



STANISLAUS COUNTY
MHSAPEI
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Behavioral Health & Recovery Services

**Mental Health Services Act
Prevention Early Intervention
Three-Year Program & Expenditure Plan
FY 2007/08, 2008/09, 2009/10**

April 2009

**Mental Health Services Act
Prevention Early Intervention
Three-Year Program & Expenditure Plan
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**PEI COMPONENT OF THE THREE-YEAR PROGRAM AND
EXPENDITURE PLAN FACE SHEET**

**MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2007-08, 2008-09 and 2009-10**

County Name: Stanislaus	Date: April, 2009
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

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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 _____

County Mental Health Director

Date

Executed at _____, California

County: Stanislaus

Date: April 6, 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

- Denise Hunt, R.N., M.F.T., Behavioral Health Director
- Madelyn Schlaepfer, Ph.D., Behavioral Health Associate Director
- Stanislaus County Mental Health Board

b. Coordination and management of the Community Program Planning Process

- Denise Hunt, R.N., M.F.T., Behavioral Health Director
- Karen Hurley, MFT, MHSA Planning Coordinator

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

PEI Planning Team

- Karen Hurley, MFT, MHSA Planning Coordinator
- Dan Souza, LCSW, Technical Consultant
- Ruben Imperial, Prevention Coordinator/Public Information Officer
- Hugo Ramirez, Community Development Specialist
- Teresa Garibay, Administrative Clerk III

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

The local community planning process was guided by a commitment to be inclusive, representative, and to elicit meaningful participation of diverse communities, including but not limited to underserved cultural populations, consumers, family members, potential consumers/family members, non-traditional providers of service, and people of

all ages. The entire planning process spanned seven months, emphasized methods to promote inclusion and participation of people who had not participated in MHSA planning process in the past. Its goal was to establish an authentic picture of community-wide needs, existing assets, and opportunities to build new and leverage existing communities of support.

Informed by the logic model provided in the PEI Program Plan Guidelines and with input from stakeholders, the planning process involved three phases:

- Broad stakeholder phase: education, outreach and identification of community need
- Representative stakeholder phase: analysis, recommendations and consensus
- Development of plan, public review and hearing phase: community-wide review prior to plan submission

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

All members of the community were welcomed to participate throughout all phases of the community planning process as actively as they desired. Many opportunities were available from July 2008 through March 2009.

To ensure members of underserved and unserved populations had access to the planning process, BHRS partnered with the following organizations to conduct targeted focus groups and provide reports on community needs assessment information from specific diverse populations. An additional 200 individuals gave input through these reports. The communities engaged included: Hispanic, African American, Southeast Asian and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ). The four community-based organizations were as follows:

- El Concilio: Council for the Spanish-Speaking
- West Modesto King Kennedy Neighborhood Collaborative
- Stanislaus PRIDE Center
- The Bridge Community Center

An example of an approach used to ensure participation by individuals who would not otherwise be heard from occurred at West Modesto King Kennedy Community Center when a focus group was conducted with a group of seniors at a weekly social group meeting.

Two types of community surveys were utilized:

- Approximately 328 Emotional Health in the Community surveys were returned through stakeholder meetings, postal service, and other methods.
- Asset Assessment survey asked key partners to assist in identifying various types of prevention programs that already exist in the County: 49 existing programs were identified.

Additional community needs assessment data obtained from local stakeholders came from other sources that include input from underserved/unserved individuals including:

- MHSA planning processes conducted in 2005 and 2007 for Community Services & Supports (CSS) and Workforce Education & Training (WET)
- Stanislaus County Health Services Agency's Community Health Assessment 2008, and
- BHRS Substance Abuse Prevention Plan 2006

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.

To ensure inclusion of diverse and underserved/unserved populations throughout Stanislaus County, BHRS partnered with the following organizations to co-sponsor community stakeholder meetings in nine communities in Stanislaus County.

- Family Resource Center, Community Collaboratives and School Resource/Health Centers in Hughson, Ceres, Turlock, Newman, Grayson, Oakdale, Riverbank, Patterson, and Modesto
- Area Agency on Aging and Veteran's Affairs - Modesto
- National Alliance on Mental Illness (NAMI-Stanislaus) - Modesto
- Consumers -Modesto
- Child and Youth Service Providers & Family Members - Modesto
- Stanislaus County Health Services Agency/Public Health - Modesto
- Turlock Community Collaborative - Turlock/South County
- Parents United – Modesto

(The PEI Planning Team conducted the stakeholder meetings. In one case, a Spanish-speaking member of the community-based organization requested to co-present with the Spanish-speaking member of the PEI Team.)

Through this effort, over 500 people attended twenty-five community stakeholder meetings in nine communities throughout Stanislaus County. Detailed demographic information was not collected describing all participants at these workgroups. However, nine additional meetings were conducted for Spanish-speaking community members throughout the County and four additional meetings were conducted in strategic locations with youth and transition age youth. The PEI Planning Team developed an overview of who participated, illustrated in Table 1.

Table 1: Overview of Stakeholder Targeted Focus Group Participants

Location · Focus Group	Stakeholders	English	Spanish	Children /TAY	Adult	Older Adult	Black	Asian	Latino	White	Family Member	Consumer	Homeless	LGBTQ
Ceres	· English · Spanish	X	X		X				X	X	X	X		
Hughson	· English · Spanish · Youth	X	X	X	X	X			X	X	X	X		
Modesto	· English · Spanish	X	X	X	X	X	X	X	X	X	X	X	X	X
Newman	· Community	X			X					X	X	X		
Oakdale	· School · Spanish	X	X		X				X	X	X	X		
Patterson	· English · Spanish	X	X		X				X	X	X	X		
Riverbank	· English · Youth	X		X	X				X	X	X	X		

Location · Focus Group	Stakeholders	English	Spanish	Children /TAY	Adult	Older Adult	Black	Asian	Latino	White	Family Member	Consumer	Homeless	LGBTQ
Turlock · English · Spanish · Homeless		X	X		X	X			X	X	X	X	X	X
Westley /Grayson · Community · Youth		X	X	X	X				X	X	X	X		
Modesto · Aging Services		X			X	X			X	X	X	X		X
Ceres · Alcohol and Drug Providers and Clients · Co-occurring Issues		X			X		X	X	X	X	X	X	X	X
Modesto · Parents United		X		X	X	X				X	X	X		X
Modesto · NAMI-Family Members		X			X	X	X		X	X	X	X		X
Modesto · Healthcare Providers		X			X	X	X		X	X				
Modesto · Child and Youth Providers		X	X	X	X		X		X	X	X	X		X
Modesto · Stigma and Discrimination Workgroup · Consumers		X			X		X	X	X	X	X	X	X	X

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

BHRS partnered with the following organizations to co-sponsor two community stakeholder meetings with invitations specifically extended to consumers/family members:

- National Alliance on Mental Illness (NAMI) - Stanislaus Chapter
- Stanislaus Chapter of Mental Health Consumers, Peer Recovery Network members, BHRS Peer Recovery Advocate and Family Advocate co-sponsored a stakeholder meeting devoted to stigma and discrimination prevention strategies

Consumers/family members attended virtually all stakeholder meetings/targeted focus groups held throughout the county.

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:

- **Individuals with serious mental illness and/or serious emotional disturbance and/or their families**
- **Providers of mental health and/or related services such as physical health care and/or social services**
- **Educators and/or representatives of education**
- **Representatives of law enforcement**
- **Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families**

Broad Stakeholder Phase: Education, Outreach and Identification of Community Need: The PEI planning process was built upon knowledge gained from lessons learned and partnerships established during the Community Services and Supports and Workforce Education and Training components of MHSA. Stanislaus County BHRS conducted an extensive planning process that included many opportunities for stakeholders to participate:

- The community planning process took place from July 2008 through March 2009

- Over 500 unique individuals representing one hundred fifty-nine (159) community organizations attended twenty-five focus group meetings in nine cities throughout Stanislaus County (September 16 through October 15, 2008)
- Nineteen (19) agencies/community-based organizations partnered with BHRS to co-sponsor targeted focus groups throughout the county (September 16 through October 15, 2008)
- Over 200 culturally/ethnically diverse individuals gave input through reports submitted by four community-based organizations serving Latino, African American, South East Asian and LGBTQ communities/neighborhoods
- Approximately 328 community members completed our Emotional Health in the Community survey
- Approximately 25 key partners participated in the Asset Assessment survey to identify existing prevention programs in the County: 49 programs were identified. (August 2008 through September 2008)
- Additional stakeholder input was incorporated from previous MHSA planning processes: Community Services & Supports (CSS) over 1500 stakeholders gave input and Workforce Education & Training (WET) approximately 400 stakeholders gave input
- Data from Stanislaus County Health Services Agency's Community Health Assessment 2008 included 2,800 face-to-face interviews
- BHRS Substance Abuse Prevention Plan included key stakeholder input

Additional opportunities for stakeholder participation:

- BHRS MHSA Newsletter included articles about PEI Planning in the following issues; May, June, July, September, November, December 2008, and January and February 2009
- The MHSA Planning Coordinator (or other members of PEI Planning Team) were available for contact by phone, email or in person for individual concerns or input to be expressed
- Four Representative Stakeholder Steering Committee meetings were conducted (December 2, 17, 30, 2008; February, 24 2009)
- Seven PEI workshops were conducted to propose program selections for PEI Projects (January 16 – 22, 2009)
- The PEI Plan was available during 30-day public review and comment period, (February 25 through March 26, 2009)
- Informational Meeting was conducted during 30 day review (March 11, 2009)
- MHSA Planning Coordinator spoke about MHSA - PEI to a group of Modesto Jr. College students (Human Services Department – CASRA students) (March 16, 2009)
- Public Hearing was held by the Mental Health Board (March 26, 2009)

Individuals representing one hundred fifty-nine (159) different organizations and community groups from throughout Stanislaus County participated in the local PEI Planning Process.

Representative Stakeholder Phase: Analysis, Recommendations and Consensus: The Representative Stakeholder Steering Committee (RSSC) is currently comprised of 44 individuals representing many diverse stakeholder groups throughout the County, as shown in Table 2. Approximately 50% of the individuals involved in the Representative Stakeholder Steering Committee have been partners in MHSA planning since the beginning and also faithfully participated in earlier phases of planning processes. The role of the RSSC was first established during planning for the MHSA CSS Plan when membership of the Steering Committee was determined by the requirements of the Mental Health Services Act.

Throughout the years, the RSSC has continued as it was originally intended, the committee has grown in its diversity and its power to participate in the process. This is a crucial point to keep in mind when considering the importance of what is being asked of the representative members of the committee. Each time a new MHSA component is introduced and an initial plan is being developed, a variety of methods are used to engage deeper levels of community input and ownership of the process. There are always more needs identified than can be addressed in the plan that is ultimately developed. As a result, there is a need to make tough decisions about where to start with each initial plan.

During the PEI planning process the RSSC members participated fully, voluntarily and more extensively on behalf of their communities than ever before. They took the time to attend 3 meetings in the month of December when many other demands competed for time and energy. The scope of the discussions necessarily included the current budget reality of decreasing public mental health services.

Given the budget reality of shrinking services, less people served each year and the need for more natural community supports, the BHRS Director shared three strategic initiatives that had emerged from the planning process. The RSSC was asked to consider the possibility that the Stanislaus PEI plan could be smart and sustainable in design with these strategic initiatives as the framework:

- Community Capacity Building,
- Mental Health Promotion and
- Prevention & Early Intervention Projects

The committee was further asked to consider the possibility that rather than depending on an increasingly and inadequately funded public mental health system to take care of mental health needs, community capacity building would

strategically leverage PEI funds to identify, catalyze, mobilize and support the strengths, assets and resources that exist within communities to meet these needs. The capital for leveraging PEI funds would come in the form of the community's many strengths, assets and resources including leaders, individuals, groups, organizations, facilities, knowledge, and other sources of funding. Key elements of community capacity building would include PEI Projects that would be established, mental health promotion campaigns to be integrated with existing community assets, such as networks of social support, healthcare systems, school systems, and community-based organizations. Expected outcomes would be a community that supports emotional wellness and resiliency, public awareness of stigma and discrimination as real issues to be eliminated, and easy early access to appropriate help when needed.

The RSSC embraced and fully utilized the strategic initiatives and shared vision for the future throughout the consensus process and adopted community themes, project proposal ideas and "rough" resource allocation. The result is that each project in the plan and its programs is designed to uniquely address a key issue related to community capacity building that was identified in the stakeholder input process. All the programs are linked to one another with intent to achieve the overall goal expressed in the vision described above. BHRS honors the commitment and dedication of this group of representative stakeholders to achieve a PEI plan that will make a difference, will build our community's capacity to support emotional health and be sustainable in the years to come.

Table 2: Representative Stakeholder Steering Committee Roster 2008:

Partner Organization/Community
Consumers <ul style="list-style-type: none"> · Youth · TAYA · Adult (2)
Family Members <ul style="list-style-type: none"> · Youth · Adult (2) · Older Adult
Diverse Communities <ul style="list-style-type: none"> · African American · Assyrian · Latino · LGBTQ · Native American · Southeast Asian
Social Services <ul style="list-style-type: none"> · Stanislaus County Community Service Agency · First 5 Commission

<p>Education</p> <ul style="list-style-type: none"> · Modesto City Schools · Stanislaus County Department of Education · CSU Stanislaus
<p>Law Enforcement</p> <ul style="list-style-type: none"> · Modesto Police Department · Stanislaus County Sheriff's Office
<p>Health Care: Public & Private</p> <ul style="list-style-type: none"> · Stanislaus County Health Services Agency/Public Health · Golden Valley Health Centers · Doctor's Medical Center · Psychiatric Medical Group
<p>Senior Services</p> <ul style="list-style-type: none"> · Area Agency on Aging and Veteran's Affairs · Commission on Aging
<p>Probation/Juvenile Justice</p> <ul style="list-style-type: none"> · Chief Probation Officer
<p>Housing & Employment</p> <ul style="list-style-type: none"> · DRAIL · Stanislaus Housing and Supportive Services Collaborative
<p>Public Mental Health Labor Organization</p> <ul style="list-style-type: none"> · SEIU Local 535
<p>BHRS Staff</p> <ul style="list-style-type: none"> · Children's System of Care · Stanislaus Recovery Center-AOD/Co-occurring Treatment Center
<p>Faith Based Organizations</p> <ul style="list-style-type: none"> · Interfaith Ministries · United Samaritans
<p>Regional Areas: South & Westside</p> <ul style="list-style-type: none"> · Turlock Collaborative · Westside Community Alliance
<p>Contract Providers of Public Mental Health Services</p> <ul style="list-style-type: none"> · Children's Services · Adult Services · CSS Outreach and Engagement Services
<p>District Attorney</p>
<p>Public Defender</p>
<p>Courts</p>
<p>Stanislaus County Chief Executive Office</p>

A variety of methods were used to ensure that the PEI planning process included required and recommended stakeholders. Key strategies included, but were not limited to the following:

- Specifically encouraging and inviting required and recommended stakeholder participation (e.g., BHRS Director phone calls to other County Department Heads)
- Co-sponsoring targeted focus groups with community based organizations to engage stakeholders in all geographic regions of the county (e.g., Prevention Coordinator/Public Information Officer worked through existing collaborative relationships with Family Resource Center, Community Collaboratives, and School Resource/Health Center Coordinators to quickly establish a workable schedule and promotional flyers in English and Spanish)
- Ensure that stakeholder meetings were offered at times of day and locations that were accessible to required and recommended stakeholders (e.g., PEI Planning team scheduled planning meetings at all times of the day and evening based on recommendations of the co-sponsoring local organization to maximize participation)
- Offer incentives to consumers and family members to participate (e.g., BHRS used PEI Community Planning funds to provide incentives for meetings including food, funding for childcare during stakeholder meetings, stipends to consumers and family members, printing and copying costs to co-sponsors of stakeholder meetings)
- Use a variety of methods to promote and invite stakeholders to participate (e.g., BHRS MHSAs website and MHSAs Newsletter are now established sources of information and updates for stakeholders. Stakeholder meetings and resource information were promoted using both methods)

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

Every stakeholder meeting was viewed as an opportunity to provide training and information. In Stanislaus County, many members of county staff and local stakeholder groups have participated in MHSAs planning processes in the past and in the PEI community planning process many participants are new to MHSAs information.

To achieve an inclusive and meaningful approach to training people at all levels of knowledge, the PEI Planning team established a practice of “tailoring” the information to each group with the following parameters:

- Stakeholder meetings were scheduled for up to two hours
- PowerPoint Presentation included comprehensive information about MHSAs (English and Spanish version of PowerPoint were used)

- A flexible approach to the amount of review was based on the information needs of each group
- A complete paper copy of the PowerPoint presentation was given to everyone as a take-away resource

It should be noted that many savvy groups of key stakeholders wanted the entire overview of “MHSA Basics” even though it was a review. One stakeholder aptly put it, “There are so many aspects to it, I learn something new every time!”

Methods used to ensure all stakeholders received training to participate in process:

- The BHRS Monthly Leadership Meeting is attended by all leadership staff and Program Coordinators. Using a standing item on the agenda of “MHSA Updates,” the BHRS Director and/or MHSA Planning Coordinator gave updates on the status of MHSA components and statewide activities. Leaders and Coordinators took the information and educate program staff and other partners. Elements of PEI planning have been a frequent topic of update/education this year.
- BHRS MHSA Newsletter is published monthly. The MHSA Planning Coordinator wrote an educational article every month regarding some aspect of MHSA planning. PEI articles were published in the following issues with educational information about PEI Planning - local and statewide: May, June, July, September, November, December 2008, and January and February 2009.
- CIMH sponsored PEI-related webcast trainings throughout 2008. BHRS promoted these educational opportunities and provided access in a central location for all interested stakeholders. Average attendance was 10 -15 people.
- CIMH sponsored the Central Region PEI Regional Roundtable Training on July 31 & August 1, 2008. Twenty (20) individuals from Stanislaus County attended the informative trainings primarily stakeholders from Representative Stakeholder Steering Committee and the PEI Planning Team. This training was, for Stanislaus County, very timely and resulted in an energizing kick-off to the local stakeholder process.

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 was enhanced by lessons learned from CSS process, subsequent processes for additional CSS funding (Growth Funds and Augmentation Funds), and the WET planning process.

These important lessons assisted BHRS in achieving new levels of inclusiveness, transparency, and consensus in the PEI community planning process. Examples of how the lessons learned specifically apply to the PEI planning process include:

- **Inclusiveness** – from the CSS planning process we learned that attendance at Town Hall meetings is pretty light. Flyers in BHRS clinics and ads in local newspapers do not extend a strong enough invitation to ensure community participation. By partnering with community-based organizations that have existing relationships and strong connections in the local community, an entirely different response was received. Drawing from this lesson, all PEI planning meetings conducted during the Broad Stakeholder Phase were co-sponsored with community-based organizations and partner agencies.
- **Consensus and Transparency** – The local CSS planning process was unprecedented in its transparency and use of consensus process with representative stakeholders. Prior to MHSa planning, BHRS had not done anything of that scale or depth with community members. The lesson learned in 2005 was that it was actually possible to bring a diverse group of community stakeholders together, many with competing interests, and, in a spirit of cooperation, they would work together to achieve consensus. Drawing strongly on that experience, the PEI representative stakeholder process was actively designed to include more aspects of the plan to be part of consensus-building processes (e.g., resource allocation decisions). This brought the intended (hoped for) consequence of a new level of transparency in local planning.

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.

BHRS is committed to continuous quality improvement in all aspects of the organization. The following measures of success demonstrate effective, inclusive outreach was achieved during PEI community program planning. Four examples that measure a successful outreach effort are described:

- Three hundred twenty-eight (328) surveys were completed and returned from a very broad cross-section of the community. The survey was entitled Emotional Health in the Community. Four questions were designed to result in a subjectively assessed and described definition of what community members considered important to emotional health in their family and community. The survey was posted on the local MHSA website and given to every stakeholder who attended a meeting during Broad Stakeholder Process. Brief highlights of who responded to the survey follow:

327 out of 328 respondents indicated their age:

- 5% 17 years or younger
- 11% 18 – 24 years of age
- 6% 25 – 29 years of age
- 68% 30 – 59 years of age
- 10% 60+ years of age

190 out of 328 respondents indicated their race/ethnicity:

- 41% Hispanic/Latino
- 5% African American
- 2% Asian/Pacific Islander
- 5% Native American/Alaska Native
- 41% Caucasian
- 8% Other/Chose not to answer

270 out of 328 respondents indicated the town where they live:

- 46% Modesto
- 17% Turlock/Denair
- 3% Hughson
- 5% Westside (Grayson, Westley, Patterson, Newman)
- 13% Ceres/Keyes
- 16% Eastside (Oakdale, Riverbank)

- Contracting with community-based organizations serving culturally/ethnically diverse populations produced a measure of successful engagement in the planning process. Outreach to underserved cultural populations

and individuals with trauma-based issues such as Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities has been most successfully achieved by contracting with organizations who work in the community and with community members. An example of how this worked was with the Stanislaus PRIDE Center that produced survey results by using their website, weekly newsletter, and targeted focus groups. The top community issue identified was the need for suicide prevention in the LGBTQ community, especially in high school age youth.

- Approximately 25 key partners who represent diverse geographic and cultural communities/agencies were convened on November 12, 2008, to review community assessment themes that were emerging from the broad stakeholder process. These 25 key community representatives assisted in coordinating the community stakeholder meetings within their communities as well. Upon review of the emerging community assessment themes, the group endorsed the themes as representative of their individual communities as well as the overall community. This important feedback gave the PEI Planning Team a “green light” to proceed to the next phase of the planning process.
- Feedback/Comment Forms rating participant satisfaction were used as a measure of success. Satisfaction during the Broad Stakeholder Phase is described by the following:
 - All participants were encouraged to offer feedback and comments at every gathering.
 - Some participants preferred to give verbal feedback only. Verbal feedback was expressed to members of the PEI Planning Team and generally was very appreciative of the opportunity to contribute to the process and hopeful for the community outcomes.
 - Diverse participation contributed to a robust planning process and excellent feedback for future planning.
 - Over 100 unique responses were offered in the “My Comments/Suggestions” section of the feedback forms. Though mostly positive comments were received, positive and negative comments were offered (e.g. “It was a very good talk and good participation. Hear our call, we need your help”, “More information prior to the meeting as to the scope and purpose” and, when things did not go as participants expected, “The facilitators need to be better trained to direct the group process.”
 - Quantitative results:
 - 395 Feedback Forms received
 - 100 from Spanish-speaking individuals
 - 82 from Youth/TAY
 - Overall satisfaction ratings were 92.6% favorable

- Highest rated response: “The data from the process was presented in a way I can understand.” - 368 out of 392 respondents (93.9%) gave this statement a favorable rating
- Second highest rated response: “I had the opportunity to provide input for the MHSA planning process” - 367 out of 393 respondents (93.4%) gave this statement a favorable rating

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

a. The date of the public hearing:

Public Hearing was conducted on Thursday, March 26, 2009, 5:00 p.m., at the regularly scheduled Stanislaus County Mental Health Board meeting at 800 Scenic Drive, Modesto, CA.

