEI program is designed to prevent a mental health problem from getting worse. These programs are directed toward people for whom a short-term (less than one year), relatively low-intensity intervention is appropriate to measurably improve their mental health, avoid the need for more extensive mental health treatment or services, or prevent a mental health problem from getting worse.

Do you have any questions about what is intended by prevention or early intervention?

Disclaimer

The contents of this interview will be kept confidential, meaning your name will not be attached to anything you say; however we would like to present a list of names in the plan of those who we have interviewed. Do you consent to have your name shared in the public document? ❑ Check if Yes

Interview Questions

1) Did you participate in the community services and supports planning process for MHSA?
If yes; Was there anything that you remember coming out of the CSS planning process that is relevant to the prevention and early intervention plan.

2) What current prevention and early intervention activities are you aware of in San Joaquin County?

3) Are there significant gaps in current prevention and early intervention activities?

a. Children, Transitional Age Youth, Adults, Older Adults
b. Population groups (i.e. race or ethnicity, socio-economic, LGBT, etc)
c. Geographic location (i.e. Ripon, Lodi, etc)
d. What do you see right now in your work that is the biggest problem – why are these needs/gaps

4) What do you think should be done to address these gaps?

5) Do you have any data on the needs or gaps that you identified?

6) I am going to read you a list of the state mandated Prevention and Early Intervention Priority Populations. After I read you the list please tell me the TWO population groups from this list that you believe are the most important groups to target for San Joaquin County.

a. Underserved cultural populations
b. Individuals experiencing onset of serious psychiatric illness
c. Children/youth in stressed out families
d. Trauma exposed
e. Children/youth at risk of school failure
f. Children/youth at risk of experiencing juvenile justice involvement

Is there anything you would like to add about why these are your priorities?

7) I am going to read you a list of the state mandated Prevention and Early Intervention Key Community Mental Health Needs. After I read you the list please tell me the TWO Key mental health needs from this list that you believe are the most important needs to target for San Joaquin County.

a. Disparities in access to mental health services
b. Psycho-social impact of trauma
c. At risk children, youth and young adult populations
d. Stigma and discrimination
e. Suicide risk

Is there anything you would like to add about why these are your priorities?

8) What level of intervention do you think is best for San Joaquin County? (intervention level(s) Universal or Indicated and for example *educating* a community to reduce stigma, *training* professionals to identify and refer, provide *screening* to all or some with high risk, targeted early intervention, general prevention through increasing assets),

9) What are the setting(s) where you want to intervene? (school, health centers, probation, home, other community setting)

10) Are there any evidence based best practices that you feel would be exciting to bring to San Joaquin County's prevention and early intervention efforts?

11) Would you be willing to help this planning effort by organizing a focus group or distributing newsletters of the planning process? (if yes, record e-mail address)

12) Is there anything we did not ask about that would help this planning effort?

Demographics

Per the state guidelines for planning purposes it is important for us to compile demographics on the people that have participated in the planning process. These demographics will be kept confidential and only used to report on total numbers included in the planning effort.

❑ Decline to answer demographic questions

Do you identify yourself as a consumer or a family member of a consumer of mental health services?
❑ Check if Yes
❑ Consumer
❑ Family Member
❑ Check if No

Please indicate your age range:
❑ 18-25
❑ 26-59
❑ 60 and older

Do you consider yourself to be:
❑ Male
❑ Female
❑ Transgender

What is your race ethnicity? Do you consider yourself:

❑ White/Caucasian

- ❑ Black/African American
- ❑ Hispanic/Latino
- ❑ Southeast Asian
- ❑ Other Asian or Pacific Islander
- ❑ American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)
- ❑ Mixed Race: _____
- ❑ Other: _____

Thank you for your time today. Your input has been very valuable. If you have any questions or would like to talk to someone at the Mental Health Department regarding this interview please contact Frances Hutchins at (209) 468-3698.

Any comments?

Do you have any other comments or concerns?
Is there anything you would like to tell me about this interview process?

