San Luis Obispo County Mental Health Services Act

Proposal for the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan

San Luis Obispo County
Behavioral Health
Department
Prevention Services

Submitted for Public Review
November 18, 2008

Submitted to CA Department of Mental Health
December 24, 2008

San Luis Obispo County Mental Health Services Act
Draft Prevention and Early Intervention Component
of the Three-Year Program and Expenditure Plan

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County Name: San Luis Obispo	Date:11-17-2008

MENTAL HEALTH SERVICES ACT (MHSA)

PREVENTION AND EARLY INTERVENTION COMPONENT

OF THE THREE-YEAR

PROGRAM AND EXPENDITURE PLAN

Fiscal Years 2007-08 and 2008-09

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

County Mental Health Director	**Project Lead**
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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

INTRODUCTION

The San Luis Obispo County Behavioral Health Department (SLOBHD) is excited to put forth this plan to receive Prevention and Early Intervention (PEI) component funds. The goal of the proposed PEI programming is to build the capacity of the community to increase resiliency by decreasing risk factors, and increasing the protective factors which promote positive mental health and reduce the negative impact of mental illness.

The Mental Health Services Act (MHSA) was enacted into law January 1, 2005. This followed the passage of Proposition 63 in November 2004, which proposed a 1% tax on adjusted annual income over $1,000,000. The MHSA is dedicated to transforming the public mental health system and seeks to reduce the long-term adverse impact from untreated serious mental illness.

MHSA funds are divided into five distinct components, which are:

- Community Services and Supports
- Workforce Education and Training
- Capital Facilities and Technology
- Prevention and Early Intervention
- Innovation

Together they create a continuum from prevention and early intervention to comprehensive, intensive interventions, within an integrated, high quality, transformational service delivery system.

The plan herein is created to receive PEI component funds, which were released in 2007, with PEI Guidelines revised August, 2008. The SLOBHD is slated to receive an additional $1.5 million annually as a result of this PEI Component.

Funding parameters have been established by California's Department of Mental Health (DMH) including:

- All ages must be served;
- At least 51% of the county's overall PEI budget must be targeted to individuals age 25 and under;
- Funds cannot be used for services to individuals who have been diagnosed with a serious mental illness or their families.

By statute, counties are required to develop a three-year work plan that follows the DMH's guidelines. This plan must be created in collaboration with consumers, family members, providers, and other community stakeholders and circulated for public comment prior to being submitted to the DMH.

The following PEI Plan is a result of nine months of extensive and intensive stakeholder involvement. It represents new and expanded programming in order to serve individuals prior to the development of serous mental illness, or alleviate the need for additional or extended mental health treatment.

The proposed Prevention and Early Intervention approaches shift the mental health system from a "fail-first" to a "help-first" approach. The prevention programs bring

mental health awareness into the entire community through universal and targeted education initiatives and dialogue. Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness. The early intervention programs provide assistance at the earliest possible signs of mental health problems and concerns, without having to wait for the problem to get worse before help is available.

The PEI programs proposed in this plan incorporate the transformational concepts adopted by the Mental Health Services Oversight and Accountability Commission (OAC). The concepts follow:

- Community Collaboration
- Cultural Competence
- Individual and Family-driven Programs and Interventions, with Specific Attention to Individuals from Underserved Communities
- Wellness Focus, Which Includes the Concepts of Resilience and Recovery
- Integrated Service Experience for Individuals and their Families

MHSA funds will be used to implement the following five new projects, which include eleven distinct components. Services are expected to begin in Spring 2009. They were selected based on DMH's required outcomes and approved strategies, funding criteria and our community's input and priorities. Their implementation represents a significant shift in mental health programming for our county.