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.

During the 30-day public review and comment period conducted from February 25 through March 26, 2009, the PEI Plan was circulated using the following methods:

- Public notices were posted in seven newspapers throughout Stanislaus County including a newspaper serving the Latino community. The notice included reference to www.stanislausmhsa.com and a phone number for requesting a copy of the draft plan
- An electronic copy was posted on the County’s MHSA website: www.stanislausmhsa.com
- Paper copies were sent to 13 branches of Stanislaus County Public Library resource desks
- Electronic notification was sent to all BHRS service sites with a link to www.stanislausmhsa.com announcing the posting of the draft plan and how to obtain copies
- Representative Stakeholder Steering Committee members, Mental Health Board members, and other interested stakeholders were sent notice informing them of the start of the 30-day review and how to obtain a copy of the draft plan
- An Informational Meeting was held on March 11, 2009, 4:00 – 5:00 p.m., at 800 Scenic Drive, Redwood Room, Modesto, CA

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

A number of excellent comments were received during the 30-day public review and comment period and no additional comments were received during the public hearing.

Community stakeholders submitted by fax, email, telephone calls and personally delivered to the MHSA planning office. Methods of submission of comments included Feedback Form, narrative paragraph in email and two were given over the phone to PEI Planning Team members. All comments are valued and every comment received is included, as received. Comments are de-identified and names, within comments, are shown as initials only (e.g. "K").

No substantive changes were made to the overall plan in response to comments submitted, however, a number of small changes and edits were incorporated as suggested by comments. All input will be utilized to inform implementation following plan approval.

Community stakeholder groups offering comments included the following: consumers, family members, NAMI members, child/youth service providers, mental health board members, public health nursing staff, community media, senior serving agency staff, BHRS staff, a member of the arts community, and a social work educator.

Mental Health Board members were given the opportunity to review responses to public comments prior to submission of this plan.

Comments are listed in no particular order, bulleted and in italics. BHRS response follows each comment.

COMMENT:

- *What I propose is to leave the total number served at 400 but do the following changes:*

Proposed - Total, 400

PEARLS - Early Intervention, 225

Senior Peer Counseling - Prevention, 75

Senior Center W/out Walls - Prevention, 100

NEW - Total, 400

PEARLS - Early Intervention, 100

Senior Peer Counseling - Prevention 100

Senior Center W/out Walls - Prevention, 200

BHRS RESPONSE:

Proposed numbers served for PEARLS program are based on information from a research article on the model program in King County, Washington with some consideration for inflation and California costs. Adjustments may be made based on responses from potential bidders' proposals for implementation. The proposed plan is not being revised due to overall project numbers served remaining the same.

COMMENT:

- *The Individuals with Disabilities Education Act (IDEA) is a United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities. It addresses the educational needs of children with disabilities from birth to the age of 21.*

Early intervention and prevention services have historically focused on the needs of children, specifically children 0-5 given that this is the time of the greatest potential to create lasting effects on the developing brain and parent child relationships.

A missing piece in the MHSA PEI is mention of specific services to young children; there is mention of services to children in the juvenile system, early onset of psychosis and treatment of children who are being sexually abused. Early intervention service is about early identification and treatment before a child is sexually abused, before a child is in the juvenile system and before there is the onset of mental illness in adults. A positive shift is in direction towards community development and partnerships.

Resilience is cultivated and nurtured through relationships; resilience is not innate to a person. Early intervention with children is about fostering resilience and those relationship skills, which will develop into resilience

BHRS RESPONSE:

Research suggests that meaningful relationships with caring persons foster resiliency in youth of all ages. This is intended to be part of the fundamental framework for all PEI projects and programs that focus on resiliency. Per DMH Guidelines, 51% of funds must be dedicated to programs for children and youth ages 0-25 years of age. Stanislaus County has budgeted 54.5% of resources to child/youth services.

It is expected that new child/youth-serving PEI programs will interface with existing child/youth-serving programs such as the BHRS-operated Leaps and Bounds Program which provides childcare consultation at early education settings and in families with mental health services that support the social emotional development of young children ages 0 – 5 years.

COMMENT:

- *I would like to suggest directing program development towards building on the success of other early intervention programs and moving ahead with the community focus of BHRS - Stanislaus County.*
 1. *The consultation model developed by Leaps and Bounds, CSOC-BHRS - Stanislaus County has proven to identify children before problems interfere with their ability to be in early education centers. Consultation allows for the development of community partners to respond to the social emotional needs of children, especially children 0-5. Establishing responsive learning environments for a multitude of children is early intervention at it's best. Prevent the cyclical of the effects of mental illness on to the next generation of young children*
 2. **Proposal:** *Fund mental health clinician to work with Stanislaus County Health Department in an early intervention post partum treatment program. Clinician will work with public health nurses and social workers to provide treatment. Clinician would be assigned to the Leaps and Bounds team in order to access and or provide psychiatric treatment and be located at sites designated by health department. This would be an opportunity to provide mental health services to pregnant mothers who are uninsured and unable to access mental health services. Prevention at this time can change the direction of the life trajectory for a mother and infant impacted by mental illness. This is turn can prevent social emotional and developmental delays in the child.*

BHRS RESPONSE:

Routine screening of pregnant women is a key component of the Health/Behavioral Health Integration Project. Qualified providers will have the opportunity to respond to RFP/RFA following plan approval and will be required to interface with existing resources such as Stanislaus County Health Services Agency's Healthy Birth Outcomes Program which focuses on prevention services to women, including teenage moms, at risk of having abnormal birth weight, stillborn or other health compromised babies.

COMMENT:

- *When you do contracts for implementation, I hope you will use management by objectives techniques. This would cover a mission statement, with multiple strategies, and tactics, with results or outcomes which would be measured in regular time increments.*

For instance:

Parents United would have a mission statement:

Educate the community about the destructive nature of child sexual abuse

A Strategy would be to teach youth about "good touch - bad touch".

A tactic is to provide teacher training to implement in class training with a goal of 20 teaches per quarter.

A Result or outcome is 20 teachers were trained over the last quarter. The goal was met but not exceeded.

We should measure each organization providing PEI as to how they are collaborating with other sister PEI organizations within the county.

BHRS RESPONSE:

It is agreed that implementing partners/contractors should utilize effective planning and performance measurement approaches. Contracts will establish measurable performance and process outcomes for each program including, but not limited to, individual outcomes, program outcomes and system outcomes. Collaboration with other implementing organizations will be a contract requirement for all participating in PEI implementation.

COMMENT:

- *I was impressed with the efforts made to include the whole community in developing the plan rather than relying of “Experts” to define what the problems are and how they should be solved.*

My major concern is that the community must continue to be involved in the implementation phase. In terms of media, the community will be involved to the extent that community media rather than commercial media is involved. The traditional understanding of the role of communication in development as adopted by commercial media is often one that seeks mainly to change individual behaviors. The assumption is that there are those who know what the problems and solutions are – the experts, and they need to communicate their wisdom to the community in order to bring about change. A more effective media campaign is defined as a process of public and private dialogue through which people define who they are, what they want and how they can get it. Sustainability of social change will happen to the extent that the communication for social change is empowering, horizontal [versus top-down], gives voice to the underserved, and is biased toward local content and ownership.

More often than not, when a media campaign is launched a commercial PR firm is brought in to guide it and they in turn depend on commercial media – the experts. Community media is ignored. The experts are positioned as agents of change and the community as objects of change. If you want to involve the community in the process you must include community media in the process. Once you identify community media, have them define their best practices and have them demonstrate how they come to identify them as best practices.

BHRS RESPONSE:

Agreed. It was always the intent to include community media in the implementation phase. Language is added to the Emotional Wellness Education/Community Support Project to specifically state this intent. It is anticipated that both commercial PR firms and community media will be essential to the successful implementation of the proposed PEI plan.

COMMENT:

- *The Community Capacity Building Team idea seems really great to me as long as it stays focused on supporting natural community processes and enfranchises these equal to or more important than traditional interventions.*

Your willingness to point out that community members were pretty consistent in pointing to the effectiveness of community support at the grass roots is absolutely essential to the notion of prevention, rather than the post trauma interventions that are typical of professionally driven supports.

BHRS RESPONSE:

It is agreed that supporting natural community processes that enfranchise and empower community members is essential. The Plan reflects this intent, especially in the Community Capacity Building Project.

COMMENT:

- *I am concerned that Modesto is playing such a large role in shaping the experience, politics as usual seem to have driven much of this.*

BHRS RESPONSE:

The community planning process extended to nine cities in Stanislaus County and included 25 stakeholder meetings; more than one in most outlying areas. An effort was made to describe the intent to invest in local communities that was strongly expressed during community planning process. Projects include a description of the overall intent to implement programs throughout the county in partnership with local neighborhood collaborative organizations. Actual communities will be selected based on responses from potential implementing partners throughout the County.

COMMENT:

- *One last concern was in your identified outcomes, measures of success. They are all still locked into changed behavior of unruly individuals without any expectations that systems transform. The assumption under this is that we are still looking to support defective individuals in our communities. I think that if you look at the input from community people you will here that they need a reshaped institutional response system that values their experience and does not perceive them as problems. It would be good to see, among your other outcomes, some expectation that systems transform.*

BHRS RESPONSE:

This thoughtful and forward thinking comment will be used to inform and influence the development of specific performance measures during implementation. Transformation of service delivery systems is a desired outcome of all MHSA-funded programs. BHRS believes that MHSA is the opportunity to transform from a “fail first to a help first” system.

COMMENT:

- *PEIR program - tailor model to local needs*

BHRS RESPONSE:

Agreed. During implementation, the program model will be adapted to local conditions while still maintaining fidelity to key elements. All model programs will require some adaptation to local needs, realities, and conditions.

COMMENT:

- *Safety net - implement these programs in a way that truly creates a place of safety*

BHRS RESPONSE:

The overall PEI Plan focuses on development of a variety of community supports that “touch” people early in “safe” places where people already voluntarily meet, such as faith/spirituality-based support groups. The intent of this is to create a safety net that is available early.

COMMENT:

- *I'd like to recommend that all PE&I projects and programs dealing with children and transition age youth explicitly have the “40 developmental assets’ resiliency approach imbedded as a requirement, both as a strengths/resiliency approach and as a specific outcome measure. This would allow the varied approaches to have a common component and to have a common outcome measure.*

BHRS RESPONSE:

Resiliency approaches are at the heart of the plan and the overall intent of the PEI Plan is to build programs that support and build resiliency. 40 Developmental Assets is an excellent approach that is based on resiliency research. Implementing partners will be encouraged to utilize this resource, however at this time there is no established screening tool using the 40 Developmental Assets Approach.

COMMENT:

- *I think that this is not enough money to provide a quality service throughout Stanislaus County.*

BHRS RESPONSE:

There is always more need identified that can be met by a plan such as this one. The intent is to implement quality prevention and early intervention programs throughout Stanislaus County within the limits of the resources allocated to the programs. Throughout the plan leveraging of resource including use of volunteers, partnering with existing community organizations, utilizing local strengths and resources, and federal reimbursement were identified and will be pursued during implementation.

COMMENT:

- *My fear is that this service will be stuck in Modesto only.*

BHRS RESPONSE:

There is no intent to centralize services in Modesto. An effort was made to describe to fully describe the intent to invest in local communities that was strongly expressed during the community planning process. Projects include a description of the overall intent to implement programs throughout the county in partnership with local neighborhood collaborative organizations. Actual communities will be selected based on responses from potential implementing partners throughout the County.

COMMENT:

- *I have found from experience or even computer seldom work. What works is word-of-mouth. The point serving 500 folks across all systems of care/ages is overly ambitious.*

BHRS RESPONSE:

Agreed. During implementation all programs will be encouraged to utilize a variety of effective means of communication including word-of-mouth outreach approaches.

COMMENT:

- *A significant strength of this plan is the emphasis on locating care within community centers already established as point of source information for many families in our county. Families who are already familiar with local resource centers will be much more likely to avail themselves of needed mental health services at known resource centers. It also can help alleviate transportation barrier that affects many families from seeking care at centralized locations (Modesto) when they live at outlying areas of the county.*
- *A further strength is the proposed Health/Behavioral Health Integration Project. Embedding mental health clinicians at primary care centers will also increase access/increase treatment for underserved/uninsured. Here at Community Health Services, we see clients who for the most part are low income and either have Medi-Cal or no insurance. Knowing that mental health is part of well being and if neglected can lead to self treatment with substance abuse, or inadequate coping and damaged relationships which can carry over to another generation, attempting to find care linkage for these clients is a high priority for us, especially if the client is pregnant or undocumented or an undocumented child. In these times of shrinking services, seeing the projected plan of having mental health clinicians available to assist with mental health services and system navigation will help a great deal with the clients we serve. I would propose Community Health Services (PH/CHS) as a site for collaboration. We currently refer a number of clients now to Leaps and Bounds from our Healthy Birth Outcomes Program; this plan could strengthen the linkage between the programs and increase the timeliness of clients receiving mental health services.*

BHRS RESPONSE:

Agreed. Strengths of this plan emphasize locating care within centers that are already established for many families as well as integrating behavioral health into primary care. Program sites and implementing partners for the Health/Behavioral Health Integration Project will be selected through RFA/RFP process.

COMMENT:

- *Arts - noted 100,000 in budget. One thing Artist "K" and I noted, trained support group leaders, professional artists, and I have a UCR art minor in studio art, and resume of printmaking and watercolor workshops. Some other programs, stipend or paid staff support, clients, as support group leaders, yet for us, problem on that, we're not art therapists.*

BHRS RESPONSE:

There is no intent to require training as an art therapist for providers within the Adult Art Program in the Adult Resiliency and Social Connectedness Project. Program staff will be selected by implementing partners.

COMMENT:

- *Will there be any employment of artists, who do art workshops in this 100,000 allocation. I did the last frame and mattes workshop, off \$150 NAMI materials mini grant, free donation of site by King Kennedy, free instruction by me, matte tape and four special mattes purchased at Artel, and others at Nasco West, using my special customer discount. I realize part of this budget goes to staff salary and gas to drive the van, and some staff for group I did the workshop with, got paid by county funds. I who have the expertise, did not. No MHSa stipend for new innovative program. I also don't get stipend on arts and recovery presentation in CIT either.*
- *Friends are Good Medicine, \$75,000. Just note, DBSA Stanislaus did make a stand alone proposal on that, web based, no cost to county. That was on their all volunteer group basis. If the money has to be spent, any way to add client jobs, something that sustains us in housing, etc, in this operation.*

BHRS RESPONSE:

Types of positions and qualifications will be determined in consultation with implementing partners. Whenever possible, the hiring of persons with lived experience as consumers/family members will be encouraged. No PEI programs have been implemented prior to PEI plan approval.

COMMENT:

- *In Our Own Voice. Why not use the usual BHRS way of doing it, rewrite own idea, and do speaker's bureau, or Celebrations in Recovery hits the road into the community. I know I just not into telling the sad tale of woe, or how much zyprexa helped, oops, didn't help me get to ARTS, does help. I feel unscripted, speakers, best, ad hoc. This requires verbal and not stage fright struck volunteers as me, used to doing other sorts of presentations.*

BHRS RESPONSE:

During implementation, the program model will be adapted to local conditions while still maintaining fidelity to key elements. All model programs will require some adaptation to local needs, realities, and conditions. Implementing partners will be encouraged to avoid the pitfalls noted in your comment.

COMMENT:

- *Getting back to art, would this mean an actual budget, such you could rent my easels for a change. Theatrically, do you have budget for props, such as hand puppets, should we develop puppet show, teachable to kids, as example.*

BHRS RESPONSE:

Costs for materials and equipment similar to those noted appear to be consistent with the intent of the program.

COMMENT:

- *In our arts deal, we also have walk, as in art walk, walking groups. The exercise, also mutual support component, including the support component of transport to get easels from one non profit and back, is part of our project, also need repair of frames cost, as "M" has lost two frames to damage in the 500 N. Ninth display.*

- *When you add in, more than funding for some materials and staff, but into the nuts and bolts of arts production, to be truly participatory useful programs, your budget may be light. Don't base it on our art projects ability to barter real venues, staffing from other sources, and having to invest our dollars, in lieu of paycheck but on the occasional art sale, my own art walk investment on that basis, including "M" no longer gets the \$10 for gas, nor "K" the \$15 food allowance, I'm in personally, over \$3,600 a year, unpaid, transportation costs, not included. I have to make \$4,000 in art sales, just to cover that, before I can raise rate for band or musician, pay other support tasks and transportation, or rent gallery space or hall. And I'm doing two on this basis, out of my pocket. That's only one, once a month event, involves on artists end, six to thirteen artists, support help of transportation, all volunteer, 150 to 350 attendees to event, changing crowd thru the year, each month.*

BHRS RESPONSE:

There is always more need identified than can be met by a plan such as this one. The intent is to implement quality programs throughout Stanislaus County within the limits of the resources allocated to the programs. Throughout the plan, leveraging of resources including use of volunteers, partnering with existing community organizations, utilizing local strengths and resources, and federal reimbursement were identified and will be pursued during implementation.

COMMENT:

- *Will also note, "K" and I use higher grade art materials, as do most programs in area for students, than what we've run into. My donation of pads to the mattes and framing group, using acceptable, but low end on that, in the donated drawing pads. Quality of the materials used, often an esteem and value issue of the artist, when you can afford it, you find it often helps just to have better tools to work with.*

BHRS RESPONSE:

The connection between quality of materials and the valuing of persons will be noted during implementation.

COMMENT:

- *How and who do you expect to get in terms of volunteers needed to assist staff in implementing programs. One volunteer has enough at this time, just to make review meetings, feels broader work in this area much needed to make these programs effective. Dollars sitting vs. volunteers trained and doing job is important application in these budgets, and need to identify these volunteers in advance of program....*

BHRS RESPONSE:

Support of volunteers is an important matter. Many of the programs within this plan are intended to utilize volunteers. Implementing partners will be encouraged to identify volunteers. BHRS Workforce Education and Training plan is designed to provide assistance and training in the development of volunteers.

c. The estimated number of participants:

35 participants were present at the public hearing and 12 out of 13 Mental Health Board members were present.

County: Stanislaus

The Community Capacity Building Project

Date: 4/6/09

PEI Project Name: 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	X	X	X	X

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

The Community Capacity Building Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the County.

The data analysis and community input process used for PEI was built on the successes of the CSS process, while also incorporating lessons learned along the way. The PEI planning process began with extensive outreach to ensure accessibility to stakeholders who wished to participate. The PEI Planning Team; in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in nine towns in Stanislaus County. Four community-based organizations that serve diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. The communities engaged included: Hispanic, African American, Southeast Asian and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ).

A key theme of the broad stakeholder process came from all outlying communities and/or those representing underserved cultural communities. The input was clearly stated that investing PEI funding in their communities (geographic as well as cultural communities) to increase the capacity of the community to provide the prevention and early intervention services and supports was needed and the most sustainable way to use funds effectively. They offered input that suggested investment in local communities is more powerful than putting programs in traditional mental health or human service organizations. Further, that access to underserved cultural populations could be strengthened by expanding resources that sustain natural supports in local communities; e.g., individuals, faith-based organizations, community health centers and collaborative organizations such as Family Resource Centers and School Resource/Health Centers.

Stakeholders reported that people support each other through difficult times through a variety of community-based supports and services beyond the systems of public mental health. Many communities have trusted local community center, community collaborative or school-based programs that families already have some type of relationship or connection with. Through these community-based, local and trusted locations, community members find support for mental health crisis even though these are not mental health-specific programs or services. For example, Family Resource Center Director reported that programs such as the Healthy Birth Outcomes provide support through difficult times for many of the women in the program. The support group component of the program at times acts as a support group for moms experiencing stress because of substance abuse or family issues at home. Although the group convenes to support healthy birthing practices, the social support has far greater impacts than those solely related to health outcomes.

General stakeholder meetings were followed by four Representative Stakeholder Steering Committee (RSSC) meetings whose core responsibility was to provide guidance to Stanislaus County in establishing initial priorities for each component plan of MHSA. By utilizing a consensus model with the RSSC, agreement was gained on Community Assessment Themes, Project Proposals and rough resource allocation for projects to be included in the PEI Plan. The draft plan was also reviewed with the RSSC prior to posting for 30-day review and comment.

To help describe the needs of communities for prevention and early intervention services, the PEI Planning Team presented Community Assessment Themes that incorporated additional data and information obtained from previous MHSA planning processes [Community Services & Supports (CSS) and Workforce Education & Training (WET)], the Stanislaus County Health Services Agency's Community Health Assessment 2008, and the BHRs Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of the needs of Stanislaus County.

Data Analysis:

The recently completed Stanislaus County Community Health Survey posed several questions to 2,800 Stanislaus County residents, the majority of whom were Hispanic/Latino, regarding health care and other concerns. Thirty percent (30%) of the respondents reported feeling so sad or hopeless almost every day for two weeks in a row or more that they stopped doing some usual activities. One question asked: "If you needed mental health treatment (counseling or other help) in the past 12 months, were you able to receive it in 2008?" Forty three percent responded with a "No" to the question. Of those that needed help but were unable to receive mental health treatment, many respondents received help from friends (26%), family (25%), and their church (20%). Community stakeholders affirmed these statistics.

This finding is considered within the following context:

- More than 13% of respondents have experienced homelessness (living in a shelter, on the street, in a vehicle, or homeless due to foreclosures).
- Several public mental health service programs in outlying areas of Stanislaus County (long term Mental Health Centers in Patterson, Ceres and Oakdale) have closed in the past three years due to decreased funding.
- The number of persons being served by the public mental health system within Stanislaus County is decreasing as overall capacity of the agencies shrinks.
- Significant transportation barriers have always existed and still do exist between outlying areas of the county and Modesto where most services are primarily located.

- Cultural and linguistic barriers exist for individuals from underserved cultural communities. Even those who live closer to services in Modesto and Turlock do not use the service for these reasons.
- Community stakeholders expressed consistently across the county that they lack information about when they might need behavioral health services, what services exist, where they are located and how to access them.

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This project responds to stakeholder input from underserved cultural populations to invest in their communities and increase overall capacity to address existing needs and disparities in mental health care.

The project will fund strategies to increase targeted communities' behavioral health capacity in the areas of (1) leadership development, (2) organizational capacity, and (3) community capacity by utilizing Asset-Based Community Development strategies and approaches. The project will also expand community capacity using the Promotores/community health worker model by training and employing community behavioral health workers from targeted communities.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions

Implementing partners are expected to be community-based collaborative organizations and groups that will work toward identifying, mapping and building the capacity of local behavioral health assets within local community locations and settings.