Potential Prevention and Early Intervention Strategies for San Joaquin County

A. Public Awareness and Education

1	*Anti-Stigma Campaign (eg: billboards or radio PSAs)*	Building on existing anti-stigma campaigns (NAMI, Mental Health America, silver Ribbon, etc) conduct a broad based public education campaign to reduce stigma and encourage public support of people with mental illnesses.
2	*School based mental health curriculums (eg: Teenage Health Teaching Modules)*	A comprehensive school health curriculum for grades 6 to 12 that provides adolescents with the knowledge and skills to act in ways that enhance their immediate and long-term health, including behavioral and attitude changes and willingness to self-report unhealthy behaviors.
3	*Consumer Speakers' Bureau (eg: In Our Own Voices)*	A public education program developed by NAMI in which two trained consumer speakers share compelling stories about living with mental illness and achieving recovery. Events can target consumer groups, students, law enforcement officials, educators, interested civic groups and others.
4	*Mental Health 101/Crisis Intervention Training*	Provide basic training in mental health signs and symptoms, crisis intervention, available services and supports to law enforcement officers. Recent tragic actions by police officers resulting in the injury of community members with severe emotional disturbances could have been prevented had officers been trained to recognize mental illness and recognize when to call in crisis response teams. Late referrals and diagnosis for mental health issues could be rectified with better teacher training. Other community partners, such medial providers, social service providers and clergy could benefit from such trainings as well.

B. Prevention

1	*Life Skills for Young Children(0-5) (eg: Tools of the Mind or Incredible Years)*	A preschool and kindergarten-based program that builds strong foundations for school success by promoting intentional and self-regulated learning. Based on research that shows that academic achievement is associated with a child's ability to regulate social, emotional, and cognitive behaviors. Training and curricula addresses parents, teachers, as well as children and promotes emotional and social competence and prevents, reduces, and treats aggressive, defiant, oppositional and impulsive behaviors in children.
2	*School Age Programs (eg: Second Steps or Early Risers)*	A universal classroom-based intervention designed to reduce impulsive and aggressive behaviors and increase protective factors and social-emotional competence. Organized by grade level, the program teaches children empathy, problem-solving skills, risk assessment, decision making, and goal-setting skills. A multi-component, developmentally focused, competency-enhancement program targets elementary school students who are at risk for developing conduct problems, including substance use. The program uses integrated child, school, and family-focused interventions to move high-risk children onto a more adaptive developmental pathway.
3	*Parenting Programs (eg: Dare to be You)*	Serves high-risk families with children (2-5). Families engage in parent-child workshops that focus on developing the parents' sense of competence and satisfaction with the parent role, appropriate child management and problem-solving strategies, improving family and peer relationships and children's developmental attainments, including resiliency.
4	*Comprehensive Family Supports (eg: Family Resource Centers or Beacon Centers)*	Neighborhood based programs provide comprehensive services for families, including employment training, nutritional support, parenting classes, recreation, financial counseling, etc. Provided in neighborhood or school settings, and staffed by members of the local community.

C. Assessment

1	*Integrated primary care and mental health care services*	Reduces stigma by providing complete health and wellness services, including education. Multidisciplinary teams with mental health specialists promote mental health by offering universal voluntary screenings, early interventions, if appropriate, assessment and referral and short-term psychotherapy/counseling.
2	*Court ordered juvenile and family assessments (eg CASA advocates)*	In order to affect the mental health needs of young people who are involved in the juvenile justice system, there must be continuums of services that are provide assessment, goal setting, behavior change, access to resources and ongoing support. The mission of the case planning and advocacy program is to support youth in the juvenile justice system by assisting them to identify their needs and strengths so that they have opportunities to make positive changes in life.
3	*School based mental health screening (eg: Teen Screen)*	The program provides early identification of middle school- and high school-aged youth in need of mental health services due to risk for suicide and undetected mental illness. TeenScreen can be implemented in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting.
4	*Home Delivered Meals Prevention and Screening (eg: Meals on Wheels with Depression screening training)*	Meals on Wheels mental health outreach program trains staff and volunteers who deliver meals to conduct depression screenings with home delivered meals to clients who are at risk for depression and suicide.

D. Early Intervention

1	*Mentoring Programs (eg: Across the Ages, Peer mentoring, Big Brothers/ Big Sisters)*	Mentoring initiative targeting youth with a goal of enhancing resiliency of children in order to promote positive development and prevent them from engaging in high-risk behaviors such as substance use, sexual activity, or violence.
2	*Life Skills Classes and Support Groups*	Provide community based classes and support groups to teach parenting skills, coping skills, anger management, life skills. Include substance abuse recovery components in every effort.
3	*Youth Empowerment Programs (eg: Transition to Independence)*	Transition Facilitators assist youth in making a successful transition into adulthood and achieve personal goals in employment, education, living situation, personal adjustment, and community life functioning. They also work collaboratively with family members and other providers to manage cases, provide assessment and coaching. May target extremely high-risk youth including those at risk of school failure or juvenile justice involvement.
4	*Short-Term Therapies (eg: Functional Family Therapy, PEARLS)*	A family-based prevention and intervention program for high-risk youths, ages 11 to 18, and their families. FFT has been applied successfully in a variety of multiethnic, multicultural contexts and can be used within the juvenile justice system. Programs to encourage active rewarding lives for seniors: An intervention for adults, 60+, with minor depression, who receive home-based social services. PEARLS provides 8 individual home-based counseling sessions to reduce symptoms of depression and improve health-related quality of life. Counseling includes problem solving treatment, and social and physical activity planning.