- *Mental Health Awareness and Stigma Reduction Project.* A county-wide universal and selective prevention project for all ages that includes education for school-aged youth, teachers, and parents, a media campaign, as well as targeted outreach to underserved cultural populations.
- *School-based Wellness Project*. A prevention and early intervention project to build wellness and resiliency, and reduce risk factors and stressors among elementary, middle and high school students.
- *Family Education and Support Project*. This prevention and early intervention project includes parenting classes and resources, and "on demand" coaching for parents facing specific challenges.
- *Early Care and Support for Underserved Populations.* This selective prevention and early intervention project provides self-sufficiency supports for high-risk transition-aged youth, depression screening and supports for older adults, and outreach and engagement services to low-acculturated Latino communities.
- *Community Wellness Project*. Resource Specialists and Community-based brief or short-term therapeutic services will be provided in this prevention and early intervention project.

The Prevention and Early Intervention funds provide an unprecedented opportunity for the San Luis Obispo County Behavioral Health Department and its partners to engage in an array of programs that will have immediate, long lasting and far-reaching positive impacts for many members of our community.

County: San Luis Obispo (SLO County) Date: November 17, 2008

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

The San Luis Obispo County Behavioral Health Department Administrator, Karen Baylor, Ph.D, MFT in conjunction with Nancy Mancha-Whitcomb, Mental Health Services Act Division Manager, had the overall responsibility for ensuring that the Community Program Planning Process was carried out as required by statute.

Ms. Mancha-Whitcomb was responsible for participating in statewide discussions and ensuring that DMH Notices and communications were followed, and that a compliant, feasible proposed PEI plan was submitted to DMH for approval.

A County Mental Health Services Accountant II, Lisa Anderson, is dedicated to MHSA and had the overall fiscal responsibility during the planning process.

Frank Warren, Program Supervisor within Drug and Alcohol Services, was the lead for writing the plan document, and will work with the MHSA Oversight and Accountably Commission to obtain approval of the plan. Mr. Warren will be responsible for PEI program implementation.

A 34-member Community Planning Team of diverse public and private stakeholders was responsible for guiding the planning process, analyzing community input, and selecting projects in accordance with community priorities. That membership is described further in Section 1c below.

An independent planning consultant, Dale Magee, was contracted to design and manage the planning process resulting in project selection and assist Mr. Warren in writing the plan document. Ms. Magee was also responsible for the 2005 CSS Community Program Planning Process.

b. Coordination and management of the Community Program Planning Process

From January through October 2008, the planning consultant coordinated and managed all components necessary to conduct a comprehensive community input and program planning process, including: the recruitment and coordination of the Community Planning Team and age-specific workgroups; a publicity campaign; develop and distribute surveys, create informational materials; conduct focus groups and stakeholder interviews; synthesize and analyze input data; create data reports; identify community priorities; research program options and details, and facilitate the Planning Team's project selection process.

A mental health therapist experienced in community partnerships and integrated systems of care was dedicated half time from February through June 2008, to assist with outreach and input efforts, especially to reach underserved rural communities, age groups, and cultural populations.

From March through May 2008, the bilingual/bicultural psychologist who directs the CSS Latino Services Program and chairs County Mental Health's Cultural Competency Committee conducted extensive outreach to low-acculturated Latino communities and other Latino groups, and conducted focus groups, interviews and PEI presentations. She also served an advisory role to the planning consultant.

An internal SLOBHD work team met at least monthly beginning September 2007 to review the PEI Guidelines, formulate the overall planning process, refine survey and input instruments, track the state and local planning process, and develop program and projects details. Those members included:

- Karen Baylor, Ph.D, MFT Behavioral Health Administrator
- Nancy Mancha-Whitcomb, MHSA Division Manager (joined January 2008)
- Frank Warren, Drug and Alcohol Services (DAS) Program Supervisor
- Lisa Anderson, MHSA Accountant
- Rhea Liiamaa, Systems Affirming Family Empowerment (SAFE) Coordinator (January - June 2008)
- Brad Sunseri, Youth Services Division Manager (September - December 2007)
- Janet Amanzio, Adult Services Division Manager (September - December 2007)
- Dale Magee, planning consultant

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

The comprehensive Community Program Planning Process began in August 2007 and consisted of four phases:

1. "Plan to Plan." August 2007 through January 2008.
2. Community Outreach and Input. February through April 2008.
3. Data Analysis; Priorities and Strategy Identification. May through August 2008.
4. Project Selection and Design. August 2008 through October 2008.