To reach underserved and hard-to-reach communities, stakeholders specifically stated, "Reach beyond the usual suspects" of community-based organizations. This theme reverberated through many community stakeholder meetings and key informant interviews. Continually throughout the planning stakeholder process, community-based organization stakeholders from the rural, African-American, Latino, and Asian communities all emphatically challenged Stanislaus County BHRS to reach beyond the community-based organizations that have historically been funded to provide services. Following stakeholder input to "reach beyond the usual suspects", this project's strategies address organizational capacity building for local grassroots organizations and groups to effectively administer both public and private resources to deliver services and to connect with behavioral health assets at the local level already supporting people through mental health crisis.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The Community Capacity Building Project activities will be offered throughout the county in a place-based approach that includes community anchored, diverse settings, (e.g., schools, parks, community centers, family resource centers/community collaboratives, places of worship, etc.).

Targeted communities are underserved cultural communities (Hispanic/Latino, Asian, African-American and LGBTQ) as well as communities that are geographically isolated due to transportation and other barriers.

Highlights of new or expanded programs:

Asset-Based Community Development (ABCD) works from the principle that every single person has capacities, abilities and gifts and that the quality of an individual life depends in part on the extent to which these capacities are used, abilities expressed and gifts given. Recognizing the assets of individuals and communities is more likely to inspire positive action for change from within than an exclusive focus on needs and problems. ABCD focuses on what is present in a community rather than what is absent, requires a fresh look at marginalized communities and sees opportunities rather than problems. Asset-Based Community Development's primary goals include increasing behavioral health capacity at three levels: (1) Individual and Leadership Development, (2) Organizational Development, and (3) Communities.

This program will be made available to underserved communities and community leaders throughout Stanislaus County but will include two specific initiatives that promote, support, and further develop Asset-Based Community Development strategies in the Latino and faith-based communities. Utilizing ABCD strategies, BHRS will convene leaders and stakeholders within these respective communities to identify best practice approaches to increase behavioral health capacity and to promote emotional health and wellness in their respective communities. The collaborative's work and mission will come forth from an inclusive process that reaches non-traditional partners to provide support and leadership to local behavioral health Asset-Based Community Development efforts. This project will be integrated organizationally and programmatically with strategies being implemented as part of the Stanislaus County Alcohol and Drug Abuse Prevention Plan to insure an overall behavioral health approach (while insuring that funding requirements and limits for specific funding streams are met).

Promotores and Community Health Workers play a critical role in promoting community-based health education and prevention, particularly in communities historically underserved by the U.S. health care system. Promotores and

Community Health Workers represent a rich spectrum of characteristics that make them the bridge between health care institutions, professional providers and community residents in need of health care services. Promotores have a natural capacity to provide "genuinely holistic health prevention is the notion of "ecological relevance." Promotores are indigenous to Latino immigrant communities they serve, speak the same language, are intrinsically involved in the host community, and are committed to providing "servicio de corazon" (heartfelt service). As a result, they are able to provide culturally sensitive service, establish trust in the community and receive feedback from communities. The Promotores/Community Health Worker continuum includes diverse titles and roles within health and human service agencies such as peer educator, health advocate, outreach worker, block parent, community health worker, and Promotores, among others. Promotores and Community Health Worker strategies will aim to increase the capacity of community members and health outreach workers who serve as liaisons between their community and social service organizations. This program will do this by:

- Identifying and mapping existing Promotores and Community Health Workers
- Funding expansion of Promotores and Community Health Workers in Stanislaus County that have the capacity to address behavioral health concerns, including problems with co-occurring alcohol and drug problems, in their communities
- Convening Promotores and Community Health Workers to address the emotional health and wellness within the Spanish-speaking communities they serve.
- Providing Promotores and Community Health Workers behavioral health training and staff development opportunities

Actions to be performed to carry out the PEI project, including frequency or duration of key activities

Stanislaus BHRS will create a Community Capacity Development Team to facilitate the coordination, communication, training, support and technical assistance of selected communities. Four or more implementing sites will be selected through Requests for Proposals/Qualifications/Applications process. Selected implementing partner organizations and communities will be required to demonstrate their capacity to serve culturally underserved populations and ability to collaborate with other programs within their communities. Selections will be made based on even distribution of projects throughout the county, methods of community collaboration, and community needs.

Key milestones and anticipated timeline for each milestones

Pre-Implementation: April – June 2009

- Conduct community-wide Prevention Summit
- Develop RFP/RFA/RFQ
- Promote the project through outreach to underserved cultural and geographic communities
- Conduct bidders' conference to encourage new potential bidders

July – December 2009

- Review bidders' proposals, finalize selection of successful bidders
- Develop contracts with partner agencies
- Begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Asset-Based Community Development	Individuals: 1000 Families: 0	Individuals: 0 Families: 0	12
Promotores and Community Health Workers	Individuals: 1000 Families: 0	Individuals: 1000 Families: 0	12
TOTAL PEI PROJECT ESTIMATED UNDULICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 2000 Families: 0	Individuals: 1000 Families: 0	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

Implementing partners will be trained and required to establish collaborative relationships with Stanislaus Behavioral Health and Recovery Services to facilitate referrals between programs and effective use of mutual resources. Promotores/Community Health Workers will be trained to follow up to ensure that community members received needed treatment or assessment.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Implementing partners will be required to develop linkages with organizations, (e.g., family resource centers, other places of worship, advocacy organizations, community collaboratives, domestic violence and substance abuse treatment, etc.), through Asset-Based Community Development strategies. The goal is not only to better utilize existing resources, be they traditional or non-traditional, but also to create new leaders, resources and community-based systems.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

Stanislaus County BHRS will establish a Community Capacity Building Team to support selected programs. This team will provide technical assistance and training to selected, targeted communities as well as convene partners, as needed, to facilitate communication and mutual learning. Consultants and other experts will be made available to selected partners to assist in their community capacity building.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

The programs in this project are a part of an overall strategy to facilitate and develop local, community collaborative networks, both formal and informal, that can fill existing needs and gaps by increased behavioral health prevention and early intervention capacity within those communities using the strengths and resources within the community.

Asset-Based Community Development is intended to mobilize community strengths and assets on behalf of community members. The ABCD process looks beyond just formal services and organizations and attempts to mobilize individuals and groups within the community as well as those who can contribute. Implementing communities will be expected to map and inventory their existing community-based organizational resources and determine what resources they bring to the issue at hand, in this case, behavioral health (mental health and co-occurring issues of mental health and alcohol and other drug issues) service and support capacity. As a result, implementing communities will develop effective structures and processes for collaboration and communication.

The Promotores/Community Health Workers will be based in Family Resource Centers, community collaboratives and School Resource/Health Centers that have existing linkages and collaborative relationships with schools, community health centers, primary care, substance abuse supports and other neighborhood resources. By strategically increasing community-based resources such as Promotores and Community Health Workers, this program will further develop these networks through outreach to individuals and families within their own communities.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

The Community Capacity Building Project will intentionally engage health service providers, including primary care, community clinics to increase collaboration with local, community-based behavioral health capacity building efforts.

Describe how resources will be leveraged and sustained.

The nature of this project is to leverage community resources including knowledge and skills of individuals and groups. It is anticipated that the implementing partners will utilize community volunteers, existing facilities, and other existing resources. The goal is sustainability through use of the “natural” resources that exist within communities for healthy supportive environments and mutual aid and support.

7. Intended Outcomes

Describe intended individual outcomes.

- Identification of community leaders
- Increased behavioral health knowledge and awareness
- Linkage with community resources for individuals/families identified by Promotores/Community Health Workers

Describe intended system and program outcomes.

- Increased behavioral health service and support capacity within targeted communities and organizations
- Improved organizational capacity
- Map of the network of community-based behavioral health assets

Describe other proposed methods to measure success.

This project provides opportunity for participatory action research and other community-based research by graduate students and other evaluators. BHRS will actively pursue opportunities to evaluate effectiveness of community capacity building efforts related to behavioral health supports in the community.

What will be different as a result of the PEI project and how will you know?

Individuals and families from underserved communities within Stanislaus County will experience increased access to supportive environments, needed information, resources and support to address behavioral health concerns.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

Implementing partners will be trained and required to establish collaborative relationships with Stanislaus Behavioral Health and Recovery Services MHSA CSS Outreach and Engagement programs to facilitate referrals between programs and effective use of mutual resources. Service coordination for individuals with more severe mental illness who are identified through the Community Capacity Building Project will occur primarily between the PEI programs and BHRS Assessment Teams.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Implementing partners will have access to WET resources including relevant training, financial incentives and career ladder services.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Specifics unknown at this time - CFTN Plan submission anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 1. Community Capacity Building

Provider Name (if known): Stanislaus County Behavioral Health and Recovery Services

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	1,000
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	1,000
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Behavioral Health Advocate - 2.0 FTEs	\$0	\$0	\$111,446	\$111,446
				\$0
				\$0
b. Benefits and Taxes @ 38 %			\$42,350	\$42,350
c. Total Personnel Expenditures	\$0	\$0	\$153,796	\$153,796
2. Operating Expenditures				
a. Facility Cost				
	\$0	\$0	\$4,000	\$4,000
b. Other Operating Expenses	\$0	\$0	\$226,918	\$226,918
c. Total Operating Expenses	\$0	\$0	\$230,918	\$230,918
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$140,000	\$140,000
	\$0	\$0	\$0	\$0
	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$140,000	\$140,000
4. Total Proposed PEI Project Budget	\$0	\$0	\$524,714	\$524,714
B. Revenues (list/itemize by fund source)				
None known at this time				
	\$0	\$0	\$0	\$0
	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$524,714	\$524,714
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 1. Community Capacity Building

Provider Name (if known): Not known at this time

Intended Provider Category: Not know at this time

Proposed Total Number of Individuals to be served: FY 07-08 0 FY 08-09 0 FY 09-10 2,000

Total Number of Individuals currently being served: FY 07-08 0 FY 08-09 0 FY 09-10 -

Total Number of Individuals to be served through PEI Expansion: FY 07-08 0 FY 08-09 0 FY 09-10 2,000

Months of Operation: FY 07-08 0 FY 08-09 0 FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	\$0	\$0		\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				
_____				\$0
c. Total Personnel Expenditures				
	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost				
_____	\$0	\$0	\$0	\$0
b. Other Operating Expenses				
_____	\$0	\$0	\$0	\$0
c. Total Operating Expenses				
	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$1,193,700	\$1,193,700
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts				
	\$0	\$0	\$1,193,700	\$1,193,700
4. Total Proposed PEI Project Budget				
	\$0	\$0	\$1,193,700	\$1,193,700
B. Revenues (list/itemize by fund source)				
None known at this time				
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue				
	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project				
	\$0	\$0	\$1,193,700	\$1,193,700
6. Total In-Kind Contributions				
	\$0	\$0	\$0	\$0

County: Stanislaus

Emotional Wellness Education/Community Support

Date: 4/6/09

PEI Project Name: 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>		
4. Stigma and Discrimination	X	X	X	X
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
A. 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	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	X	X

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

The Mental Health Awareness and Education Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the County. The data analysis and community input process used for PEI was built on the successes of the CSS process while also incorporating lessons learned along the way. The PEI process began with extensive outreach to ensure accessibility to stakeholders who wished to participate. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in nine towns in Stanislaus County.

Four community-based organizations that serve diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. The communities engaged included: Hispanic, African-American, Southeast Asian, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ).

To help describe the need for prevention and early intervention, the PEI Planning Team presented Community Assessment Themes that incorporated additional data and information obtained from previous MHSA planning processes: Community Services & Supports (CSS) and Workforce Education & Training (WET), Stanislaus County Health Services Agency's Community Health Assessment 2008, the BHRS Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of the needs of Stanislaus County.

Community stakeholders affirmed statistics reported in the Community Health Assessment as true in their experience and that of their communities. Stakeholders also reported that people support each other through difficult times through a variety of community-based supports and services that exist outside of public mental health and public social services.

Many communities have trusted local community centers, collaboratives, and school-based programs that families have relied upon and have established, trusting relationships for years. Through these community-based, local, and trusted locations, community members access supports. Though the help they receive is not specialized mental health or alcohol and other drug prevention or treatment services, a considerable amount of support is available through these organizations that makes a difference in the lives of individuals in their surrounding communities.

Community stakeholders identified an increase of awareness and education for service providers and community-at large as a priority for achieving positive mental health and wellness outcomes. They identified a need for increased ability to recognize early signs of mental health problems and use tips for prevention and early intervention.

Stakeholders reported that many informal and formal groups already work to support people through emotional and mental health problems and that by increasing access to and improving transfer of information, referral information databases, and linguistically appropriate educational materials, access to services early and at appropriate levels would be greatly increased.

Stakeholders identified a broad multimedia campaign that raises awareness about emotionally healthy lifestyles as important to the overall community in the goals of improving emotional health and decreasing stigma coupled with access to more extensive information about behavioral health concerns in multiple languages.

As communities become aware of the facts about mental illness, healthy, resiliency-based practices would be advanced and attitudes changed resulting in reduction in the self-stigma that is often a barrier to seeking help.

Data Analysis:

Recently completed Stanislaus County Community Health survey posed several questions to 2,800 Stanislaus County residents, the majority of which were Hispanic/Latino, regarding health care and other concerns. Thirty percent (30%) of the respondents reported feeling so sad or hopeless almost every day for two weeks in a row or more that they stopped doing some usual activities. One question asked “If you needed mental health treatment (counseling or other help) in the past 12 months, were you able to receive it in 2008?” Forty three percent responded with a “No” to the question. Of those that needed help but were unable to receive mental health treatment, many respondents received help from friends (26%), family (25%), and their church (20%). Community stakeholders affirmed these statistics.

Studies indicate that friends seem to help buffer people against a whole host of stressful events including illness at all ages and stages.

Sources indicate that emotional health education and awareness can be effective when including a variety of strategies, all aimed at having a positive impact on mental (emotional) health.

Like all other health promotion, mental health promotion involves actions that create living conditions and environments to support individuals’ mental health and allow them to adopt and maintain healthy lifestyles. This includes a range of actions that increase the chances of more people experiencing better mental health. Many public health concerns have been significantly impacted by public awareness and education campaigns. Emotional health is linked to many health concerns as noted on the Center for Disease Control (CDC) website (text underlined for emphasis in this Plan):

- The effects of mental illness are evident across the life span, among all ethnic, racial, and cultural groups, and among persons of every socioeconomic level.
- Mental health is integral to overall health and well-being and should be treated with the same urgency as physical health.
- Mental illness can influence the onset, progression, and outcome of other illnesses and often correlates with health risk behaviors such as substance abuse, tobacco use, and physical inactivity.
- Depression has emerged as a risk factor for such chronic illnesses as hypertension, cardiovascular disease, and diabetes, and can adversely affect the course and management of these conditions.
- The challenges for behavioral health are to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment, remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to mental health services for all persons, particularly among populations that are disproportionately affected.

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This project will establish two new community-based programs using strategies to increase mental health wellness, education and awareness, and link to a countywide strategic effort to expand access and develop local social and emotional support groups. The primary focus is on reducing stigma and discrimination that results, in disparities in access to behavioral health services. All educational materials will also be produced in Spanish.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions.

Implementation partners for the mental health promotion campaign are expected to be marketing and community media with expertise in social marketing strategies. They will be selected through RFP/RFA/RFQ process and be required to develop innovative collaborations and partnerships (countywide) that link with and build upon each other.

Friends are Good Medicine campaign will be administered by Stanislaus BHRS but will partner with a wide variety of support groups, faith and community organizations to expand support groups throughout the county.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The Emotional Health/Wellness Awareness and Education Project incorporates both universal and selective prevention strategies. One program will be a public information project that will be a countywide mental health and wellness multimedia campaign with a universal target population which will develop unique strategies for addressing specific culturally underserved populations. The other program will facilitate expansion and development of social support networks to increase overall access to social support for at-risk individuals and families in each of the priority populations.

Highlights of new or expanded programs.

The Mental Health Promotion Campaign - A professional and experienced Stanislaus County marketing and/or advertising firm will develop and implement a countywide multimedia campaign that helps families, educators, health care providers and young people recognize mental health problems and seek or recommend appropriate services. The campaign will include mental health and wellness messages aimed at reducing stigma associated with mental health and mental health issues co-occurring with substance abuse. The goals will be to increase the public's awareness of behavioral health concerns and to provide information on how to develop and maintain emotional wellness and resiliency. The campaign will include key implementation features identified through the community stakeholder process:

- Utilize Spanish language community media such as radio and newspaper
- Develop unique social marketing strategies for underserved cultural populations
- Local public service announcements/English and Spanish
- High profile marketing venues such as bus exterior/interiors, bus stop benches and billboards.
- Written emotional wellness promotion materials that carry consistent countywide theme and messages.
- Assimilate and distribute broader campaign materials and messages into local communities via Promotores, community health outreach workers, schools, health clinics, etc.
- Establish and/or use existing web-based strategies (e.g., Network of Care) to promote emotional wellness

Friends are Good Medicine Program - This program significantly expands a successful selective prevention program that includes both a broad mass media campaign and support for the development and expansion of community social support groups. It will address the role of supportive relationships as a critical determinant of mental health, physical health and co-occurring issues of mental health with substance abuse. The program will promote the critical importance of a network of social support to health maintenance and will stimulate community activities that connect people and provide

opportunities to enhance personal relationships in everyday life. Building on the promotional campaign this program will provide:

- Countywide clearinghouse for materials in Spanish and English
- Directory to publicize support groups to make mutual-aid available to everyone
- Information and assistance source to groups in database
- Self-help in both the general and professional communities
- Leadership training, consultation, assistance to groups, and information sheets on topics of interest to self-helpers
- Linkages with community-based organizations to develop additional support groups
- Introduction of peer support in new areas
- Community-level implementation of the Mental Health Promotion Campaign

Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

The Friends are Good Medicine campaign will provide training and supportive technical assistance to support groups and support group leaders throughout the county. It will work with the Mental Health Promotion Program to promote support group utilization and creation through outreach, linking with community organizations, and following up on inquiries. Individuals who are the focus of services will be involved in its development. The overall projects will be linked with the PEI Community Capacity Building Project to provide necessary training and technical assistance as well as to facilitate networking and communication leading to mutual support and learning. It is expected that these community capacity building activities will increase over the initial implementation and decrease and stabilize at some point in the future as communities and organizations develop their skills and capacity.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April – June 2009

- Conduct communitywide Prevention Summit
- Develop and release RFP/RFA/RFQ
- Conduct bidders' conference to encourage new potential bidders

July – October 2009

- Hire or assign program staff
- Review bidder’s proposals, finalize selection of successful bidders
- Develop contracts with partner organizations
- Begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Mental Health Promotion Campaign	Individuals: 50,000* Families:	Individuals: Families:	12
Friends are Good Medicine	Individuals: 500 Families:	Individuals: Families:	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 50,500 Families:	Individuals: Families:	12

*This is a universal prevention program where it is difficult to estimate impact at this time. This estimate is based on a conservative estimate that 10% of the county population will actually utilize the information for some benefit, small or large.

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

All promotional materials (ads, signs, brochures, TV and radio spots, etc.) will include a phone number and/or website address for the general public to access more information about behavioral health services needed.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Friends are Good Medicine directory will provide information on available support groups throughout the county as well as a central phone number to call for information about support groups.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

Programs in this PEI project will also be linked with the Community Capacity Building Project to provide necessary technical assistance and training for implementing partners. Additionally, the Community Capacity Building Project will facilitate linkage and communication with other PEI providers for purposes of mutual support and learning.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

The RFP/RFA/RFQ process will stipulate that the Mental Health Awareness and Education Project programs and strategies must intentionally engage multiple diverse cultural communities throughout Stanislaus County, specifically targeting local community settings and priority populations. Primary locations for disseminating information and establishing support groups include, but are not limited to, primary healthcare, Family Resource Centers, community collaboratives, in-school and afterschool programs, etc.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

By promoting emotional wellness throughout the community and expanding access to social and emotional support, the overall network of behavioral healthcare should be enhanced. By establishing support groups in specific neighborhoods or rural communities near or within community health centers their capacity to address a variety of behavioral health concerns will be increased. An informed public including at-risk individuals and families make better consumers of behavioral health resources.

Describe how resources will be leveraged and sustained.

Mental Health Awareness and Education Project programs and strategies must intentionally leverage existing emotional and social support group resources organized in Stanislaus County. Volunteer support group leaders will be recruited and trained and local community settings will be encouraged to provide space at their locations for support groups. Wherever feasible and strategically effective, free public service access to media outlets will be pursued. Community partner agencies will be encouraged to apply for grants and other opportunities for expanding and leveraging this project with strong support from BHRS.

7. Intended Outcomes

Describe intended individual outcomes.

- Increased awareness of behavioral health services and supports
- Increased capacity to obtain social support
- Increased capacity for emotional wellness and resiliency

Describe intended system and program outcomes.

- Increased number of support groups throughout the county
- Increased capacity to network existing communities of support
- Increased capacity to deliver social and emotional supports

Describe other proposed methods to measure success.

Individual success stories and testimonials are a good measure of success. Individualized experiences will provide a vivid picture of how effectively the campaign is working.

What will be different as a result of the PEI project and how will you know?

Stanislaus County will be a community that embraces emotional health and wellness as a central part of everyday life and a community that has de-stigmatized help-seeking in times of need. Access is freely available and fully utilized throughout the community to obtain information about how to access support for all levels of emotional health.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

Individuals with more severe mental illness who are identified through the Mental Health Promotion campaign and through support group leaders will be linked with the Stanislaus BHRS assessment team and screened for eligibility for CSS programs. It is also expected that CSS outreach and engagement programs will utilize promotional and educational

materials produced through this project. Outreach and engagement programs will also be encouraged to identify opportunities for support group development as well as utilize existing social and emotional support resources.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Implementing partners will have access to WET resources including relevant training and career ladder services.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Unknown at this time - CFTN plan development and submission anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 2. Emotional Wellness Education/Community Support Development

Provider Name (if known): Stanislaus County Behavioral Health and Recovery Services

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	500
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	500
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Behavioral Health Advocate - .5 FTE	\$0	\$0	\$27,862	\$27,862
				\$0
				\$0
b. Benefits and Taxes @ 38%			\$10,587	\$10,587
c. Total Personnel Expenditures	\$0	\$0	\$38,449	\$38,449
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$500	\$500
b. Other Operating Expenses	\$0	\$0	\$11,051	\$11,051
c. Total Operating Expenses	\$0	\$0	\$11,551	\$11,551
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$25,000	\$25,000
	\$0	\$0	\$0	\$0
	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$25,000	\$25,000
4. Total Proposed PEI Project Budget	\$0	\$0	\$75,000	\$75,000
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
	\$0	\$0	\$0	\$0
	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$75,000	\$75,000
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 2. Emotional Wellness Education/Community Support Development

Provider Name (if known): Not known at this time

Intended Provider Category: Not known at this time

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	50,000
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	50,000
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	\$0	\$0	\$0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$571,850	\$571,850
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$571,850	\$571,850
4. Total Proposed PEI Project Budget	\$0	\$0	\$571,850	\$571,850
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$571,850	\$571,850
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

County: Stanislaus

PEI Project Name: Adverse Childhood Experience Interventions

Date: 4/6/09

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth, and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

The Adverse Childhood Experience Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the County. Stanislaus County BHRS conducted focus groups dedicated to identifying needs strategies and best ways to implement services. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in nine cities in Stanislaus County.