MHSA Community Input Forms
PEI Priorities

Strategy Breakout Group (Please check appropriate box):

- ❑ Public Awareness & Education
- ❑ Prevention
- ❑ Assessment
- ❑ Early Intervention

List your top two strategies here:

1) _____

2) _____

Strategy 1

Please explain why you selected this strategy?

What needs does this strategy help address?

Is there anything else you would like us to consider about this strategy?

Strategy 2

Please explain why you selected this strategy?

What needs does this strategy help address?

Is there anything else you would like us to consider about this strategy?

Other Considerations

MHSA Community Input Forms
PEI Priorities

Key Community Needs (Please check 2 boxes):

- ❑ Disparities in Access to Mental Health Services*
- ❑ Psycho-Social Impact of Trauma
- ❑ At-Risk Children, Youth and Young Adult Populations
- ❑ Stigma and Discrimination*
- ❑ Suicide Risk*

Please explain why you selected these key community needs….

Priority Populations (Please check 2 boxes):

- ❑ Underserved Cultural Populations
- ❑ Individuals Experiencing Onset of Serious Psychiatric Illness
- ❑ Children/Youth in Stressed Families
- ❑ Trauma-Exposed
- ❑ Children/Youth at Risk for School Failure
- ❑ Children and Youth at Risk of Juvenile Justice Involvement

Please explain why you selected these Priority Populations….

PUBLIC COMMENTS

This page intentionally left blank.

Notice of Public Hearing

San Joaquin County Mental Health Services Act (MHSA)

Prevention and Early Intervention (PEI) Recommended Plan

On April 6, 2009 at 6:00 p.m. at the Mental Health Center, 1212 N. California St., Stockton, under auspice of the San Joaquin County Mental Health Board, a public hearing will be held on the Prevention and Early Intervention (PEI) Recommended Plan.

Public Comments,

Received February 10, 2009 – April 6, 2009

This is a great plan for early intervention and prevention. I think San Joaquin County is going in a great direction! – Jeff Giampetro

Please include in anti-stigma portion specifically the NAMI anti-stigma campaign presentations – Gertie Kandris

Incorporate more on co-occurring disorders into Project I, these are important concepts for the volunteer cultural brokers to understand and must be included in the mental health 101 trainings. It is also important to make sure we leverage as many opportunities as possible. Especially with MediCal billings – Raul Sanchez

Board of Supervisors,

April 7, 2009

There were no public comments, although that was offered. The comments from the members of the Board of Supervisors included:

- *Ensure that funding goes to provide services.*
- *Concern for the May 19 election, and the impact if Proposition 1E passes.*
- *Recommend local stakeholders in districts and schools be involved in addition to County Office of Education.*
- *Consider providing suicide prevention in the County Adult Jail.*

In response to these comments, slight modifications were made to page 82 to clarify the intention that the LivingWorks Suicide Prevention Train the Trainer series would include participant(s) engaged with corrections facilities to ensure that suicide prevention training was brought to probation and corrections staff at both the juvenile and adult facilities.

ATTACHMENTS: ADDITIONAL PEI FUNDING REQUESTS

This page intentionally left blank.

Attachments: Additional PEI Funding Requests

1. Exhibit E: 2009-2010 PEI Funding Request
2. 2009-2010 PEI Work Plan
3. Technical Assistance Request

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Attachments

Exhibit E: **2009-2010 PEI Funding Request**

FY 2009/10 Mental Health Services Act
Prevention and Early Intervention Funding Request