More than 3,000 individuals were involved in the Community Program Planning Process throughout the phases. Stakeholders were involved from the beginning and will continue once PEI projects are operating.

Phase I: Plan to Plan (August 2007 - January 2008)
This phase was for educating the work team on the PEI guidelines and DMH's approach, for strategy development for the community input process, and to gather resources to ensure a successful Community Program Planning Process. This was primarily an internal effort yet key stakeholders provided valuable input and guidance.

The existing MHSA CSS Community Planning Team, whose membership includes most of the representatives required for the PEI planning process, was consulted in December 2007 to provide recommendations on outreach strategies and stakeholder groups to include during the forthcoming PEI community input process. More than 25 people, including consumers, family members and Latino community representatives, contributed.

Recruitment for the PEI Community Planning Team began during this phase. Both "required" and "recommended" stakeholders were enlisted.

The 34-member PEI Community Planning Team first convened in January 2008 for a PEI component orientation and training. The Planning Team represents most of the required and recommended PEI groups, and serves as the oversight body for the Community Program Planning Process, and ensured a comprehensive and inclusive input process and that the resulting proposed PEI Plan reflected the sprit of the community's wishes.

The **Community Planning Team** membership includes representatives from the following groups (some members represent more than one group):

- Individuals with mental illness (at least 4)
- Consumers (at least 2)
- Family members (at least 7)
- Family Advocates
- Behavioral Health Department Administrator
- California Polytechnic University (Cal Poly), Counseling Services
- Community Members at Large
- County Jail / Custody
- County Office of Education
- Department of Social Services
- Drug and Alcohol Services
- Economic Opportunity Commission
- Family Care Network
- Law Enforcement
- Mental Health Board
- Mental Health Adult and Youth Services (MHS)
- Mental Health Services Cultural Competency Committee
- MHSA Administrative Staff
- MHSA Latino Outreach and Services
- National Alliance on Mental Illness (NAMI)
- Older Adult Full Service Partnership (FSP)
- Probation Department
- Psychotherapists, private practice (active and retired)
- Public Health Department
- SAFE System of Care
- Family Resource Centers
- San Luis Obispo County Community Foundation
- Special Education Local Plan Area
- Transitions-Mental Health Association (T-HMA)
- Tri-Counties Regional Center

The Community Planning Team met nine times through October 2008, in addition to numerous between-meeting communications, briefings and readings, individual meetings with the planning consultant, and members serving on age-specific Workgroups (described later in this section). The Planning Team will continue to be involved during the implementation and operations of the PEI Plan and at least one representative will serve on the executive MHSA Advisory Council.

Phase II: Community Input and Outreach (February - April 2008)
This was an extensive outreach and engagement process to educate and inform the community about the MHSA PEI component, PEI activities and opportunities, and gain diverse input to determine key community needs, priority populations and strategy recommendations.

Thousands of stakeholders were included during Phase II using various strategies including surveys, focus groups, interviews, presentations, and a media campaign.

Outreach and input efforts began February 1, 2008 and ended April 30, 2008. Over 3,000 individuals provided input through surveys, focus groups, forums, interviews and presentations. And through a publicity campaign, tens of thousands of more SLO County community members learned about the PEI programming process, concepts of prevention, and increased awareness of mental illness.