Four community-based organizations serving diverse cultural communities independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. The communities engaged by these organizations include: Hispanic, African American, Southeast Asian and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ). Almost all focus groups included parents of children and youth. Additionally, four focus groups were conducted for youth in different areas of the County (Riverbank, Hughson and Grayson); many of these youth were Latino. The West Modesto King Kennedy Neighborhood Collaborative conducted focus groups and surveys of African American youth at school sites.

Focus groups were also conducted for children and youth providers including juvenile justice representatives, child abuse service providers and with the local chapter of National Alliance on Mental Illness (NAMI).

The following needs were identified by stakeholders throughout the process that were related to the selection of this project:

- Early intervention and expanded resources for children who experience trauma and their families
- Early intervention at the onset of serious mental illness
- Early intervention with youth who become involved in the juvenile justice system
- Need for services to Spanish-speaking families
- Community education and training regarding mental health concerns
- Social support (e.g., telephone warm lines, peer support, support groups, etc.)

Programs selected for the project were a result of a series of program selection workgroups held in January 2009 following the RSSC recommendations for PEI Projects. The workgroups recommended the following program areas: expansion of early intervention for Spanish-speaking victims of child sexual abuse, expanded outreach and education to the community (especially the Spanish-speaking community) regarding the identification of and early intervention in child

sexual abuse, peer support strategies for individuals and families experiencing child sexual abuse, evidence-based interventions for youth beginning their involvement in the juvenile justice system, and the establishment of an early psychosis intervention program within the county.

Data Analysis:

Children and Youth at Risk of or Experiencing Juvenile Justice Involvement – Although the North American youth crime rate has declined over the past decade, young people of 18 years continue to account for a large proportion of police arrests; about 17% in United States and 23% in Canada (Statistics Canada, 2003; US Department of Justice, 2004). The aggression and delinquent behavior seen in adulthood shows the aspects of stealing, violating curfews, verbal abuse, physical abuse, rudeness and harsh talk with parents and friends first noted in adolescence.

Stanislaus County Probation data indicated that for 2008, almost 200 juveniles were on probation for violent offenses. This is 29% of all juveniles on probation. One hundred of those were on informal probation, meaning they were most likely first offenders or less serious offenses where early intervention can have a significant impact.

Trauma Exposed Individuals - The incidence of child abuse reports (including child sexual abuse) for 2006 in Stanislaus County is 73.8 per 1000 population of children 0-17 years of age, which exceeds the statewide average of 49 per 1000 children.

Based on studies cited by the “Darkness to Light” organization dedicated to confronting child sexual abuse, the following data on child sexual abuse in the United States is offered:

- 1 in 4 girls are sexually abused before the age of 18
- 1 in 6 boys are sexually abused before the age of 18
- An estimated 39 million survivors of childhood sexual abuse exist in America today
- 30-40% of victims are abused by a family member
- Approximately 40% are abused by older or larger children whom they know
- Therefore, only 10% are abused by strangers
- The median age for reported abuse is 9 years old
- More than 20% of children are sexually abused before the age of 8
- Over 30% of victims never disclose the experience to ANYONE

Consequences of child sexual abuse - Impacts begin affecting children and families immediately. These effects can continue throughout the life of the survivor so the impact on society for just one survivor continues over multiple decades.

- How a victim's family responds to a report of abuse plays an important role in how the incident affects the victim.
- Sexually abused children who keep it a secret or "tell" and are not believed are at greater risk than the general population for psychological, emotional, social and physical problems often lasting into adulthood.
- Children who have been victims of sexual abuse are more likely to experience physical health problems (e.g., headaches).
- Victims of child sexual abuse report more symptoms of Post-traumatic Stress Disorder (PTSD), more sadness, and more school problems than non-victims.
- Victims of child sexual abuse are more likely to experience major depressive disorder as adults.
- Young girls who are sexually abused are more likely to develop eating disorders as adolescents.
- Adolescent victims of violent crime have difficulty in the transition to adulthood, are more likely to suffer financial failure and physical injury, and are at risk to fail in other areas due to problem behaviors and outcomes of the victimization.

Drug and/or Alcohol Problems - Victims of child sexual abuse report more substance abuse problems. 70-80% of sexual abuse survivors report excessive drug and alcohol use.

- Young girls who are sexually abused are 3 times more likely to develop psychiatric disorders or alcohol and drug abuse in adulthood than girls who are not sexually abused.
- Among male survivors, more than 70% seek psychological treatment for issues such as substance abuse, suicidal thoughts and attempted suicide.
- Males who have been sexually abused are more likely to violently victimize others.

Individuals Experiencing Onset of Serious Psychiatric Illness - Considerable data and evidence of success in other countries (England/Australia) was found in a literature/Internet search to support the efficacy of Early Psychosis Intervention Programs. A few data points are offered in support of the proposed program:

- Studies have shown that the average age of onset for schizophrenia in men is 18 years of age and that early diagnosis and treatment greatly improve recovery.

- A recent research study funded by National Institute of Mental Health (NIMH) found that early identification of mental health risk factors could predict up to 80% of adolescents who are going to develop psychosis.
- Center for Health Services reports that publicly funded county mental health programs (traditional services) reach only about 2% of the 13 – 17 year old population.
- Studies have shown that specialized early psychosis intervention services are 1/3 to ½ the cost of traditional mental health services and produce better outcomes such as: return to usual levels of functioning, low relapse rate and no to low levels of symptoms.
- Extended duration of untreated psychosis becomes more difficult to treat in adulthood and can develop into co-occurring disorders.

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The programs in this project address the needs expressed by stakeholders for expanded responses to childhood traumatic experiences including child sexual abuse, early onset of serious mental disorders, and juvenile justice involvement. This project addresses key community needs of the psychosocial impact of trauma, at-risk children and youth, as well as focusing on trauma-exposed youth and their families, persons experiencing the early onset of serious mental disorders, and early involvement in the juvenile justice system.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions

Children and Youth at Risk of or Experiencing Juvenile Justice Involvement - Stanislaus Behavioral Health and Recovery Services (BHRS) has an existing and strong relationship with the Stanislaus County Juvenile Probation Department. BHRS provides integrated behavioral health services through a team at the Juvenile Justice center to persons on probation and living in the community as well as who are incarcerated. The Teaching Pro-Social Skills Program (TPS) will expand this existing partnership to include early intervention to youth who are just becoming involved with the juvenile justice system who have demonstrated aggressive or violent behaviors. Locating the expansion with the existing team will allow for communication and ease of referral between the juvenile probation system and behavioral health providers, within the Juvenile Justice Behavioral Health Team, who are already familiar with TPS.

Trauma Exposed Individuals - The Stanislaus County Parents United Chapter/Child Sexual Abuse Treatment Team (CSATT) currently delivers a range of peer/family support and treatment services to persons who are victims of child

sexual abuse and provides treatment to convicted offenders. The Child Sexual Abuse Prevention and Early Intervention program will expand the work of Parents United/CSATT to address the needs of Latino families, provide peer support through the establishment of a warm line and peer sponsorships as well as expand their community education and outreach.

Individuals Experiencing Onset of Serious Psychiatric Illness -The Early Psychosis Intervention Program, modeled after the Portland Early Identification and Referral program, will be a new program whose provider will be selected through a Request for Proposals process. The program will not be sited within traditional mental health settings.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

Children and Youth at Risk of or Experiencing Juvenile Justice Involvement - Youth from diverse cultural groups with aggressive behaviors resulting in involvement in the juvenile justice system will be the focus of the TPS program. The primary goal will be to work with youth experiencing first contact with the juvenile justice system to prevent further or higher level involvement. Latino and African American youth are disproportionately represented in the juvenile justice system and this program has been demonstrated to be effective with these cultural populations. While participants may be on probation and/or referred from Probation or the Juvenile Court, all participation will be voluntary. Incarcerated youth will not be eligible for TPS under this project.

Trauma Exposed Individuals - Stakeholders repeatedly noted the need to address the disparity in access for Spanish-speaking individuals and families. During the stakeholder process it was noted that Spanish language services for child sexual abuse intervention were very limited and inaccessible (e.g., existing services are centered in Modesto). The expanded services are intended to expand the Spanish language capacity of the existing program and to expand outreach, community education and peer support (including a telephone warm line) throughout the county.

Individuals Experiencing Onset of Serious Psychiatric Illness - Youth who have experienced early onset of serious psychiatric illness and family members noted there was often a delay in identification of symptoms that resulted in a delay in linkage to much needed services. This delay often resulted in escalation of symptoms, traumatic incidents and negative impact on academic and social status at school. The Early Psychosis Intervention Program is targeted to serve youth who are experiencing early signs of mental illness through increased public awareness and responsive early assessment and intervention. Identification of early signs, early assessment and intervention will be available for youth and families countywide. Cultural and linguistic capacity to serve diverse cultural populations will be included in outreach and early

intervention approaches. The public awareness and education component will occur throughout the county though the program could likely be sited in a centralized location in Modesto.

Highlights of new or expanded programs

Teaching Pro-Social Skills (TPS) is a comprehensive psycho educational skills program designed for aggressive children and youth at risk of or experiencing juvenile justice involvement. Based on the Aggression Replacement Training, TPS and its component procedures are (1) skill streaming – which teaches a curriculum of pro-social, interpersonal skills, (i.e., what to do instead of aggression), (2) anger control training – to teach youth what not to do if provoked, and (3) moral reasoning training – to promote values that respect the rights of others and help youth want to use the interpersonal and anger management skills they are taught. Aggression Replacement Training was first employed and evaluated in schools and delinquency centers in 1978. Since that time, an extended series of studies has demonstrated its skill learning, anger control and recidivism reducing potency. The U.S. Department of Education's Expert Panel on Safe, Disciplined and Drug Free Schools has recognized Aggression Replacement Training as a promising program. The U.S. Department of Justice, the American Correctional Association, and the Home Office, United Kingdom have also designated it as a model program.

Expanded Child Sexual Abuse Prevention and Early Intervention expands the effective strategies used by the Parents United/Child Sexual Abuse Treatment Team to address the trauma associated with child sexual abuse. The expansion will provide the addition of Spanish-speaking programming for adults who were molested as children, establishment of 24 hour/7 day a week Warm Line for individuals and families affected by child sexual abuse, expansion of peer sponsorships and the capacity to provide education about child sexual abuse to Spanish-speaking and other audiences. (Peer Sponsorships is a program of volunteer families who provide support to families who have just been identified as experiencing child sexual abuse. Sponsoring families have also experienced child sexual abuse but have successfully engaged in treatment and recovery.)

Early Psychosis Intervention, based on the Portland Identification and Early Referral (PIER Program) from Portland, Maine, provides services for young people between the ages of 12 and 25 who are at risk for serious mental illnesses. The program includes community education to increase awareness of signs and symptoms and early access to screening, assessment, education, treatment and supports for young people and their families. By getting help early, an individual's chances greatly improve for staying in school, working, maintaining friendships and planning for the future. The implementing partner will be required to provide bilingual Spanish/English early intervention services as well as community education. Materials used for public education will be developed in Spanish as well as English. Attention to local needs will need to be balanced with fidelity the model.

Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Existing partnerships with Stanislaus Juvenile Probation and Parents United Organization/CSATT will be expanded through contract for the Child Sexual Abuse Prevention and Early Intervention and Teaching Pro-Social Skills.

The Early Psychosis Intervention Program partner will be selected through a Request for Proposals (RFP) process and is unknown at this time.

Programs in this project will be linked with the PEI Community Capacity Building Project to provide necessary training and technical assistance as well as facilitate networking and communication leading to mutual support and learning. It is expected that these Community Capacity Building activities will increase over the initial implementation and decrease and stabilize at some point in the future as communities and organizations develop their skills and capacity.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April – June 2009

- Conduct community-wide Prevention Summit
- Develop and release RFP for Early Psychosis Intervention Project
- Conduct bidders' conference to encourage potential bidders for Early Psychosis Intervention Project
- Begin contract discussions with Stanislaus County Juvenile Probation and Parents United

July – October 2009

- Review bidders' proposals, finalize selection of successful bidders
- Develop contracts with partner agencies to begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Teaching Pro-Social Skills (TPS)	Individuals: 0 Families: 0	Individuals: 75 Families: 0	12
Expanded Child Sexual Abuse Prevention and Early Intervention	Individuals: 200 Families: 100	Individuals: 25 Families:	12
Early Psychosis Intervention (PIER Model)	Individuals: Families:	Individuals: 40 Families:	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 200 Families: 100	Individuals: 140 Families: 0	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

TPS will be provided within the integrated Juvenile Justice Behavioral Health system. Youth who do not respond to TPS or who are perceived to need specialty mental health services can be easily linked onsite with the necessary assessment and referral to the Juvenile Justice FSP or other services within Children's/TAY System of Care as well as primary care.

Parents United/CSATT is the County's established key provider of child sexual abuse treatment and has the experience to transition persons needing more extensive treatment to appropriate individual or group treatment. Linkages exist to refer individuals needing specialty mental health services to various BHRS assessment teams, other community-based treatment resources as well as primary care.

The Early Psychosis Intervention Program will be required to establish linkages and partnerships with the BHRS Children's/AY System of Care for extended treatment, if needed, as well as relationships with primary care referral sources, as needed.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

The Juvenile Justice Behavioral Health Team has capacity within the team to identify, educate and treat substance abuse disorders. Though Parents United/CSATT does not offer substance abuse assessment or treatment, there are clinical staff who are experienced in educating, identifying issues and making initial assessments of the need for referral and specialized treatment. The proposed new Early Psychosis Intervention Program will include substance abuse education and assessment in the prescribed early intervention protocols that fit with this evidence-based model. Additionally, the two providers of expanded programs within this project have extensive knowledge and long-standing partnership with community resources of all types. These providers will do what they do best and link youth/families they serve to needed service, whatever it may be; community-based, agency-based or faith-based. Their knowledge and partnerships include those not traditionally defined as mental health and they have experience creatively linking

individuals with non-traditional programs and community supports. The proposed new Early Psychosis Intervention Program will be required to use an assessment tool that fits within this evidence-based model and links youth/families to other needed services.

Additionally, all partners will be required to collaborate with local community-based organizations such as Family Resource Centers, neighborhood collaboratives, and school resource/health centers that provide a range of services to individuals and families.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

This project includes three programs, two of which will be implemented by experienced existing partners who have the infrastructure, policies and community credibility to successfully achieve desired outcomes. The programs are designed to build upon and leverage existing assets and resources that exist within each of these organizations. They understand and agree that community capacity building is a feature of prevention and early intervention success and sustainability. Projects in this plan will be linked with Community Capacity Building Project to ensure providers of all PEI projects have the necessary technical assistance and training they need. Additionally, Community Capacity Building Project will provide linkage and communication between projects and programs to facilitate mutual support and learning. Using the Asset Based Community Development Approach, providers will be encouraged to collaborate and partner with other entities and engage non-traditional community resources.

The third program, Early Psychosis Intervention, requires specialized knowledge and skill to achieve outcomes. The provider will be selected based on experience, knowledge and reputation to implement such a new and emerging approach to early intervention. Consultation from experienced early psychosis intervention programs modeled after the PIER Program will be obtained to assist in the program's development to appropriately serve local needs.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

All projects within this PEI Plan have been selected and designed to increase the overall capacity to provide behavioral health services and supports to individuals and families within Stanislaus County. Collaboration will be required between implementing agencies and other local community organizations and resources (e.g., health clinics, schools, local government, etc.) All projects will be linked to overall capacity building strategy to leverage collaborative relationships and unique strengths of each community into more than their component programs. These organizations and collaborative relationships will be provided with technical assistance, support and training, as needed, to not only implement the programs in this project but also to identify and create additional related resources that build resiliency within children and youth in their communities. Additionally, the Community Capacity Building Project will provide linkages and communication between communities that facilitate support and learning from one another.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers

Stanislaus County has a rich network of Family Resource Centers, neighborhood collaboratives and school resource/health centers. They provide prevention and early intervention services and supports to families within these communities and have partnerships with local schools, larger public agencies and community-based organizations. They employ individuals from targeted communities and have governance and advisory boards composed of representatives of communities they serve, lack stigma associated with more formal agencies, especially mental health programs, and are in a position to identify at-risk children and youth including youth at risk of substance abuse, violence and school failure. All programs in this project will be required to partner with these organizations and community collaboratives. These partnerships will focus on facilitating referral and training to programs in this project that will enable community-based organizations to enhance their services.

Specifically, Parents United/CSATT Program will provide community education and training in partnership with these organizations and collaboratives throughout the county.

Early Psychosis Intervention will provide training and awareness education to school personnel and healthcare providers throughout the County to facilitate the identification and referral of persons with early onset of psychosis, minimizing duration of untreated illness.

Describe how resources will be leveraged and sustained.

Two components of this project (TPS and Expanded Child Sexual Abuse Prevention and Early Intervention) will build on existing programs and partnerships utilizing established resources, relationships, strengths, knowledge, skill and volunteers. Within each of the three programs, some services may be eligible for federal reimbursement through Early and Periodic Screening Diagnosis and Treatment (EPSDT) for eligible participants. Providers will be encouraged to pursue such reimbursement without negatively altering programmatic goals and values. TPS and Parents United programs will utilize existing space. Parents United will also build on extensive volunteer resources within the organization for Warm Line and Peer Sponsorships.

7. Intended Outcomes

Describe intended individual outcomes.

Teaching Pro-Social Skills

- Reduced incidents of aggressive behavior by participants
- Reduction in referral to higher level of juvenile justice intervention such as detention.

Expanded Child Sexual Abuse Prevention and Early Intervention

- Reduction in PTSD, depression, eating disorders, and alcohol and drug abuse in adult program participants
- Supportive peer relationships
- Increased parental knowledge of treatment and support resources
- Increased parental knowledge of how to keep children safe from child sexual abuse
- Increased parental knowledge of the impact of child sexual abuse

Early Psychosis Intervention

- Identification of early onset of psychosis
- Reduced duration of untreated psychosis
- Significant decrease in psychiatric symptoms

- Significant reduction in likelihood of hospitalization and/or re-hospitalization
- Improved life functioning
- Decreased use of alcohol/drugs

Describe intended system and program outcomes.

Teaching Pro-Social Skills

- Increased awareness of impact of aggressive behavior in schools
- Increased availability of peer support for youth experiencing early aggressive behavior
- Reduced dropout and school failure rate related to aggressive behavior and juvenile justice involvement

Expanded Child Sexual Abuse Prevention and Early Intervention

- Increased community awareness of impact of child sexual abuse
- Increased availability of peer support for child sexual abuse victims and their families
- Increased access to treatment for Spanish-speaking adults molested as children

Early Psychosis Intervention

- Increased public awareness of early signs of psychosis
- Decreased use of public funds for long-term, costly mental health services

What will be different as a result of the PEI project and how will you know?

Children and youth will get help they need with adverse experiences early enough to prevent negative impacts on their lives. Delays in treatment will be reduced or eliminated thereby avoiding suffering and everlasting, long-term negative consequences of inadequate or no treatment.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

Juvenile Justice Behavioral Health Team is knowledgeable about treatment and recovery resources that are available including CSS programs for children and youth. They are skilled in assessment of individuals who may need these programs and are able to coordinate referrals easily.

Parents United/CSATT has knowledge of existing treatment resources and will receive training related to specific CSS programs, as needed.

Selected partner for the Early Psychosis Intervention Program will provide extended services, be fully informed of MHSA CSS programs, and screen and refer for assessment.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Program partners will have access to WET resources including training, career academies, clinical supervision, career ladder support, and financial assistance for staff.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Unknown at this time, planning for CFTN will occur in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 3. Childhood Adverse Experience Intervention

Provider Name (if known): Stanislaus County Behavioral Health and Recovery Services

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>75</u>
Total Number of Individuals currently being served:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>-</u>
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>75</u>
Months of Operation:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>12</u>

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Mental Health Clinician II - .75 FTE	\$0	\$0	54,678	\$54,678
				\$0
				\$0
b. Benefits and Taxes @ 38%			20,778	\$20,778
c. Total Personnel Expenditures	\$0	\$0	\$75,456	\$75,456
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$14,544	\$14,544
c. Total Operating Expenses	\$0	\$0	\$14,544	\$14,544
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$0	\$90,000	\$90,000
B. Revenues (list/itemize by fund source)				
EPSDT	\$0	\$0	\$15,000	\$15,000
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$15,000	\$15,000
5. Total Funding Requested for PEI Project	\$0	\$0	\$75,000	\$75,000
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 3. Childhood Adverse Experience Intervention

Provider Name (if known): Not know at this time

Intended Provider Category: Not know at this time

Proposed Total Number of Individuals to be served:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>475</u>
Total Number of Individuals currently being served:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>-</u>
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>475</u>
Months of Operation:	FY 07-08	<u>0</u>	FY 08-09	<u>0</u>	FY 09-10	<u>12</u>

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	\$0	\$0	\$0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$714,276	\$714,276
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$714,276	\$714,276
4. Total Proposed PEI Project Budget	\$0	\$0	\$714,276	\$714,276
B. Revenues (list/itemize by fund source)				
EPSDT	\$0	\$0	\$25,000	\$25,000
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$25,000	\$25,000
5. Total Funding Requested for PEI Project	\$0	\$0	\$689,276	\$689,276
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth, and Young Adult Populations	X	X		
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families				
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	<input type="checkbox"/>	<input type="checkbox"/>

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

Child and Youth Resiliency and Development Project resulted from a collaborative planning process conducted in Stanislaus County that involved diverse stakeholders throughout the County. BHRS partnered with children and youth serving community-based organizations and schools to co-sponsor targeted focus groups dedicated to formulating needs, strategies and best ways to implement services to children and youth. Youth representatives and advocates actively participated throughout the PEI planning process. BHRS partnered with children's service providers to conduct a large (approximately 60 people attended) focus group for persons who work with children and youth. Among the partners were representatives from the County Office of Education and Modesto City Schools.