County: San Joaquin Date: 2/3/2009

	PEI Work Plans		FY 09/10 Required MHSA Funding	Estimated MHSA Funds by Type of Intervention			Estimated MHSA Funds by Age Group			
	No.	Name		Universal Prevention	Selected/ Indicated Prevention	Early Intervention	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult
1.	PEI-1	Reducing Disparities in Access	$14,000	$14,000					$14,000	
2.	PEI-2	School-based Prevention Efforts	$710,000		$710,000		$710,000			
3.	PEI-3	Connections for Seniors and Adults	$318,255		$318,255				$100,000	$218,255
4.	PEI-4	Empowering Youth and Families	$3,305,547			$3,305,547	$750,000	$2,155,547	$400,000	
5.	PEI-5	Suicide Prevention and Supports	$151,400			$151,400	$102,400	$25,000	$24,000	
6.										
7.										
8.										
9.	Subtotal: Work Plans[a/]		$4,499,202	$14,000	$1,028,255	$3,456,947	$1,562,400	$2,180,547	$538,000	$218,255
10.	Plus County Administration		$1,002,948							
11.	Plus Optional 10% Operating Reserve		$611,350							
12.	Total MHSA Funds Required for PEI		$6,113,500							

a/ Majority of funds must be directed towards individuals under age 25--children, youth and their families and transition age youth . Percent of Funds directed towards those under 25 years= 83.19%

2009-2010 PEI Work Plan

San Joaquin County MHSA Planning		FY 09/10 PEI Allocation		
Project	Program	On-Going $	Additional $	One-Time $
1. Reducing Disparities in Access: $216,800 (4%)				
	Behavioral Health Services Transformation			
	Mental Health 101	$14,000		
2. School-based Prevention Efforts: $635,000 (11%)				
	Expanding School-based Prevention Programs	$600,000	$75,000	
	School Based Prevention BHS Management Analyst 1 (PT)	35,000		
3. Connections for Seniors and Adults: $318,255 (6%)				
	Senior Peer Counseling	$138,255		
	Mental Health in Primary Care Settings*	$180,000		
4. Empowering Youth and Families: $3,347,397 (59%)				
	Mental Health Clinician III for project clinical supervision (FT)	$117,000		
	Mental Health for Youth at Risk of Juvenile Justice**	$595,000	$114,772	
	Comprehensive Youth Outreach and Early Intervention	$600,000		
	Comprehensive Family Support Programs	$600,000	$150,000	
	Mentally Ill Offender Crime Reduction Grant	$210,000		
	Co-occurring Disorders for TAYS 16-21			$918,775
5. Suicide Prevention and Supports: $126,400 (2%)				
	Suicide Prevention in Juvenile Hall	$102,400		
	NAMI - Peer Advocates	$24,000	$25,000	
Administration: $921,968 (15%)				
	PEI Coordinator	$105,368		
	PEI Administration @ 15%	$402,997	$261,728	$151,875
	PEI Evaluation and Fidelity Support (1%)	$80,980		
	PEI Operating Reserve @ 10%			$611,350
Total: $6,113,500 (100%)		$3,805,000	$626,500	$1,682,000

All projects indicated in this 2009-2010 Work Plan have been described above, within the 2008-09 PEI Plan.

Training, Technical Assistance and Capacity Building Funds Request Form
(Prevention and Early Intervention Statewide Project)

Date: February 9, 2009	County Name: San Joaquin
Amount Requested for FY 2008/09: $101,400	Amount Requested for FY 2009/10: $101,400

Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).

San Joaquin County Behavioral Health Services (BHS) proposes a four-year comprehensive initiative to reduce disparities in access to publically funded mental health services through training, technical assistance, and capacity building. BHS and our community partners will engage in strategic activities to strengthen the county mental health system's alignment on core values and issues related to reducing disparities in access and improving service delivery for underserved populations.

The primary activities and goals for this initiative will be:

1. Promote Culturally and Linguistically Accessible Service (CLAS) standards throughout mental health serving organizations.
   Goal: Improve cultural or linguistic service delivery.

2. Integrate mental health and alcohol & other drug services.
   Goal: Provide "multiple access points" to treatment services.

3. Provide all community partners with training and resources in sustainability planning.
   Goal: Strengthen local capacity to support mental health needs in our underserved communities.

4. Develop shared outcomes and tools to measure service quality, access, and cultural responsiveness.
   Goal: Ensure all programs use data to support continuous program improvement.

5. Conduct community planning process to identify additional training, technical assistance or capacity building needs.
   Goal: Engage underserved communities in designing the scope, content, and approach of this initiative.

All of our community partners will be invited to participate in this initiative.

(Continued next page.)

The County and its contractor(s) for these services agree to comply with the following criteria:

1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County's Three-Year Program and Expenditure Plan.
2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services.
3) These funds shall only be used to pay for the programs authorized in WIC Section 5892.
4) These funds may not be used to pay for any other program.
5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC Section 5892.
6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities.
7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines.

Certification

I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.

_____
Director, County Mental Health Program (original signature)