The community input process used for PEI was built on successes of the CSS process while also incorporating lessons learned along the way. The PEI process began with extensive outreach to ensure accessibility to stakeholders who wished to participate. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in nine communities in Stanislaus County. Nine focus groups were conducted in Spanish and three focus groups were conducted with youth in different areas of the county (Riverbank, Hughson and Grayson). Many of the youth who participated were Latino. Most focus groups included parents and/or advocates of children and youth.

Four community-based organizations that serve diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. The communities engaged by these organizations included: Hispanic, African American, Southeast Asian, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ). West Modesto King Kennedy Neighborhood Collaborative conducted focus groups and surveys of African American youth at school sites.

To further describe the needs of children and youth, the PEI Planning Team incorporated data and information obtained from previous MHSA planning processes: Community Services & Supports (CSS) and Workforce Education & Training (WET), Stanislaus County Health Services Agency's Community Health Assessment 2008, and BHRS Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of the needs of the priority populations in Stanislaus County.

The following themes emerged:

- Need for positive, fun alternatives for youth activities and skills development
- Participants believed that adult and peer mentors are important for at-risk youth

- Alcohol and drug problems within families negatively affect children and youth
- A need to develop pro-social skills in children and youth

After considering stakeholder input and other data, the Representative Stakeholder Steering Committee recommended a project that focused on facilitating emotional resiliency factors with high-risk children and youth. Several workgroups with representatives from key stakeholder groups were conducted in the weeks following the consensus process to identify and suggest programs and strategies to be selected.

Schools and community-based sites were strongly recommended by local stakeholders as an ideal setting for behavioral health prevention and early intervention services that help build resiliency in at-risk children and youth who may be in one or more of the following priority populations: at risk for school failure, stressed families, at risk for juvenile justice, or underserved cultural populations. Additionally, youth stakeholders recommended integrated youth-driven or youth-centered mentorship activities, services and resources for enhancing resiliency.

Data Analysis:

Studies indicate there is a huge educational attainment gap between Anglos, African Americans, and Latinos in Stanislaus County in terms of high school graduation rates.

Educational attainment for African American and Latino 19 & 20 year olds in Stanislaus County was only modestly above 50% based on 2000 Census data.

The population projections of the California Department of Finance indicate huge growth in minority populations, particularly in the Latino population.

There is a strong link between educational attainment and mental health problems. Based on the California Health Interview Survey (CHIS), the rate of mental health needs for “less than high school education” is three times more than for college grads.

Educational test scores illustrate it is not a mystery who will not graduate. The vast majority of “non high school graduates” have English Language Acquisition (ELA) and math STAR test scores “below basic” or “far below basic” in the second grade. Many of the low academic achievers in the second grade have attendance and behavioral problems.

Information from American Academy of Child and Adolescent Psychiatry studies indicate children/youth in families with alcoholism or substance abuse are at risk for a variety of issues that can produce long-lasting relationship problems including: feeling guilt or responsibility for the substance abusing parent, anxiety, embarrassment, inability to develop close relationships and trust others, anger and depression.

Children of alcoholics are four times more likely than other children to become alcoholics.

Most children of alcoholics have experienced some form of neglect or abuse.

Children in alcoholic/substance abusing families may be at risk for a number of problem behaviors including:

- Failure in school; truancy
- Lack of friends; withdrawal from classmates
- Delinquent behavior such as stealing or violence
- Frequent physical complaints such as headaches or stomach aches
- Abuse of drugs or alcohol;
- Aggression toward other children
- Risk-taking behaviors
- Depression or suicidal thoughts or behavior

Whether or not their parents receive treatment for alcoholism/substance abuse, children/youth can benefit from educational programs and mutual-help groups.

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

Child and Youth Resiliency and Development Project addresses the needs expressed by stakeholders to focus on facilitating emotional resiliency among high-risk children and youth through mentoring, education, life skills training, peer support and community leadership opportunities. It addresses key community needs of at-risk children, youth and young adult populations by focusing on these priority populations: children and youth in stressed families, at risk for school failure, at risk of or experiencing juvenile justice involvement, and underserved cultural populations. Two programs are included: Leadership and Resiliency Program and Children are People.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions

Activities/services in this project will be provided primarily through collaborative relationships between community/school-based organizations serving diverse populations; e.g., family resource centers, neighborhood collaboratives, school resource/health centers and after school programs.

Local community organizations will be encouraged to engage in collaborative relationships with others in their community to develop responses to the requests for applications. For example, family resource centers, neighborhood collaboratives, and school resource/health centers could partner with schools, recreation programs and other youth serving organizations/groups. It is expected that partnerships with individuals and organizations that do not traditionally serve children and youth will be included to ensure opportunities for youth community service (e.g., animal advocacy, health care, historical preservation, environmental, etc.).

Children are People (CAP) will require partnerships with substance abuse treatment programs, child welfare agencies, organizations serving victims of domestic violence, and other organizations or community groups serving children from families with substance abusing parents/guardians and kinship care providers. In addition to traditional county-based substance abuse programs, this project will encourage family resource centers, neighborhood collaboratives and school resource/health centers to include CAP groups within the activities they offer in their after school programming. Doing so will ensure access to this prevention strategy for at-risk youth in outlying areas where transportation and other factors are barriers to services in traditional centralized locations.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

Youth from diverse cultural groups in stressed families, at risk for school failure, and/or at risk for involvement in the juvenile justice system will be the primary focus of this project's programs. Services will be established in communities in outlying geographic areas of the County where few youth activities and resources exist. Significant numbers of youth from underserved cultural populations will have access to this community-based approach. Collaborative partnerships in local communities will sponsor mentorship opportunities that include peers and adults from targeted communities.

Four specific sites will be selected through a Request for Applications process for the Leadership and Resiliency Program (LRP).

The CAP program will be offered to children of substance abusing parents or other primary caregivers. This program is most effectively delivered within substance abuse treatment programs, domestic violence centers, schools and community-based sites such as family resource centers, neighborhood collaboratives, and school resource centers. Up to ten sites will be selected for this program.

Highlights of new or expanded programs

Leadership and Resiliency Program (LRP) is a school-and/or community-based program for youth ages 14-19 that enhances internal strengths and resiliency, prevents involvement with substance abuse and violence, helps youth avoid school failure and involvement with juvenile justice. Specific activities include resiliency groups, adventure and outdoor activities, community service opportunities, conflict resolution, social skills training and peer mentoring. Individuals who are the focus of this program will be involved in its development.

Children are People (CAP) is a program for children of alcoholics or substance abusing parents/caregivers. CAP is a psycho-educational, problem-solving program designed to address, in a small group setting, the problems of children in third through fifth grades who are exposed to family substance abuse. The program consists of 8-10 sessions. Each weekly session includes opening and closing exercises and a topic for learning/discussion that addresses a specific psychosocial concern children may encounter. The program will include training and supervision to staff and qualified volunteers at up to ten different sites within the county. The program curriculum is available from Substance Abuse Mental Health Services Administration (SAMHSA).

Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

New partnerships with schools and community-based organizations will build on the existing strengths and resources that exist within these organizations including space, volunteers, community donations and opportunities for service. Implementation partners will be selected through a request for proposals (RFP) process and are unknown at this time.

Programs in this project will be linked with the PEI Community Capacity Building Project to provide necessary training and technical assistance as well as facilitate networking and communication leading to mutual support and learning. It is expected that these Community Capacity Building activities will increase over the initial implementation and decrease and stabilize at some point in the future as communities and organizations develop their skills and capacity.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April – June 2009

- Conduct community-wide Prevention Summit
- Develop and release RFP/RFA/RFQ
- Conduct bidders’ conference to encourage potential bidders

July – October 2009

- Review bidders’ proposals, finalize selection of successful bidders
- Develop contracts with partner agencies to begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Youth Leadership and Resiliency	Individuals: 400 Families: 0	Individuals: 0 Families: 0	12
Children Are People	Individuals: 120 Families: 0	Individuals: 0 Families: 0	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 520 Families: 0	Individuals: 0 Families: 0	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

This project is a selective prevention program focused on at-risk youth. Providers will be linked collaboratively with local primary care providers, many of which will have integrated behavioral health services. Providers will be encouraged to utilize this resource for initial screening. Information about the Early Psychosis Intervention Program, County Children's System of Care services and other treatment and recovery resources will be available to these programs. Training and technical assistance will be provided, as needed, to facilitate referral of participants who are perceived to need assessment for serious mental illness or serious emotional disturbance.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Family resource centers, community collaboratives and school resource/health centers that serve specific culturally underserved populations will be encouraged to apply for funding under this project. These agencies were active participants in the stakeholder process and expressed strong community needs and interest in offering these programs. These centers currently provide a range of services and supports such as counseling, parent education, support groups, high-risk perinatal support, youth activities, benefits advocacy, referral and linkage, case management, home visitation, etc., that may be utilized by program participants. These agencies typically employ persons from their targeted communities (either geographic or population based), have credibility within their communities and linkages with more formal, traditional agencies such as Behavioral Health and Recovery Services, Health Services Agency (Public Health), Haven/Women's Center and the Community Services Agency.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

This project includes two programs which will be implemented by new community-based organizations that have the infrastructure, policies, and community credibility to achieve the outcomes. The programs are designed to build upon and leverage the existing assets and resources that exist within these organizations. They will understand and agree that community capacity building is a feature of prevention and early intervention success and sustainability.

Projects in this plan will be linked with Community Capacity Building Project to ensure the providers of all PEI projects have the necessary technical assistance and training they need. Additionally, Community Capacity Building Project will provide linkage and communication between projects and programs to facilitate mutual support and learning. Using the Asset Based Community Development Approach, providers will be encouraged to collaborate and partner with other entities and engage non-traditional community resources.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

All projects within this PEI Plan have been selected and designed to increase the overall capacity to provide behavioral health services and supports to individuals and families within Stanislaus County. It is anticipated that programs in this project will be implemented, primarily, through contracts with small community-based organizations located throughout Stanislaus County and serving specific geographic communities or populations. Collaboration will be required between implementing agencies and other local community organizations and resources (e.g., health clinics, schools, local government, etc.)

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Stanislaus County has a rich network of family resource centers, neighborhood collaboratives and school resource/health centers which are located near and frequently linked with community health centers. They provide prevention and early

intervention services and supports to families within these communities and have existing partnerships with their local community health centers. By partnering with them to provide the prevention and early intervention services in this project, they will have increased capacity to meet the needs of the children and youth, capitalizing on the inherent strengths of these partnerships.

Describe how resources will be leveraged and sustained.

Funding allocated to this project is relatively small but will be leveraged by using community strengths and existing resources. Placing these projects within several community-based organizations will maximize the opportunity to build resource and capacity in their communities. Success of programs will be leveraged by the knowledge, credibility, and creative resource of the community, staff and boards.

Resiliency and Leadership Program will utilize community volunteers and opportunities for service and donated goods (tickets, incentives, space, etc.).

CAP will train and provide supervision to staff and volunteers of implementing partners to conduct CAP groups within their programs.

Both of these programs are selective prevention programs and not eligible for federal reimbursement.

7. Intended Outcomes

Describe intended individual outcomes.

- Improved school attendance by participants
- Reduced incidents of aggressive behaviors
- Increased knowledge of the negative impact of substance abuse
- Increased feelings of self-worth
- Increased community involvement by participants
- Reduced incidents of disciplinary action in schools for participants

Describe intended system and program outcomes.

- Increased capacity of local communities to facilitate child and youth resiliency

Describe other proposed methods to measure success.

- Parental satisfaction

What will be different as a result of the PEI project and how will you know?

Children and youth from underserved cultural communities will demonstrate resiliency to challenges by refusing alcohol and drug use, increased involvement in the community, increased participation in leadership roles and staying in school and out of trouble.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

This project is primarily a selective prevention program and few referrals to CSS programs are anticipated. CSS TAY outreach and engagement workers may encounter youth who may benefit from the Leadership and Resiliency Program. Staff of the programs in this project as well as CSS TAY programs will be educated about the services provided by each other and methods of accessing the service.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Youth participants in the Leadership and Resiliency Program will be provided information about WET programs that match with their interest (e.g., mental health career pathways). Staff of programs will be eligible to participate in behavioral health training provided through the WET plan initiatives. All providers will be encouraged to link youth and adult participants who indicate an interest in a behavioral health career with appropriate WET volunteer or career development programs.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Unknown at this time - CFTN plan development and submission anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 4. Child and Youth Resiliency and Development

Provider Name (if known): Stanislaus County Behavioral Health and Recovery Services

Intended Provider Category: County

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	120
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	120
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Mental Health Clinician II - .6 FTE	0	0	\$43,743	\$43,743
				\$0
				\$0
b. Benefits and Taxes @ 38%			16,622	\$16,622
c. Total Personnel Expenditures	\$0	\$0	\$60,365	\$60,365
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$14,635	\$14,635
c. Total Operating Expenses	\$0	\$0	\$14,635	\$14,635
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$0	\$75,000	\$75,000
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$75,000	\$75,000
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 4. Child and Youth Resiliency and Development

Provider Name (if known): Not known at this time

Intended Provider Category: Not known at this time

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	400
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	400
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	0	0	0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$489,276	\$489,276
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$489,276	\$489,276
4. Total Proposed PEI Project Budget	\$0	\$0	\$489,276	\$489,276
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$489,276	\$489,276
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

County: Stanislaus

Adult Resiliency and Social Connectedness

4/6/09

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	<input type="checkbox"/>	<input type="checkbox"/>	X	X
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>		
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	X	X
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	X	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input type="checkbox"/>	<input type="checkbox"/>	X	X

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

The Adult Resiliency and Social Connectedness Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the county. BHRS partnered with family resource centers and other community-based organizations to co-sponsor targeted focus groups dedicated to formulating needs, strategies and best ways to implement services to adults.

The data analysis and community input process used for PEI was built on successes of the CSS process, while also incorporating lessons learned along the way. The PEI process began with extensive outreach to ensure accessibility to stakeholders who wished to participate. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in the nine towns in Stanislaus County. Four community-based organizations that serve diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the racial/ethnic/cultural communities they serve. The communities engaged included: Hispanic, African American, Southeast Asian, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ).

To help describe the need of adults, the PEI Planning Team presented community assessment themes that incorporated additional data and information obtained from previous MHSA planning processes: Community Services & Supports (CSS) and Workforce Education & Training (WET), Stanislaus County Health Services Agency's Community Health Assessment 2008, and BHRS Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of the needs of Stanislaus County.

Throughout the planning process, stakeholders representing all populations overwhelmingly expressed the power of peer-to-peer activities in learning, recovery and social connectedness. Methods of addressing internalized stigma through consumer-driven empowerment projects (such as arts activities) to transform their identities from ones defined by illness to ones defined by artistry were strongly suggested. Additionally, stakeholder representatives from culturally underserved communities noted stigma was a major barrier to seeking and accessing mental health services within their communities.

Programs selected for the project were a result of program selection workgroups held in January 2009 following the RSSC recommendations for PEI Projects. Workgroup participants recommended wellness approaches such as yoga, meditation, spirituality activities, and involvement with arts to prevention of mental distress. Participants suggested that using arts activities would create more natural links to community-based locations (e.g., partnering with schools, family resource centers, and faith-based and social support groups).

Faith-based organizations places of worship were consistently regarded by stakeholders throughout the planning process as community resources with extraordinary potential to engage community members in activities for resilience and social connectedness.

Data Analysis:

More than 30% of respondents of the Stanislaus County Community Health Survey 2008 indicated that during the past 12 months, they felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. For those respondents who did not get professional mental health assistance, the most common resources to whom they turned were: friends (26%), family (25%), church (20%), doctor (11%), and spouse (10%).

Substance Abuse and Mental Health Service Administration (SAMHSA) evidence suggests that one of the causes of discrimination and stigma associated with mental illnesses is a misperception that people who have mental illnesses lack the same interests and abilities as everyone else. Art, including visual and performing arts, can be a powerful force in correcting this misperception. Using music, dance, painting, sculpture, poetry, theater and more, people with mental illnesses can demonstrate their creativity, insightfulness and intelligence. Through art they send the message "I work, live and play, just like you." The intent of this type of message to the general population is to lead individuals to question and ultimately reject stigmatizing myths. Also, the confidence-building and peer support found in arts programs can be powerful forces in recovery from mental illnesses.

Studies suggest discrimination and stigma have made it harder and harder for people with mental illnesses to get and/or keep a job, find a home, get health insurance and fit into their neighborhoods and communities.

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Adult Resiliency and Social Connectedness Project serves adults who experience stigma and discrimination related to mental illness and who lack needed social support. The project will reduce barriers in access to early mental health interventions by addressing stigma associated with mental illness and emotional health problems. Stigma reduction strategies include: expanded social support networks, culturally appropriate support and early mental health interventions offered in non-stigmatizing settings. This includes expanding existing communities of support and enhancing linkages between communities of support. Programs will also help establish non-stigmatizing personal identities in persons who

experience mental illness and/or co-occurring issues of mental illness and substance abuse through channeling their creative talents into new areas. These creative activities will also include stigma reduction messages to community groups and individuals.

Program strategies will reduce the negative psychosocial impact of trauma among underserved cultural/racial/ethnic populations by increasing social supports within these communities through faith/spirituality based organizations.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions.

Multiple implementation partners may include, but not be limited to, visual and performing arts organizations, peer recovery networks, advocacy groups, community-based and faith/spirituality-based organizations with sufficient capacity to implement the scope of one or more programs in the Adult Resiliency and Social Connectedness Project.

All program activities will be offered throughout the county in a place-based approach that includes community anchored, diverse settings, (e.g., schools, parks, community centers, theaters and galleries, family resource centers/community collaborative, places of worship, etc.).

Multiple churches and other centers of worship will be key partners for Faith/Spirituality-Based Resiliency and Social Connectedness Program.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic, and/or cultural populations to be served.

This project addresses two areas of concern with adults in Stanislaus County: impact of self-stigma within individuals and stigma that results in discrimination in communities.

Stigma and discrimination most often manifest as subtle and not so subtle barriers to accessing needed services. As barriers, they are made more significant when combined with complex cultural and linguistic elements in underserved cultural populations. The known result addressed in this project is disparities in accessing behavioral health services.

Psychosocial impact of trauma is often a result of inability to access needed, adequate and timely mental health services. When services cannot be accessed, symptoms persist and suffering increases. If social support and connectedness to community exists, it is often negatively impacted by increased stigma and discrimination based on the untreated or under-

treated mental illness. It is the 'perfect storm' that affects adults who suffer from under treated or untreated mental illness, become socially isolated and, possibly, become homeless or institutionalized.

Adult Resiliency and Social Connectedness Project intends to offer a variety of avenues of social support and connectedness with the intent of creating protective factors that offer the opportunity to build resiliency in individuals experiencing stigma and discrimination due to serious mental illness.

The project will be designed to be accessible to people in all parts of the county with an enhanced emphasis that is not on the individual's illness but rather be on their interest in learning how to change self-stigmatizing thinking, interest in the arts and interest in faith-based support. All three programs in this project are to be available at community-accessible sites throughout the county, especially in communities with underserved cultural populations.

Highlights of new or expanded programs.

In Our Own Voice (IOOV) – Anti-Stigma Program - This is a new universal prevention program that provides a mental health education program developed by National Alliance on Mental Illness (NAMI) in which two trained consumer speakers share compelling personal stories about living with mental illness and achieving recovery.

IOOV is an opportunity for those who have struggled with mental illness to gain confidence and to share their individual experiences of recovery and transformation.

Throughout the IOOV presentation, audience members are encouraged to offer feedback and ask questions. Audience participation is an important aspect of IOOV because the more audience members become involved, the closer they come to understanding what it is like to live with a mental illness and stay in recovery.

IOOV presentations are given to consumer groups, students, law enforcement officials, educators, providers, faith community members, politicians, professionals, inmates and interested civic groups.

The goal of IOOV is to meet the needs of consumer-run initiatives to set a standard for quality education about mental illness. The quality education comes directly from individuals who have been in the position of experiencing social stigma. The program intends to: 1) offer genuine work opportunities that make a difference in the community, 2) encourage self-confidence, reduce self-stigma and increase self-esteem in presenters/educators, 3) carry a message of hope and focus on the message 'Recovery is possible.' Recovery is the point in someone's illness in which the illness is no longer the first

and foremost part of his or her life, no longer the essence of all his or her existence - this is the time when work on self-stigma is most powerful.

The project in Stanislaus County will recruit persons in recovery from diverse cultural backgrounds to make the program linguistically appropriate and to better address the complex ideas of stigma and mental illness that exist in their communities.

Arts for Adult Resiliency and Social Connectedness - This new artistic self-expression selective prevention program helps individuals resolve conflicts, be problem solvers, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness and achieve insight. The arts are universal in their power to express the range of human emotion and, therefore, accessible to all underserved cultural and racial/ethnic populations.

Both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health (NIH) have developed lists of alternative approaches to mental health care including dance/movement activities to integrate emotional, physical and cognitive facets of self; music/sound activities to stimulate the body's opiates and endorphins to reduce stress, grief, and depression; and other expressive activities such as visual arts that foster, among other things, self-awareness and personal growth.

Arts for Adult Resiliency and Social Connectedness will support community members, especially those with a mental illness or co-occurring disorders, in developing their artistic craft and finding an outlet for their creative abilities through art in all forms. These activities will raise public awareness and acceptance of the creative talents of people living with mental illness or co-occurring disorders who are involved in the arts (e.g., painting, film, photography, sculpture, music, literature, and drama). These artists will engage other adults in the community to organize creative workshops and other activities that promote resiliency and social connectedness by addressing stakeholders' recommendation to provide opportunities for parents and other adults to unwind, hone their interests and create mutual support among peers. Activities may include operating a drop-in art studio that holds exhibitions, writing workshops, performance rehearsals and other artistic activities.

Faith/Spirituality-Based Resiliency and Social Connectedness - This new selective prevention program addresses support of resiliency and social connectedness with three key areas of need: lack of transportation, need to eliminate stigma, and desire for faith/spirituality community connections.

Transportation is a barrier to accessing services throughout Stanislaus County. One of the community assessment themes this plan is based on is orienting services locally. Many concerns are overcome when programs are located in places where people already go for other services or activities. Churches and faith organizations are located throughout the county, more than one in every community. They are readily accessible and many underserved communities are organized around churches, temples, and other places of worship.

Churches and faith organizations will be encouraged to engage individuals in spiritual interests as a means to facilitate emotional resiliency. Factors that support resiliency such as knowledge, social support, and connectedness are key elements of what is provided in faith organizations. They are natural gathering places that offer support to congregation members and others. Faith-based participants in the stakeholder process indicated that, with education about mental illness, they feel this project is a natural fit that does not include some of the barriers that might be present in other settings.

Faith-/Spirituality-Based Resiliency and Social Connectedness Program will facilitate, encourage and support several faith communities and spirituality groups throughout Stanislaus County to create increased social support and social connections for adults experiencing the impact of trauma and other risk factors. It is anticipated that these activities will include a variety of support groups, study groups, outreach, social and recreational activities and personal/peer based support. Partnerships with other PEI programs will allow faith organizations to provide education and information about behavioral health concerns that reduce stigma, enhance emotional wellness and support recovery.

Faith-/Spirituality-Based Resiliency and Social Connectedness will enhance the existing network of social support resources available throughout the county and may include interfaith associations and other organizations that foster faith-/spirituality-based collaboration, further leveraging this social support network for individuals with mental illness and co-occurring issues including Spanish-speaking community members. The expanded network of faith-/spirituality-based social support resources of this program will figure prominently in the Friends Are Good Medicine Program of the Wellness/Education/Community Support Project.

This program will serve as both a resource and support for initiatives that emerge out of faith/spirituality communities so that social support resources created are sustainable. Place-based activities ensure community buy-in or full ownership.

Actions to be performed to carry out the PEI project, including frequency or duration of key activities/Key milestones and anticipated timeline for each milestone.

Existing partnership with the local chapter of the National Alliance on Mental Illness (NAMI) will be expanded and new partnerships developed with individuals, groups, and organizations in the faith and arts communities. IOOV is a NAMI-developed program with national resources available for local implementation. Consultation will be requested from local arts organizations and local ministry networks will be asked to contribute to implementation.

Programs in this project will be linked with the PEI Community Capacity Building Project to provide necessary training and technical assistance as well as facilitate networking and communication leading to mutual support and learning. It is expected that these Community Capacity Building activities will increase over the initial implementation and decrease and stabilize at some point in the future as communities and organizations develop their skills and capacity.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April – June 2009

- Conduct a community-wide Prevention Summit
- Develop and release RFP/RFA/RFQ
- Conduct bidders' conference to encourage new potential bidders

July – October 2009

- Review bidders' proposals, finalize selection of successful bidders
- Develop contracts with partner agency
- Begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
In Our Own Words – Anti-Stigma Program	Individuals: 500 Families:	Individuals: Families:	12
Arts for Adult Resiliency and Social Connectedness	Individuals: 50 Families:	Individuals: Families:	12
Faith/Spirituality-Based Resiliency and Social Connectedness	Individuals: 200 Families:	Individuals: Families:	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 750 Families:	Individuals: Families:	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

Adult Resiliency and Social Connectedness Project will link individual participants in need of assessment or extended treatment for mental illness or emotional disturbance to appropriate mental health service providers by increasing

knowledge of mental health and primary care resources available in the community through outreach and awareness activities with implementing partners.

Additionally, social support facilitators will be trained in identification of onset and more advanced stages of mental illness, as well as basic system navigation.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Adult Resiliency and Social Connectedness Project will link individuals and family members to non-mental health service providers as needed. Implementing partner organizations within this project will provide many of these types of services.

Implementing partners will be required to develop linkages with the following organizations: (family resource centers, places of worship, advocacy organizations, community collaboratives, domestic violence, and substance abuse treatment, etc.). Linkages will be developed through the outreach activities of project artists, sponsoring organizations of In Our Own Voice and the expanded network that will emerge from the faith-/spirituality-based social support activities.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

This project includes three programs, one of which will be implemented by experienced existing partners who have the infrastructure and community credibility to successfully achieve the outcomes. The program is designed to build upon and leverage the existing assets and resources existing within this organization.

Projects in this plan will be linked with the Community Capacity Building Project to ensure providers of all PEI projects have the necessary technical assistance and training they need. Additionally, the Community Capacity Building Project will provide linkage and communication between projects and programs to facilitate mutual support and learning. Using the Asset Based Community Development approach, providers will be encouraged to collaborate and partner with other entities and engage non-traditional community resources.

Providers for the arts and faith/spirituality-based programs will be selected based on their interest, experience and community credibility to implement such a new and emerging approach to prevention. Consultation from individuals with expertise will be sought to assist in the programs' development.

Adult Resiliency and Social Connectedness Project will be linked with Community Capacity Building Project to provide necessary technical assistance and training for implementation partners. Additionally, the Community Capacity Building Project will facilitate linkage and communication with other PEI providers for purposes of mutual support, learning and additional non-MHSA funded opportunities.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Programs in this project will facilitate extensive collaborations and partnerships throughout the county. Some elements of the Adult Resiliency and Social Connectedness Project will be place-based and small in scale (e.g., creation of a social support group at a place of worship) while others will be much larger in scale, (e.g., creation of a countywide anti-stigma arts campaign). Regardless of program size, the Adult Resiliency and Social Connectedness Project will encourage implementation partners to collaborate with one another to enhance linkages. Project partners may include interfaith associations and individual faith communities; arts, advocacy, peer recovery, and spirituality/meditation organizations; adult schools and higher education; family resource centers, and other organizations with sufficient capacity to promote adult resiliency and social connectedness.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Implementation partners of the Adult Resiliency and Social Connectedness Project will work closely with health service providers including primary care, community clinics and behavioral health providers and organizations to ensure linkage and follow-up as needed.

Describe how resources will be leveraged and sustained

This project is based on the assumption of leveraging extensive resources provided by churches and other faith organizations, arts organizations and other community groups.

Implementation partners will be expected to recruit community volunteers, utilize existing facilities, and provide other in-kind support. Adult Resiliency and Social Connectedness Project will be sustained through PEI funding, however, implementation partners will be encouraged to further contribute in-kind support and seek additional funding.

7. Intended Outcomes

Describe intended individual outcomes.

- Increased participation in (improved access to) social support groups and activities
- Increased participation in arts by at-risk adults or persons in recovery
- Reduced internalized stigma regarding mental illness

Describe intended system and program outcomes.

- Increased number of faith/spirituality-based organizations providing social support groups and activities for at-risk adults
- Increased access to social support groups and other activities for culturally underserved communities and populations
- Increased awareness of the negative impacts of stigma on individuals
- Increased community capacity to provide social connections that are easily accessed and utilized by adults

Describe other proposed methods to measure success.

The degree to which implementation partners have established effective relationships and improved access throughout the county including outlying rural areas will be a method to measure success.

What will be different as a result of the PEI project and how will you know?

Stigma and discrimination experienced by individuals with emotional health concerns will be decreased and help-seeking through social and artistic connections will be widely promoted.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

Implementation partners will have access to technical assistance from CSS full service partners. Implementation partners will work closely with CSS outreach and engagement partners to assist in reaching underserved cultural/racial/ethnic populations.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Implementing partners will have access to WET resources including relevant training and career ladder services.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Unknown at this time - CFTN plan development and submission anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 5. Adult Resiliency and Social Connectiveness

Provider Name (if known): Stanislaus County Behavioral Health and Recovery Services

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	200
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	200
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Behavioral Health Advocate - .5 FTE	\$0	\$0	\$27,862	\$27,862
				\$0
				\$0
b. Benefits and Taxes @ 38%			\$10,587	\$10,587
c. Total Personnel Expenditures	\$0	\$0	\$38,449	\$38,449
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$1,000	\$1,000
b. Other Operating Expenses	\$0	\$0	\$35,551	\$35,551
c. Total Operating Expenses	\$0	\$0	\$36,551	\$36,551
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$0	\$75,000	\$75,000
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$75,000	\$75,000
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 5. Adult Resiliency and Social Connectiveness

Provider Name (if known): Not known at this time

Intended Provider Category: Not known at this time

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	550
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	550
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	0	0	0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$574,665	\$574,665
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$574,665	\$574,665
4. Total Proposed PEI Project Budget	\$0	\$0	\$574,665	\$574,665
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$574,665	\$574,665
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

County: Stanislaus **PEI Project Name:** Older Adult Resiliency & Social Connectedness **Date:** 4/6/09

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>		
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X

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

Older Adult Resiliency and Social Connectedness Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the county. BHRS partnered with the Area Agency on Aging and Commission on Aging to co-sponsor a targeted focus group dedicated to formulating needs, strategies and best ways to implement services to older adults. Older adult representatives and advocates actively participated throughout the PEI planning process.

Data analysis and community input process used for PEI was built on successes of the CSS process while also incorporating lessons learned along the way. The PEI process began with extensive outreach to ensure accessibility to stakeholders who wished to participate. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in the nine towns in Stanislaus County. Four community-based organizations that serve diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in depth perspective on emotional health within the ethnic/cultural communities they serve. The communities engaged included: Hispanic, African American, Southeast Asian, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ).

To help describe the needs of older adults, the PEI Planning Team presented community assessment themes that incorporated additional data and information obtained from previous MHSa planning processes: Community Services & Supports (CSS) and Workforce Education & Training (WET), Stanislaus County Health Services Agency's Community Health Assessment 2008, the BHRS Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of need in Stanislaus County.

Community stakeholders throughout the county expressed the need for transportation and suggested transportation as a PEI strategy to increase connectedness for all ages. This theme is especially important to older adults who have lost social connections because they no longer drive, have outlived friends and family or have lost ability to function independently. Overwhelmingly, there was input about how mental illness, depression, and co-occurring issues of substance abuse and physical illnesses impact many seniors. Compounding these issues is the fact that older adults are often misdiagnosed or simply overlooked due to the belief that the senior is "just experiencing the normal effects of aging." Seniors' are often vulnerable, isolated and for complex reasons experiencing reduced access to primary care and other support systems.

These themes exist in all cultural and ethnic communities throughout the county and a need for outreach, recreational, and educational activities that build protective factors of social connection and resiliency was strongly expressed.

Data Analysis:

Stanislaus County Community Health Survey was recently completed posing several questions to 2,800 Stanislaus County residents, the majority of whom were Hispanic/Latino; regarding health care and other concerns. The survey was conducted within agencies (including primary care clinics) serving primarily low-income residents.

- 24% of senior survey respondents reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.
- Of those who needed mental health treatment in the past 12 months, 31% were unable to receive treatment.
- The most common reasons for being unable to receive treatment were “No insurance” (56%), “Uncomfortable asking for help” (39%) “Couldn’t afford it” (28%), and “Transportation issues” (23%).
- For those seniors who didn’t get professional mental health assistance, the most common resources to which they turned were “church” (24%), “family” (24%), “friend” (20%), “doctor” (18%) and “spouse” (9%).
- In Stanislaus County, older adults have the highest rate of suicide of any age group and are often unable to access the care needed.

Substance Abuse Mental Health Services Administration (SAMHSA) has published the following facts about older adults:

- Risk factors for depression include: medical illness, impaired functional status, widowhood, social isolation and heavy alcohol consumption.
- A history of substance abuse is associated with increased risk of mental illness and, conversely, a history of mental illness is associated with a greater likelihood of having a substance use disorder
- Minor depression is present in 8 – 16% of older adults residing in the community, 15 – 20% of those receiving primary care services, 25 –33% in acute care hospitals, and up to 50% in long-term care facilities.
- Major depression and anxiety disorders are the most common mental health problems in older adults.
- Older adults are at a higher risk of committing suicide than any other age group.
- Older white men age 85+ have the highest suicide rate.
- Major depression is the strongest risk factor for suicide in older adults.

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

Stakeholders consistently indicated that access to needed mental health services was not available. This was especially true for older adults with early manifestations of distress, older adults who live in outlying areas of the county and older adults from ethnic minority populations. Spanish-speaking stakeholder groups especially noted the lack of access to mental health care as a major concern for individuals of all ages and their families. The expressed reasons for this lack of access included lack of services for years, recent reductions in BHRS facilities in outlying areas, lack of transportation, lack of information about what is available, general lack of awareness about mental illness, stigma and fear of labeling, and lack of awareness of effective treatment. In older adults there is a reluctance to ask for help that can be a significant barrier as well. When asked what settings older adults would feel the most comfort in receiving services, the answer frequently came back “in-home.”

This project will establish proposals to fund one or more community-based organizations to develop new programs and strategies designed to reach physically impaired and socially isolated seniors who are at higher risk of depression and suicide. The project has three types of programming that address psychosocial impacts of trauma and onset of depression and other disorders including co-occurring disorders in older adults. All program strategies begin to address stakeholder identification of community needs related to increasing supports in the community, include all age groups and improve access to services.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Bid applicants to be identified through RFP/RFA/RFQ process are expected to be senior-serving agencies that will work to educate, reduce stigma, develop innovative collaborations and partnerships (county-wide) that reduce disparities in access. Place-based service will be emphasized with the goal of infusing existing natural support sites with MHSA values/PEI interventions rather than establishing new agency-based services/providers.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The focus of this project is older at-risk adults. Community stakeholders throughout the county expressed the need for transportation as one method to increase connectedness for all ages. This theme was especially important to older adults who have lost social connections because they no longer drive, have outlived friends and family or have lost ability to function independently. Stakeholders emphasized the point that mental illness and the mix of prescribed medications with alcohol impacts many seniors who are often misdiagnosed, or their depression symptoms are overlooked due to the belief that the senior is just experiencing the normal effects of aging. Access to adequate and timely care are often complicated by stigma about mental illness, lack of awareness about the aging process as well as co-occurring issues of mental illness with substance use/abuse or physical illness. Seniors may also be vulnerable and isolated, with few support systems in place. These themes exist in all cultural and ethnic communities throughout the county. Strategies strongly suggested included outreach, recreational and educational activities that build protective factors of social connection and resiliency were.

Highlights of new or expanded programs

The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is a new early intervention program for people 60 years and older who are at risk for or have minor depression as a result of loneliness, isolation or recent loss. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS, is an established evidence-based program that provides eight sessions with a trained PEARLS counselor in the senior's home. The program is "participant-driven" and participants are helped and encouraged to feel confident in using existing community services and to attend local events. The home-based and individualized nature of this program makes it ideal for older adults who have become isolated due to losses in friendships due to death and loss of mobility due to physical changes and/or lack of transportation. Older adult stakeholders and advocates stressed over and over again the necessity of reaching out to homebound seniors who have lost contact with social connections as a method for reducing depression, suffering and suicide.

Senior Peer Counseling is a new selective prevention program based on a previously successful BHRS-based senior peer counseling outreach program with older adults that, though effective, ceased to exist in 2006 due to loss of funding. In the past, the program was based in the BHRS Senior Access Treatment Team. As a new community-based prevention program, it is proposed to be place-based where seniors go to access faith, social and recreational activities. Senior Peer Counselors will receive training and be certified as volunteers prior to engaging in peer counseling. Seniors who receive peer counseling may self-refer or be referred by other social service agencies, primary care, CSS outreach programs and

other referral sources. Individuals will be paired with a senior peer counselor who is old enough to be a peer and to have experienced many of the same life events. This community-evidence based program is successful in providing local seniors an age-mate contact who can make a difference in helping work through issues of emerging mental illness or life changes and bridge the barrier of not wanting to ask for help. Volunteers are also enriched by being able to directly contribute to the increased well-being of a member of their generation. The program will match at-risk seniors with peer counselors who have similar linguistic and cultural characteristics.

Senior Center Without Walls is based on an established and successful selective prevention program in Northern California. Local stakeholder input emphasized the need for outreach that was easy, low-cost and accessible to many at all levels of the socio-economic spectrum. Geographical location is a consideration since many diverse groups of seniors live in the most isolated in rural parts of Stanislaus County where buses and other transportation are not available. The program would offer over-the-phone activities, friendly conversation and an assortment of classes and support groups to homebound elders and those who find it difficult to go to a community senior center. Participation is possible from the comfort of home through telephone conference calls. Calls are free. A toll-free number is made available when participants register and connects them to the group conference call, which allows them to talk to each other, much like the old-fashioned “party lines”. Any type of telephone will work, even rotary dial. This is an established program in Northern California for which no research has been done to show evidence or promising practice, however, which clearly could be considered community-defined evidence.

Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

New partnerships with senior-serving agencies and community-based organizations will build on existing strengths and resources that exist within these organizations. Implementation partners will be selected through a request for proposals (RFP) process and are unknown at this time.

Programs in this project will be linked with the PEI Community Capacity Building Project to provide necessary training and technical assistance as well as facilitate networking and communication leading to mutual support and learning. It is expected that these Community Capacity Building activities will increase over the initial implementation and decrease and stabilize at some point in the future as communities and organizations develop their skills and capacity.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April – June 2009

- Conduct community-wide Prevention Summit

- Develop and release RFP/RFA/RFQ
- Conduct bidders' conference to encourage potential bidders

July – October 2009

- Review bidders' proposals,
- Finalize selection of successful bidders
- Develop contracts with partner agency
- Begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	Individuals: Families:	Individuals: 225 Families:	12
Senior Peer Counseling	Individuals: 75 Families:	Individuals: Families:	12
Senior Center Without Walls	Individuals: 100 Families:	Individuals: Families:	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 175 Families:	Individuals: 225 Families:	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The Older Adult Resiliency and Social Connectedness Project has three different approaches to linking older adults and their families to a variety of services in and out of home social supports, including but not limited to: (1) behavioral health care, (2) primary care, (3) other mental health and substance abuse providers. Linkages will include follow up to ensure that they received needed treatment or assessment. Implementing partners will be required to establish collaborative relationships with Stanislaus Behavioral Health and Recovery Services Senior Access Treatment Team as well as other established senior service mental health providers in the community to facilitate referrals between programs and effective use of mutual resources.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Older Adult Resiliency and Social Connectedness Project will connect older adults and their families to non-traditional prevention programs that increase resiliency and social connection including, but not limited to: senior centers, park and recreation programs, faith-based supports, meals programs, transportation supports and other supports as needed. All three older adult PEI programs will include outreach through non-traditional partners including underserved cultural populations to build community capacity and social connection for seniors throughout Stanislaus County. Implementing partners will be required to establish collaborative relationships with senior/aging services providers, health care providers and social service agencies to facilitate referrals between programs and effective use of mutual resources. Implementing partners will be encouraged to establish partnerships with family resource centers and neighborhood collaboratives so that services will be accessible throughout the county and integrated into local community networks. This is instrumental in establishing an across-the-age-groups theme expressed by stakeholders.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

Implementation partners will be knowledgeable in issues related to older adults. They may also be experienced senior-service agencies with existing policies that have the infrastructure and community credibility to successfully achieve outcomes. They may also be community partners who wish to expand service to older adult populations. The project is designed to build upon and leverage existing assets and resources within the implementing organization. Model programs such as PEARLS have consultation available for newly implemented sites.

Projects in this plan will be linked with Community Capacity Building Project to ensure providers of all PEI projects have the necessary technical assistance and training they need. Additionally, the Community Capacity Building Project will provide linkage and communication between projects and programs to facilitate mutual support and learning. Using the Asset Based Community Development approach, providers will be encouraged to collaborate and partner with other entities and engage non-traditional community resources.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Programs established under the Older Adult Resiliency and Social Connectedness Project will be promoted through systematic outreach countywide through civic organizations and service clubs, faith-based organizations of all types, and public and private agencies. In addition, part of the technical assistance available through Community Capacity Building Projects will include enhanced collaboration and interaction among all PEI providers.

Programs in this project will facilitate extensive collaborations and partnerships throughout the county. Some elements of Older Adult Resiliency and Social Connectedness Project will be designed to reach beyond transportation issues that many seniors face. Older Adult Resiliency and Social Connectedness Project will encourage implementation partners to collaborate with one another to enhance linkages. For example, in the PEARLS program, the PEARLS counselor is trained to recognize and facilitate linkages to primary care and other community-based services.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Programs established under Older Adult Resiliency and Social Connectedness Project will work closely with existing health service providers including primary care, community clinics and behavioral health to ensure linkage and follow-up as needed, and to emphasize the importance of continuity in healthcare for older adults.

Describe how resources will be leveraged and sustained.

It is anticipated that implementing partners will utilize community volunteers, existing facilities and other existing resources. Programs will be located in existing sites that are occupied by senior serving organizations, community and neighborhood collaboratives and others.

By requiring collaborative relationships between implementing partners and other senior/aging services, the resources and strengths of all the senior/aging services system can be leveraged to better address prevention and early interventions.

7. Intended Outcomes

Individual outcomes

- Identification of depressive disorders
- Management of depressive symptoms
- Decreasing isolation,
- Increasing social support
- Increased access to community-based services
- Identification of suicide risk

System and program outcomes

- Improved access and coordination of integrated older adult mental health service
- Increased community capacity to provide social connections that are easily accessed and utilized by older adults
- Engagement of individuals from underserved cultural populations
- Provider/volunteer satisfaction

Other proposed methods to measure success.

Overall success will be measured by the degree to which implementing partners have established effective relationships and access throughout the county, including outlying rural areas.

What will be different as a result of the PEI project and how will you know?

Seniors will be routinely included in social, community and service activities promoting healthy aspects of aging and promoting positive emotional health. Suicide rates for seniors will decrease in Stanislaus County.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

BHRS and the community agency that successfully bids for the Older Adult Resiliency and Social Connectedness Project will, in partnership with local stakeholders such as Stanislaus County Commission on Aging and Mental Health Board, promote coordination, project oversight and leveraging of resources to continue to develop and expand community capacity to support older adults.

Service coordination for older adults with more severe mental illness who are identified through PEI outreach will occur primarily between PEI Programs and CSS Senior Access Resource Team Full Service Partnership (FSP) as well as the well-established BHRS Realignment and SAMHSA-funded Senior Access Treatment Team. Manager of the two older adult service teams will work with the PEI program contractor to improve coordination and collaboration across providers and with other community-based partners.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Implementing partners will have access to WET resources including relevant training, volunteer coordination and career ladder services.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Unknown at this time - CFTN plan development and submission anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 6. Older Adult Resiliency and Social Connectiveness

Provider Name (if known): Not known at this time

Intended Provider Category: Not known at this time

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	400
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	400
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	0	0	0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$842,832	\$842,832
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$842,832	\$842,832
4. Total Proposed PEI Project Budget	\$0	\$0	\$842,832	\$842,832
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$842,832	\$842,832
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

County: Stanislaus

PEI Project Name: Health/ Behavioral Health Integration

Date: 4/6/09

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>		
4. Stigma and Discrimination	X	X	X	X
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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	X	X	X	X

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

Health/Behavioral Health Integration Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the county. Stanislaus County BHRS conducted focus groups dedicated to identifying needs, strategies and best ways to implement services. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in the nine towns in Stanislaus County. Four community-based organizations serving diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. Communities engaged by these organizations include: Hispanic, African American, Southeast Asian, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ). A specific focus group was conducted with health care providers throughout the county. Additionally, health care providers participated in many of the community focus groups held throughout the county.

To help describe the needs of older adults, the PEI Planning Team presented community assessment themes that incorporated additional data and information obtained from previous MHSA planning processes: Community Services & Supports (CSS) and Workforce Education & Training (WET)], Stanislaus County Health Services Agency's Community Health Assessment 2008, and BHRS Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of the needs of Stanislaus County.

Programs selected for the project were a result of program selection workgroups held in January 2009, following the RSSC recommendations for PEI Projects. In a workgroup focused on health care providers, participants strongly recommended expanding the very limited mental health capacity that currently exists within primary care settings as a means to address disparities in access to behavioral health care that exist for culturally underserved populations and outlying geographic locations.

Other stakeholders gave input supporting the idea that primary health care settings are desirable in that they are frequently used, generally accessible and considered non-stigmatizing service settings for behavioral health early intervention services to be delivered. Stakeholders also suggested that there is a neighborhood connection between primary care clinics, faith organizations and schools that will interact to strengthen access. Placing behavioral health prevention and early intervention strategies in these non-stigmatizing settings will ensure that community capacity will be expanded during implementation of the PEI Plan. These non-traditional settings will increase access by culturally underserved populations and allow for linkages to traditional mental health settings when stepped-up service is necessary.

Data Analysis:

Stanislaus County Community Health Survey completed in 2008 posed several questions to 2,800 Stanislaus County residents, the majority of whom were Hispanic/Latino, regarding health care and other concerns. Several questions related to behavioral health.

- One question was, “During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities in 2008?” Thirty percent of respondents indicated “Yes” in response to the question.
- A second question asked, “If you needed mental health treatment (counseling or other help) in the past 12 months, were you able to receive it in 2008?” Forty three percent responded with a “No” to the question.
- The survey was conducted within agencies (including primary care clinics) serving primarily low-income residents. Community health centers within Stanislaus County have demonstrated their ability to serve underserved cultural populations.

Surgeon General’s Report offers the following data to support integration of behavioral health in primary care settings:

- Primary care clinicians are, and will continue to be, an important first resource for parents who are worried about their child’s behavioral problems.

World Health Organization (WHO) has called integrating mental health services into primary care the most viable way of closing the treatment gap for untreated mental illnesses, characterizing primary care for mental health as affordable and an investment that can bring important benefits.

Integrated Behavioral Health Project (IBHP) website offers the following reasons to pursue behavioral health integration in primary care:

- Many people being served by public behavioral health services need better access to primary care, and conversely, community health centers serve people who need better access to behavioral healthcare.
- Psychosocial stress is a major factor in triggering physical illness and exacerbating existing chronic illnesses.
- Many individuals seeking medical services report symptoms that may be psychosomatic, i.e., physical complaints without an identifiable medical basis. In these instances, an underlying behavioral or emotional condition can increase unnecessary medical utilization and the client is often not referred to appropriate treatment.

- Group-oriented behavioral interventions have been found useful in addressing emotional factors in chronic and acute disease, improving adherence to medical regimens.
- Co-occurring problems with substance abuse often go unrecognized but can trigger or exacerbate a variety of physical illnesses and conditions e.g., accident-related injuries, gastritis, diabetes and hypertension, liver abnormalities and cardiac problems.
- Sub-clinical and clinical depression is frequently misdiagnosed or under diagnosed in general medical populations (all age groups).

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This project will establish proposals to fund behavioral health clinicians and psychiatric consultation to occur in primary care health clinics serving primarily underserved cultural communities. The project will interface with several other projects in this plan to ensure continuity of care to older adults, children/youth, and adults who are at risk of depression and suicide due to untreated behavioral health issues. The project includes one program implemented at numerous sites throughout the county to begin to address stakeholder identified needs related to increasing supports in the community, include all age groups, and improve access to services.

Stakeholders consistently indicated that access to needed mental health services was not available enough to meet the needs in their communities. This was especially true for persons with early manifestations of distress, persons who live in outlying areas of the county and those from ethnic minority populations. Spanish-speaking stakeholder groups especially noted the lack of access to care as a major concern for individuals of all ages and their families.

The expressed reasons for this increased lack of access included closing of BHRS service sites in outlying areas, lack of transportation to centrally located services in Modesto, lack of information about what is available, general lack of awareness about mental illness and treatment options, minimization by others related to the need for behavioral health treatment (stigma) and fear of labeling. When asked what settings stakeholders would feel the most comfortable in receiving services at, the most frequently mentioned setting was primary care. By avoiding the stigma often associated with behavioral health clinics, this project will address disparities in access to behavioral health care for underserved cultural communities as well as suicide risk for persons of all ages.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Implementing partners will be community health centers providing primary care primarily to low income individuals. It is expected that most will have designation as Federally Qualified Health Centers.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

Primary goal of this project is increased access to screening and early intervention services for persons from underserved communities (primarily Hispanic/Latino, Asian and African-American). Stanislaus BHRS will contract with community center organizations that have demonstrated ability to serve underserved cultural/ethnic populations. Based on stakeholder input, they will be sited in smaller outlying communities as well as underserved parts of West Modesto and Turlock.

Highlights of new or expanded programs

This project will expand on an effective model of behavioral health integration with primary care that is currently used in selected community health centers within Stanislaus County. Clinicians and psychiatrists will be embedded in five additional centers throughout the county that provide primary healthcare to lower income individuals and families. Key functions and tasks will include:

- Routine screening: establishing and implementing routine use of screening protocols and instruments to identify behavioral health conditions such as depressive and anxiety disorders and co-occurring substance abuse.
- Assessment: concurrently or upon referral from primary care provider, mental health clinicians will provide assessment of behavioral health concerns. Emphasis will be on “warm handoffs” from primary care providers that have been shown to increase return visits to the behavioral health provider.
- Consultation with primary care providers: behavioral health providers will be available to assist with treatment planning and care management.
- Brief intervention: brief, focused intervention for individuals who are in need of mental health services
- Psychiatric assessment and consultation: initial diagnostic and/or medication assessment by a psychiatrist and immediate consultation with primary care provider when requested.
- Care management: monitor and coordinate the delivery of behavioral health services including linking with other service providers.

- Stepped care: advise provider about which clients are better served at the primary care setting and which should be referred to specialty mental health.
- Disease management protocols: implementation of standardized approaches to behavioral health concerns
- Education and training: consultation and training to primary care providers and their staff to enhance their skill and effectiveness in treating behavioral health problems.

Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Request for qualifications will be requested from all community health clinic organizations within the county. It is expected that at least five sites will be selected within underserved communities. Clinics will be required to demonstrate their capacity to serve underserved populations and a commitment to integrated behavioral healthcare within their sites. Selections will be made based on the ability to leverage federal reimbursement, distribution of the service throughout the county, community system integration and community needs.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April - June 2009

- Conduct communitywide Prevention Summit
- Develop and release RFP/RFA/RFQ
- Conduct bidders' conference to encourage new potential bidders

July – October 2009

- Review bidders' proposals, finalize selection of successful bidders
- Develop contracts with partner agency to begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Embedded Mental Health Clinicians within Community Health Centers	Individuals: 0 Families: 0	Individuals: 2500 Families: 0	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 0 Families: 0	Individuals: 2500 Families:	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

Individuals who need specialty mental health care due to lack of effective response within primary care or due to serious and persistent conditions will be linked by clinicians to appropriate care within BHRS or other appropriate care and services. The model includes case management and providers will be required to provide case management services to participants including those who need to be stepped up to specialty mental health.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Providers will be encouraged to collaborate with local community-based organizations such as family resource centers, neighborhood collaboratives, and school resource/health centers that provide a range of services to individuals and families. Behavioral health clinicians must have both mental health and substance abuse competency and knowledge of community resources for a variety of psychosocial conditions. The model includes case management and providers will be required to provide case management and linkage to these other services when needed.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

Overall goal of the PEI plan is the increased capacity of communities and their organizations to provide behavioral health prevention and early intervention services. All projects in this plan will be linked with Community Capacity Building Project to ensure the providers of all PEI projects have the necessary technical assistance and training they need. Additionally, Community Capacity Building Project will provide linkage and communication between projects and programs to facilitate mutual support and learning. Using the Asset Based Community Development approach, providers will be encouraged to collaborate and partner with other entities, engage community leaders, volunteers and other resources, and generally organize supportive environments within their communities. Selected partners for this project will be required to employ behavioral health clinicians who have both mental health and substance abuse competency and knowledge of evidence-based behavioral assessments and interventions relevant to medical conditions (e.g., disease management, treatment adherence, and lifestyle change), as well as consultation liaison skills.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Due to lack of access to privately operated and publicly operated behavioral health and recovery services, many individuals with serious and persistent mental illnesses seek care within the Stanislaus County Health Services Agency primary care clinics. BHRS currently collaborates with the Stanislaus County Health Services Agency to provide limited psychiatric consultation to primary care physicians within their clinics to assist them with care management. This project will expand that collaboration to provide early intervention and some prevention services to primary care clients that are not currently within the scope of current collaboration. Expansion will also include community health centers that are not part of county Health Services Agency.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

This expansion should have the effect of making integrated behavioral health services available in all regions of the county including areas where there are little or no behavioral health services of any kind. Additionally, successful bidders will be expected to develop formal and informal linkages with local human service providers such as family resource centers, neighborhood collaboratives, school resource/health centers, schools, etc. This will further integrate behavioral health as well as primary care into local neighborhood collaboratives to improve access to care and community services.

Describe how resources will be leveraged and sustained.

By partnering with community health centers, PEI funds will leverage federal reimbursement for eligible clients for behavioral health services (early intervention), allowing a greater expansion than would otherwise be possible. This should also facilitate sustainability over time.

7. Intended Outcomes

Individual outcomes

- Identification of persons suffering from depressive, anxiety, co-occurring and other disorders.
- Reduction in depressive symptoms including suicide risk
- Participant satisfaction

System and program outcomes

- Increased overall access to behavioral health care within Stanislaus County
- Engagement of individuals from underserved cultural populations
- Provider satisfaction

Other measures of success

- Amount of leveraged federal reimbursement

What will be different as a result of the PEI project and how will you know?

Integrated behavioral health services will be available in all regions of the county including areas where there are little or no behavioral health services available. As a result, more individuals from culturally diverse populations will be able to seamlessly access non-stigmatizing behavioral health assistance along with other health services as part of an overall health/wellness approach. Resiliency and healthy coping with the normal stresses of life will improve and there will be an increase in productivity and contribution to the individual's community.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

It is expected that CSS outreach and engagement activities will identify individuals who do not need MHSA CSS services or specialty mental health services but who can be linked with primary care clinics with integrated behavioral health

components. Individuals who require stepped up care from primary care will be considered for CSS FSPs where appropriate.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

WET resources will be available to this project including access to training, clinical supervision, and loan forgiveness programs.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

Unknown at this time – plan development and submission is anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 7. Health/Behavioral Health Integration

Provider Name (if known): Not known at this time

Intended Provider Category: Not known at this time

Proposed Total Number of Individuals to be served: FY 07-08 0 FY 08-09 0 FY 09-10 2,500

Total Number of Individuals currently being served: FY 07-08 0 FY 08-09 0 FY 09-10 -

Total Number of Individuals to be served through PEI Expansion: FY 07-08 0 FY 08-09 0 FY 09-10 2,500

Months of Operation: FY 07-08 0 FY 08-09 0 FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	0	0	0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$375,000	\$375,000
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$375,000	\$375,000
4. Total Proposed PEI Project Budget	\$0	\$0	\$375,000	\$375,000
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$375,000	\$375,000
6. Total In-Kind Contributions	\$0	\$0	\$120,000	\$120,000

County: Stanislaus

School-Behavioral Health Integration

4/6/09

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	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	X	X	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>

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

School-Behavioral Health Integration Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the county. BHRS partnered with children- and youth-serving community-based organizations, NAMI, and schools to co-sponsor targeted focus groups dedicated to formulating needs, strategies and best ways to implement services to children and youth. Youth representatives and advocates actively participated throughout the PEI planning process. Stanislaus BHRS partnered with children's services providers to conduct a large, well-attended focus group for persons who work with children and youth. Among the participants were representatives from the County Office of Education, Modesto City Schools, and representatives from the local chapter of National Alliance on Mental Illness (NAMI).

Community input process used for PEI was built on successes of the CSS process, while also incorporating lessons learned along the way. The PEI process began with extensive outreach to ensure accessibility to stakeholders who wished to participate. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in nine cities in Stanislaus County. Four community-based organizations that serve diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. The communities engaged included: Hispanic, African American, Southeast Asian and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ).

To further describe the needs of children and youth, the PEI Planning Team incorporated data and information obtained from previous MHSA planning processes: Community Services & Supports (CSS) and Workforce Education & Training (WET), Stanislaus County Health Services Agency's Community Health Assessment 2008, and BHRS Substance Abuse Prevention Plan. Other sources of data were also reviewed to provide a more complete view of the needs of the priority population in Stanislaus County.

Community stakeholders resoundingly expressed and representative stakeholders agreed with the idea that programs and strategies must be place-based, situated locally, serve the particular needs and match with existing assets of the communities in which the programs and resources are situated.

Schools are recommended by local stakeholders as an ideal setting for behavioral health prevention and early intervention services for children and youth at risk for school failure, children in stressed families, underserved cultural populations and trauma-affected youth. Youth stakeholders recommended integrated student-driven or student-centered

activities, services and resources for enhancing resiliency and educators recommended additional supports and resources for teachers and other school staff.

Data Analysis:

According to Surgeon's General Report on Mental Health 1999, schools are a primary setting for potential identification of mental illness in children and adolescents, since half of all lifetime cases of mental illness begin at or before age 14.

Research has shown that unrecognized or untreated mental and emotional health illnesses increase youths' risk of school failure and dropout, alcohol and drug use as well as other difficulties.

Onset of psychosis and early signs of emotional and behavioral health problems, when not identified or left untreated in childhood or youth, may become more difficult to treat in adulthood and may develop into co-occurring disorders.

A report from the University of Maryland that studied the Parents and Teacher as Allies (PTASA) program reported the following:

- Children with undiagnosed and untreated mental illness cannot participate in school. Approximately 50% of students with mental illnesses aged 14 and older drop out of high school--the highest dropout rate of any disability group.
- Strengthening the alliance between families and schools is necessary to help prevent the unnecessary daily struggles and challenges faced by students with mental illnesses.
- School professionals admit feeling ill equipped to address the needs of students living with mental illnesses and how best to work with families on this issue. Schools are in a key position to identify mental health concerns early and to openly communicate with families.

According to the most recent California Healthy Kids Survey, nearly 1 out of 10 students in secondary education have been harassed or bullied for being gay/lesbian including when other students thought they might be gay/lesbian.

San Francisco State University's César E. Chávez Institute found that lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are up to 4 times more likely to attempt suicide than their heterosexual peers. Furthermore, LGBTQ youth who come from a rejecting family are up to 9 times more likely to attempt suicide than their heterosexual peers.

State of California Department of Education data released on July 16, 2008, revealed high dropout rates for minority students in Stanislaus County: 41% among black students, 31% among Native American students, 30% among Hispanic students, and 28% among Pacific Islander students. White students had a 15% dropout rate, while Asians had a 10% dropout rate.

There is a significant educational attainment gap between Anglos, African Americans, and Latinos in Stanislaus County in terms of high school graduation rates. Educational attainment for African American and Latino 19 & 20-year-olds for the County was only modestly above 50% based on 2000 Census data. There is a strong link between educational attainment and mental health problems. Based on the California Health Interview Survey (CHIS), the rate of mental health needs for “less than high school education” is 3 times that for college grads. Educational test scores illustrate that it is not a mystery who will not graduate – the vast majority of the “non high school graduates” have English Language Acquisition (ELA) and math test scores “below basic” or “far below basic” in the second grade. Many of the low academic achievers in the second grade have attendance and behavioral problems starting in kindergarten.

According to the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice, truancy has been correlated with students dropping out of high school and represents a risk factor for educational failure, social isolation, alcohol and drug abuse, and criminality. Thirty-six percent of Stanislaus County students (as compared with twenty-five percent of California students), were truant in 2006-2007, according to the Great Valley Center’s 2008 report, *Assessing the Region Via Indicators: Education and Youth Preparedness*. (A truant student is defined as a student with an unexcused absence or tardy for three or more days in an academic year.)

3. PEI Project Description:

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

School-Behavioral Health Integration Project is an early intervention project, with some elements of prevention, that serve at-risk children, youth, educational professionals and parents. The early intervention focus is on preventing school failure and other psychosocial problems resulting from early onset of mental illness, trauma and family stress. The project will consist of a range of multi-faceted activities including embedding a mental health clinician within a school setting to provide behavioral health consultation, substance abuse problem identification, screening and referral, support for educational professionals and parents, screening and early interventions for behavior and emotional problems of students.

Project addresses concerns raised consistently through the stakeholder process by youth, parents and educators about the increasing focus on academic achievement at the expense of other support services for at-risk children and youth. Integration of behavioral health in school supports the expressed beliefs of parents, teachers, school administrators and other community members that the most effective prevention and early intervention setting is school where children/youth spend a large portion of their day.

This project is based on elements from a variety of successful program models including school-based mental health consultation, student assistance programs, classroom-based mental health education and intervention programs, and school professionals' in-service programs.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions.

Multiple implementation partners may include schools and child/youth-serving community-based organizations that have demonstrated successful partnerships with school systems and community-based organizations offering parent/educator education and support. The project will be designed to engage graduate training programs in behavioral health professions to leverage PEI resources.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic, and/or cultural populations to be served.

School-Behavioral Health Integration Project will target youth at risk for school failure, experiencing early onset of serious mental illness, exposed to trauma, and in stressed families. Services and resources will be available to all students and school professionals and extensive interfacing with family resource centers and other child/youth-serving community-based organizations will emphasize services to underserved cultural and racial/ethnic populations.

Peer-to-peer activities will be established or expanded to serve lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students who are at special risk of trauma, substance abuse and suicide, as well as other students from underserved cultural and racial/ethnic groups.

Primary goal will be to work with youth in a school setting who are at risk of school failure due to a variety of reasons. The School-Behavioral Health Integration Project will target schools in geographic areas with extensive underserved cultural populations and with strong or emerging community infrastructure to support extensive collaboration between schools and other community assets (e.g., family resource centers, community health centers, neighborhood collaboratives, and grassroots associations).

Highlights of new or expanded programs.

The project consists of two programs: Student Assistance and School-Based Consultation and Parents and Teachers as Allies (PTASA). Both programs will rely on new and established partnerships with more than one school site within the county

Key aspects of the program include:

- On site behavioral health clinicians (full-or part-time)
- Consultation regarding behavioral health concerns to teachers, administrators and family members
- Screening, observation and assessment (with parental permission) of students for emotional health problems
- Substance abuse problem identification, screening and referral
- Student assistance services such as short-term counseling for students and their families
- Facilitation of student support groups
- Classroom mental health-oriented education and activities
- Classroom interventions
- Parent education
- Education of teachers and other school personnel
- Referral and linkage with behavioral health and other resources when needed

Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Requests for RFP/RFQ/RFA will be requested from child/youth-serving organizations throughout the county. It is expected that five or more sites will be selected to ensure many geographical areas of the county are included. Selected schools or organizations will be required to demonstrate their capacity to serve underserved cultural and racial/ethnic populations and ability to collaborate with other services and resources within their communities. Selections will be made based on distribution throughout the county, community system integration and community needs. Child/youth/family serving organizations must demonstrate partnerships with and commitment of school sites.

PTASA is a NAMI-developed program with national resources available for local implementation. Existing partnership with the local chapter of the National Alliance on Mental Illness (NAMI) will be expanded to implement the PTASA program.

NAMI will be required to develop new partnerships with individuals and groups in the community, community-based agencies who successfully bid for other programs in the PEI plan, and schools throughout the county.

Programs will be linked with PEI Community Capacity Building Project to provide necessary training and technical assistance as well as facilitate networking and communication leading to mutual support and learning. It is expected that these community capacity building activities will increase over the initial implementation and decrease and stabilize at some point in the future as communities and organizations develop their skills and capacity.

Key milestones and anticipated timeline for each milestone.

Pre-Implementation: April – June 2009

- Conduct communitywide Prevention Summit
- Develop and release RFP/RFA/RFQ
- Conduct bidders' conference to encourage potential bidders
- Begin contract discussions with NAMI-Stanislaus Chapter representatives

July – October 2009

- Review bidders' proposals,
- Finalize selection of successful bidders
- Develop contracts with partner agencies
- Begin implementation

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Student Assistance and School-Based Consultation Program	Individuals: 500 Families: 0	Individuals: 350 Families: 0	12
Parents and Teachers as Allies (PTASA)	Individuals: 120 Families: 0	Individuals: 120 Families: 0	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 620 Families: 0	Individuals: 470 Families: 0	12

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

Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

Children and youth identified as exhibiting early onset of serious mental illness or serious emotional disturbance will be screened. Those whose symptoms warrant more extensive evaluation and/or services will be referred to appropriate other in-school resources (such as special education) or to community providers. The embedded clinician will be familiar with behavioral health resources and primary care providers. Clinicians will develop collaborative relationships with key service providers, to which they make referrals, including but not limited, to BHRS Children's System of Care.

Two-hour in-service programs will be conducted with school professionals to assist them in identifying early warning signs of early-onset mental illnesses in children and adolescents. The focus is on specific, age-related symptoms of mental illnesses in youth, how best to intervene, and shared lived experiences of consumers and families. Information regarding existing treatment resources will be part of in-service.

Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Programs in the School-Behavioral Health Integration Project will require collaboration with other services and resources in the community and within the school (e.g., after school programs, clubs, athletics). The goal of collaboration between services is to ensure smooth and easy access to multidisciplinary service linkages.

Implementation partners will provide educators, student, and family members with referrals and will assist with linkage to other community resources to enhance protective and reduce risk factors both in school and at home. NAMI has a successful Family-to-Family Program offered in Spanish and English to support parents/family members.

Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

This project will be implemented by family/child/youth-serving organizations that have the infrastructure, policies and community credibility to achieve the outcomes. Programs are designed to build upon and leverage the existing assets and resources within these organizations. Organizations will understand and agree that community capacity building is a feature of prevention and early intervention success and sustainability. Clinicians will have access to consultation and supervision themselves to ensure necessary skills and resources needed to do their work.

All projects in the Stanislaus PEI plan will be linked with Community Capacity Building Project to ensure providers of all PEI projects have necessary technical assistance and training they need. Additionally, Community Capacity Building Project will provide linkage and communication between projects and programs to facilitate mutual support and learning. Using the Asset Based Community Development approach, providers will be encouraged to collaborate and partner with other entities and engage non-traditional community resources.

6. Collaboration and System Enhancements

Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

All projects within this PEI Plan have been selected and designed to increase overall capacity to provide behavioral health services and supports to individuals and families within Stanislaus County. Collaboration will be required between implementing agencies and other local community organizations and resources (e.g., health clinics, schools, local government, etc.) All projects will be linked to an overall community capacity building strategy to leverage collaborative relationships and unique strengths of each community into more than their component programs. These organizations and collaborative relationships will be provided with technical assistance, support and training as needed to not only implement programs in this project but also to identify and create additional related resources that build resiliency within children and youth in their communities.

School-Behavioral Health Integration Project implementers will be required to create and enhance linkages among schools, community-based organizations and grassroots associations that are not behavioral health service providers but have demonstrated the capacity to care for families within their community through social support, outreach programs and securing basic needs. Accessibility and permanence of community-based services, especially ones with integrated services and resources, reduce stigma commonly associated with seeking mental health services.

Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Stanislaus County has a rich network of family resource centers, neighborhood collaboratives and school resource/health centers. These community-based organizations provide prevention and early intervention services and supports to families within these communities and have partnerships with local schools, larger public agencies, and other community-based organizations. They employ individuals from targeted communities and have governance and advisory boards composed of representatives of communities they serve, lack the stigma associated with more formal agencies, especially mental health programs, and are in a position to identify at risk children and youth including youth at-risk of substance abuse, effects of trauma and school failure. Programs within School-Behavioral Health Integration Project will be required to partner with these organizations to ensure linkages and community supports for diverse underserved cultural populations.

School-Behavioral Health Integration Project will be knowledgeable about and establish relationships with existing health service providers including community clinics and behavioral health providers serving the school community to ensure linkage and follow-up as needed. These partnerships will focus on facilitating referral to programs in this project and training by project programs to enable these community-based organizations to enhance their services.

Describe how resources will be leveraged and sustained.

Resources will be leveraged through the use of schools' physical space and other in-kind school-based resources (e.g., after school programs, special education services, etc). Federal reimbursement will be pursued where feasible but will not drive programming or eligibility.

School-Behavioral Health Integration Project will be sustained through PEI funding and implementation partners will be encouraged to contribute in-kind support and seek additional funding opportunities. Sustainability will be further enhanced if graduate training programs for mental health professionals are engaged to develop field-training sites at targeted school sites. Implementing sites will be encouraged to utilize embedded clinicians to provide necessary supervision to allow for this expansion of resources.

7. Intended Outcomes

Describe intended individual outcomes.

- Reduced detentions, suspensions and expulsions of targeted participants
- Reduced absences and trancies of targeted participants
- Identification of students with behavioral health problems
- Increased educator knowledge of early warning signs of early-onset mental illnesses in children/youth
- Increased educator ability to identify and refer children/youth who show early warning signs of early-onset mental illnesses

Describe intended system and program outcomes.

- Improved access to behavioral health services for students and their families
- Increased competency of school personnel to manage behavioral health problems in students
- Teacher satisfaction
- Parent satisfaction

Describe other proposed methods to measure success and what will be different as a result of the PEI project and how will you know?

The project will increase awareness and supports in school environments as well as capacity for early intervention that prevents and avoids consequences of school failure due to untreated mental illness.

Education about early warning signs in the school environment will raise awareness in educators, children/youth, and parents that will result in increased early identification and access to services that will lead to early intervention. Delay in treatment will be reduced or eliminated, thereby avoiding suffering and the everlasting, long-term negative consequences of inadequate or no treatment.

Implementing partners of these programs, as with all projects in this plan, will be encouraged to participate in and facilitate increased capacity for addressing behavioral health concerns in their communities. The degree to which this is accomplished will be the measure of success of this project.

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

Service coordination for children and youth with more severe mental illness who are identified through School-Behavioral Health Integration Project will occur with the Children's System of Care but may also be supported by CSS General System Development (GSD) and Full Service Partnership (FSP) programs that serve children and youth, (e.g., Josie's Place, TAY Drop-in Center, Families Together or Juvenile Justice FSP.)

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

Implementing partners will have access to MHSA Workforce Education and Training (WET) resources including relevant training, career pathways and financial incentives. Graduate training programs will be encouraged to use projects sites for training of students supported by WET-funded mental health stipends.

Describe intended use of Capital Facilities and Technology (CFTN) funds for PEI projects, if applicable.

Unknown at this time - CFTN plan development and submission anticipated in FY2009/10.

PEI Revenue and Expenditure Budget Worksheet

**Form
No. 4**

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

County Name: STANISLAUS

Date: 2/23/2009

PEI Project Name: 8. School/Behavioral Health Integration

Provider Name (if known): Not known at this time

Intended Provider Category: Not known at this time

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0	FY 09-10	850
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0	FY 09-10	-
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0	FY 09-10	850
Months of Operation:	FY 07-08	0	FY 08-09	0	FY 09-10	12

Proposed Expenses and Revenues	Total Program/PEI Project Budget			
	FY 07-08	FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
_____	\$0	\$0	\$0	\$0
_____				\$0
_____				\$0
b. Benefits and Taxes @				\$0
c. Total Personnel Expenditures	\$0	\$0	\$0	\$0
2. Operating Expenditures				
a. Facility Cost	\$0	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
To be determined	\$0	\$0	\$677,276	\$677,276
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$677,276	\$677,276
4. Total Proposed PEI Project Budget	\$0	\$0	\$677,276	\$677,276
B. Revenues (list/itemize by fund source)				
None known at this time	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
_____	\$0	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$0	\$677,276	\$677,276
6. Total In-Kind Contributions	\$0	\$0	\$0	\$0

PEI Administration Budget Worksheet

Form No.5

County: Stanislaus

Date: 2/23/2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures						
1. Personnel Expenditures						
a. PEI Coordinator/Manager		1.00	\$3,693	\$56,940	\$83,138	\$143,771
b. PEI Support Staff		1.25	\$258	\$33,080	\$58,484	\$91,822
c. Other Personnel (list all classifications)						\$0
Staff Services Coordinator		1.00		\$28,379	\$70,949	\$99,328
PEI Consultant		1.00		\$22,500	\$100,000	\$122,500
Staff Services Analyst		1.00			\$58,448	\$58,448
						\$0
d. Employee Benefits 38%			\$273	\$53,542	\$140,987	\$194,802
e. Total Personnel Expenditures		5.25	\$4,224	\$194,441	\$512,006	\$710,671
2. Operating Expenditures						
a. Facility Costs			\$0	\$0	\$0	\$0
b. Other Operating Expenditures			\$41,350	\$114,809	\$280,980	\$437,139
c. Total Operating Expenditures			\$41,350	\$114,809	\$280,980	\$437,139
3. County Allocated Administration						
a. Total County Administration Cost A-87 17.88% of Salaries			\$0	\$18,627	\$66,338	\$84,965
4. Total PEI Funding Request for County Administration Budget			\$45,574	\$327,877	\$859,324	\$1,232,775
B. Revenue						
1 Total Revenue			\$0	\$0	\$0	\$0
C. Total C. Total Funding Requirements			\$45,574	\$327,877	\$859,324	\$1,232,775
D. Total In-Kind Contributions			\$0	\$0	\$0	\$0

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form
No. 6

County: Stanislaus
Date: February 23, 2009

#	List each PEI Project	Fiscal Year				Funds Requested by Age Group			
		FY 07/08	FY 08/09	FY 09/10	Total	Children, Youth, and their Families	Transition Age Youth	Adult	Older Adult
1	Community Capacity Building	\$0	\$0	\$1,718,414	\$1,718,414	\$515,524	\$429,604	\$343,683	\$429,604
2	Emotional Health and Wellness/Education Awareness and Education/Community Support Development	\$0	\$0	\$646,850	\$646,850	\$194,055	\$194,055	\$129,370	\$129,370
3	Childhood Adverse Experience Intervention	\$0	\$0	\$764,276	\$764,276	\$343,924	\$343,924	\$38,214	\$38,214
4	Child and Youth Resiliency and Development	\$0	\$0	\$564,276	\$564,276	\$282,138	\$282,138	\$0	\$0
5	Adult Resiliency and Social Connectiveness	\$0	\$0	\$649,665	\$649,665	\$0	\$0	\$649,665	\$0
6	Older Adult Resiliency and Social Connectiveness	\$0	\$0	\$842,832	\$842,832	\$0	\$0	\$0	\$842,832
7	Health/Behavioral Health Integration	\$0	\$0	\$375,000	\$375,000	\$0	\$127,500	\$123,750	\$123,750
8	School/Behavioral Health Integration	\$0	\$0	\$677,276	\$677,276	\$338,638	\$338,638	\$0	\$0
	Administration/Planning	\$45,574	\$327,877	\$859,324	\$1,232,775	\$369,833	\$308,194	\$246,555	\$308,194
	10 %Operating Reserve	\$4,557	\$32,788	\$709,791	\$747,136	\$224,141	\$186,784	\$149,427	\$186,784
	Total PEI Funds Requested:	\$50,131	\$360,665	\$7,807,704	\$8,218,500	\$2,268,253	\$2,210,836	\$1,680,664	\$2,058,747

Funding: \$1,414,500 from FY 2007-08; \$2,672,300 from FY 2008-09 and \$4,131,700 from FY 2009-10

*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" are excluded from this requirement). 54.5%

Project Budget Narrative

The eight project budgets in Form 6 represent no actual or projected costs for FY 2007/08 through FY 2008/09, and twelve months of projected costs, revenue and in-kind for Project Implementation for FY 2009/10. Upon approval of Stanislaus County's PEI three-year plan, staff will be hired/assigned, a Request for Proposal/Quote/Application (RFP/RFQ/ RFA) processes will be conducted and contracts will be awarded. At that time contractors/subcontracts and specific contract amounts will be determined.

Projects to be provided in part by Stanislaus County Behavioral Health and Recovery Services include:

Project	FTEs	Position
1. Community Capacity Building	2.00	Behavioral Health Advocate
2. Emotional Health and Wellness/Education Awareness and Education/Community Support Development	0.50	Behavioral Health Advocate
3. Childhood and Adverse Experience Intervention	0.75	Mental Health Clinician II
4. Child and Youth Resiliency and Development	0.60	Mental Health Clinician II
5. Adult Resiliency and Social Connectiveness	0.50	Behavioral Health Advocate

FY 2009/10 budgeted projections are based on the following methodologies:

Personnel - Budget amounts for county staff positions are based on the most recent county position costs for the corresponding fiscal years. If possible, Behavioral Health Advocate positions will be filled by consumers or family members.

Employee benefits – Budgets are calculated at 38% of salaries and include FICA, Workers Comp, Disability, Health & Dental Insurance and Retirement.

Operating expenses - Budgets are based on estimated services, supplies and contractor services needed to implement PEI projects that best meet the needs and cultures of the residents of Stanislaus County. County Administration A-87 costs based on the most recent Mental Health Cost Report data are also included.

Revenue – EPDST in the amount of \$40,000 is estimated for Project 3 Childhood Adverse Experience Intervention. No other revenue is anticipated at this time for all other projects.

Total Funding Requirements – Total amount of MHSA funding needed for PEI Project Implementation and services delivery.

Total In-Kind – In-kind in the amount of \$120,000 is estimated for Project 7 Health/Behavioral Health Integration. The selected provider(s) will be eligible to receive federal reimbursement. No other in-kind contributions are anticipated at this time for any of the other projects.

Administration/Planning Budget Narrative

A. Expenditures - The Administration Budgets in Form 5 represent actual planning expenditures for FY 2007/08, and projected planning expenditures for FY 2008/09. FY 2009/10 includes costs for additional administrative staff and expenses needed to support the implementation of all eight Projects simultaneously.

1. Personnel

Budget for county staff positions are based on the most recent county position costs for the corresponding fiscal years.

Staff positions include:

a. PEI Coordinator/Manager – Facilitate stakeholder meetings; facilitate PEI planning workgroups; assign projects to Consultants and other PEI staff; compile PEI plan; release PEI plan for public review; respond to all public concerns, submit plan to state. Upon approval of PEI Plan, provide oversight of RFP process and implementation of all eight PEI projects.

b. Support Staff

Administrative Clerk III – Direct support for PEI Coordinator/Manager; Coordinate meetings and presentations; answer phones, copy, maintain files and correspondence.

Account Clerk III - Assist PEI contractors with invoice preparation and submission. Process and track contractor invoices for payment.

Accountant III – Prepare PEI annual plan, budgets, revenue and expenditure reports; monitoring budget and analyze data.

c. Other Personnel

Staff Services Coordinator – Attend stakeholder and PEI workgroup meetings; complete projects and research, as needed; provide input into PEI plan. Assist Coordinator with Project Implementation. Assist PEI Staff Services Analyst with community capacity building, contractor technical assistance and program evaluation.

PEI Consultant – Attend Stakeholder and PEI workgroup meetings; complete projects and research as needed; provide input for PEI plan completion and project implementation; assist with evaluation, plan development and implementation.

Staff Services Analyst - Prepare and monitor PEI contracts. Compile Performance Measures data. Assist PEI Staff Services Coordinator with community capacity building and contractor technical assistance.

d. Employee benefits – Budgets are calculated at 38% of salaries and include FICA, Workers Comp, Disability, Health & Dental Insurance and Retirement.

2. Operating expenses - Budgets are based on estimated services, supplies and contractor services needed to plan and implement PEI projects that best meet the needs and cultures of the residents of Stanislaus County.

3. County Administration Cost A-87 - Budgets are based on the most recent Mental Health Cost Report data.

4. Total PEI Funding Requested for County Administration Budget – \$1,232,775 or 15% of total PEI funding requested for three-year plan.

B. Revenue – No additional revenue is anticipated at this time.

C. Total Funding Requirements – Total amount of MHSA funding needed for PEI Administration Planning and Project Implementation support for FYs 2007/08, 2008/09 and 2009/10.

D. Total In-Kind – No in-kind contributions are anticipated at this time.

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

County: Stanislaus

Date: 2/23/2009

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.	1 Community Capacity Building	\$1,718,414	\$687,365	\$343,683	\$687,366	\$515,524	\$429,604	\$343,682	\$429,604	
2.	2 Emotional Health and Wellness/Education Awareness and Education/Community Support Development	\$646,850	\$323,425	\$323,425	\$0	\$194,055	\$194,055	\$129,370	\$129,370	
3.	3 Childhood Adverse Experience Intervention	\$764,276	\$0	\$267,497	\$496,779	\$343,924	\$343,924	\$38,214	\$38,214	
4.	4 Child and Youth Resiliency and Development	\$564,276	\$0	\$394,993	\$169,283	\$282,138	\$282,138	\$0	\$0	
5.	5 Adult Resiliency and Social Connectiveness	\$649,665	\$162,416	\$487,249	\$0	\$0	\$0	\$649,665	\$0	
6.	6 Older Adult Resiliency and Social Connectiveness	\$842,832	\$0	\$421,416	\$421,416	\$0	\$0	\$0	\$842,832	
7.	7 Health/Behavioral Health Integration	\$375,000	\$0	\$0	\$375,000	\$0	\$127,500	\$123,750	\$123,750	
8.	8 School/Behavioral Health Integration	\$677,276	\$0	\$135,455	\$541,821	\$338,638	\$338,638	\$0	\$0	
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
26.	Subtotal: Work Plans^{a/}	\$6,238,589	\$1,173,206	\$2,373,718	\$2,691,665	\$1,674,279	\$1,715,859	\$1,284,681	\$1,563,770	
27.	Plus County Administration	\$859,324								
28.	Plus Optional 10% Operating Reserve*	\$709,791								
31.	Total MHSA Funds Required for PEI	\$7,807,704								

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=

54.34%

FY 2009/10 Mental Health Services Act
Summary Funding Request

County: STANISLAUS

Date: 4/6/2009

	MHSA Component				
	CSS	CFTN	WET	PEI	Inn
A. FY 2009/10 Planning Estimates					
1. Published Planning Estimate ^{a/}	\$11,684,900	\$5,686,800		\$4,131,700	\$914,400
2. Transfers ^{b/}	\$0				
3. Adjusted Planning Estimates	\$11,684,900	\$5,686,800	\$0	\$4,131,700	\$914,400
B. FY 2009/10 Funding Request					
1. Required Funding in FY 2009/10 ^{c/}	\$12,748,058		\$1,369,300	\$7,807,704	
2. Net Available Unspent Funds					
a. Unspent FY 2007/08 Funds ^{d/}	\$2,724,588		\$79,781	\$248,726	
b. Adjustment for FY 2008/09 ^{e/}	\$1,661,430		\$79,781	\$248,726	
c. Total Net Available Unspent Funds	\$1,063,158	\$0	\$0	\$0	\$0
3. Total FY 2009/10 Funding Request	\$11,684,900	\$0	\$1,369,300	\$7,807,704	\$0
C. Funding					
1. Unapproved FY 06/07 Planning Estimates					
2. Unapproved FY 07/08 Planning Estimates			\$1,369,300	\$1,120,200	
3. Unapproved FY 08/09 Planning Estimates				\$2,555,804	
4. Unapproved FY 09/10 Planning Estimates	\$11,684,900			\$4,131,700	\$0
5. Total Funding^{f/}	\$11,684,900	\$0	\$1,369,300	\$7,807,704	\$0

a/ Published in DMH Information Notices

b/ CSS funds may be transferred to CFTN, WET and Prudent Reserve up to the limits specified in WIC 5892b.

c/ From Total Required Funding line of Exhibit E for each component

d/ From FY 2007/08 MHSA Revenue and Expenditure Report

e/ Adjustments for FY 2008/09 additional expenditures and/or lower revenues than budgeted

f/ Must equal line B.3., Total FY 2009/10 Funding Request, for each component

Local Evaluation of a PEI Project (Form 7)

County: Stanislaus

4/6/09

PEI Project Name: Health/Behavioral Health Integration

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

The Health/Behavioral Health Integration Project has one program: Embedded Mental Health Clinicians within Community Health Centers.

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

- This project directly addresses a key goal for the PEI plan of increased behavioral health capacity within Stanislaus County and, if successful, could serve as a model for further change.
- The project establishes a key partnership with Community Health Center Organizations, which have the capacity to assist with evaluation.
- The project will have sites distributed throughout Stanislaus County and allow for comparison of different sites with different community and organizational characteristics.
- There is opportunity to measure the impact of leveraging federal funds.
- Standardized assessment tools are currently used by Community Health Centers that can be utilized to measure client status.
- There is considerable national, state and local interest in Integrated Behavioral Health/Primary Care.
- There is a considerable amount of literature about model programs which can inform the development of an effective and user-friendly fidelity tool.
- The program is relevant and important to community capacity building for behavioral health.

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

Individual outcomes.

- Identification of persons suffering from depressive, anxiety, co-occurring and other disorders.
- Reduction in depressive symptoms including suicide risk
- Participant satisfaction

System and program outcomes.

- Increased overall access to behavioral health care in Stanislaus County
- Engagement of individuals from underserved cultural populations
- Provider satisfaction

Other measures of success.

- Amount of leveraged federal reimbursement.

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	Underserved Cultural Populations
<u>ETHNICITY/ CULTURE</u>								
African American						185		185
Asian Pacific Islander						75		75
Latino						1975		1975
Native American						15		15
Caucasian						250		250
Other (Indicate if possible)								
<u>AGE GROUPS</u>								
Children & Youth (0-17)						400		400
Transition Age Youth (16-25)						400		400
Adult (18-59)						900		900

Older Adult (>60)						800		800
TOTAL						2500*		2500*
Total PEI project estimated <i>unduplicated</i> count of individuals to be served: 1500								

*The primary priority population is Underserved Cultural Communities but all participants will be screened for suicide risk. The total unduplicated count is 2500 with 100% overlap between both Suicide Risk and Underserved Cultural Population Columns.

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

Expected Outcome	Measure	Tool/Information Source	Frequency
Individual Level Outcomes			
Identification of persons suffering from depressive, anxiety, co-occurring and other disorders	Number of persons identified with behavioral health concerns by type of concern	Provider reports	Reported quarterly
Reduction in depressive symptoms including suicide risk	Participant self report of symptoms	Patient Health Questionnaire (PHQ-9)	Upon initial contact and periodically (to be determined when partner organizations are selected)
Participant satisfaction	Participant self report	Client Satisfaction Survey	At six visit intervals
System Level Outcomes			
Increased overall access to behavioral health care within Stanislaus County	Unduplicated counts of participants	Participant Demographics: Age, ethnicity, gender, language, location, behavioral health and health concerns	Collected on initial contact and reported quarterly

Engagement of individuals from underserved cultural populations	Number participants returning for second and third behavioral visits by ethnicity	Community Health Center Information System	Reported quarterly
Provider satisfaction	Self report by behavioral health and primary care providers	Provider Satisfaction tool to either be developed or selected.	Twice a year
Other Outcome Measures			
Federal reimbursement	Amount of federal reimbursement linked to program participants	Community Health Center Information Systems	Reported quarterly

5. How will data be collected and analyzed?

Stanislaus Behavioral Health and Recovery Services will expand its existing DMS/Performance Measurement Unit to manage the evaluation of this project. Additional consultants may be engaged to assist in the evaluation of this project and to assist implementing partners. The above information will be collected by the implementing partner organizations with assistance and consultation from the BHRS DMH/Performance Measurement Unit. Microsoft (MS) Access databases will be created to manage the data and allow for analysis. Analysis will primarily assess changes over time in each of the outcome areas, e.g., participant counts which are measures of access will be compared to previous client counts of Community Health Center Behavioral Health Services and Stanislaus Behavioral Health and Recovery Service System client counts. Periodic reports of findings for all measures will be prepared and disseminated. It is anticipated that additional ad hoc reports will be available from the DMS/Performance Measurement Unit upon request and approval of the Mental Health Director. All reports will protect client identification and meet all Health Insurance Portability and Accountability Act (HIPAA) requirements for management, storage and reporting of data.

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

Several of the expected outcomes are indirect measures of successful cultural competency factors (access by ethnicity, engagement by ethnicity, client satisfaction). All selected sites will have large populations of culturally

underserved populations, especially Hispanic/Latino. Healthcare providers are required by federal statute to provide language translation services and this will be expected of selected implementing partners. All instruments/forms administered to participants will be available in all threshold languages.

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

Once implementing partner organizations are selected, the PEI Project Team will work with them to finalize a fidelity tool based on the key program elements noted in the description in this plan as well as mutually determined additional key elements from model programs in the literature. Based on input during the Stakeholder input process, the tool will allow for flexibility to meet local community characteristics. Implementing partners will be required to utilize the mutually developed tool to implement and manage the program within their organizations. The PEI Program Manager, the DMS/Performance Measurement Unit, consultants and community members will visit each site twice a year and evaluate program fidelity using the tool.

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

The Representative Stakeholder Steering Committee (RSSC) serves as a partner to BHRS for all MHSA related planning processes and will be asked to serve as an evaluation advisory group for this PEI program evaluation. The RSSC represents key stakeholders and is inclusive of underserved cultural populations, all age groups and geographic areas of the county. Updates and outcome reports on all MHSA components, including PEI, will be periodically reported to them for their consideration and feedback. RSSC members will be encouraged to share outcome measurement results with the communities they represent. Results will also be reported to the Stanislaus County Mental Health Board, which has statutory responsibility for monitoring performance outcomes and reporting to the Board of Supervisors. Additionally, reports will be posted on the Stanislaus BHRS MHSA website.