In all, the community outreach and input process included:

- 2,246 respondents completing the written survey, available in hard copy and on-line, in English and in Spanish.
- 25 focus groups with 350 total participants included Spanish-speaking groups.
- Four provider/subject-matter expert forums held throughout the county with 152 total attendees.
- 12 presentations to agencies, organizations and community groups with 309 total participants.
- Tens of thousands community-wide were educated about MHSA, prevention and early intervention through newspaper ads, radio interviews, and presentations to government entities that were also televised.

The three main sources of community input data were focus groups/interviews, provider/subject expert forums, and a written survey. The survey was the most widely available source and applicable for anyone. The focus groups/interviews and forums were targeted to key stakeholders including persons with mental illness, families, a variety of providers, underserved cultural groups, and youth.

Tables 1 through 4 detail stakeholder involvement in the input process.

See Appendix B for Survey and Focus Group Results.

Table 1: 2008 PEI Focus Groups, Input Sessions, Presentations

Date	Stakeholder Group	Audience #
March 7	Entire County: KVEC Radio Show. Planning Process Kick Off	> 20,000
March 10	Focus Group: MHS Cultural Competency Committee	6
March 12/13	Provider/Subject Expert Forum: San Luis Obispo, Paso Robles. 3 sessions	126
March 12	Presentation: Criminal Justice Administrators	27
March 13	Presentation and Interview: Juvenile Justice Commission	20
March 18	Presentation: County Forensic Coordinating Team –law enforcement and human service providers	15
March 19	Focus Group: Mental Health Providers – County MHS Staff	13
March 19	Focus Group: Latino Youth - Lifebound Leadership. Nipomo.	11
March 21	Focus Group: Latino Adults - English Learner Advisory Committee (ELAC) class. Morro Bay. Conducted In Spanish.	35
March 25	Focus Group: Youth and Transitional Age Youth (TAY) at Juvenile Hall	32
March 25	Focus Group: NAMI members	25
March 31	Focus Group: Providers - Drug and Alcohol Services Staff; Prevention and Co-Occurring	10
March 21	Focus Group: Latino Adults and Youth - Rural Assistance. Conducted in Spanish	9
April 1	Focus Groups: Providers – DSS Social Workers	9
April 1	Focus Groups: Family Members - T-MHA Family Support Group	17
April 2	Focus Groups: Consumers at Vicente School – (day treatment for teens)	4
March 21	Focus Group: Latino Adults - ELAC class. Oceano. Conducted In Spanish.	10
March 27	Focus Group: Latino Outreach Council	11
April 2	Presentation and Interview: County Childcare Planning Council	18
April 3	Presentation: KVEC Radio Show	>20,000
April 3	Presentation and Interview: SLO Medical Society board of directors	7
April 4	Focus Group: Latino Adults and Youth - Rural Assistance. Conducted in Spanish	12
April 4	Presentation: County Education and Council	22
April 4	Presentation and Interview: Adult Services Policy Council	28
April 7	Focus Group: Consumers – Adults at T-MHA	23
April 7	Focus Group: Latino Parents. Conducted in Spanish. Paso Robles	38
April 8	Focus Group: Family Members – Foster Parents at Family Care Network.	8
April 8	Focus Group: MH Providers – Family Care Network Staff	10
April 8	Focus Group: High Risk TAY – Grizzly cadets	12
April 8	Presentation: County Board of Supervisors.	105 >20,000 radio coverage, + TV
April 10	Focus Group: Consumers – Vicente Youth - Teens	4
April 10	Focus Group: Consumers – Older Adults at T-MHA	8
April 10	Focus Group: Latino Parents. Conducted in Spanish. Paso Robles	16
April 16	Presentation: County Health Commission	14 + televised
April 18	Presentation: County Commission on Aging	18
April 23	Focus Group: Mental Health Providers - TMHA Staff	9
April 24	Community and Provider Forum: Providers and Teen Leaders at Arroyo Grande	26
April 24	Presentation: Vision Unida	20
Monthly	Presentation: Mental Health Advisory Board	15

Surveys were provided at all of the above activities.

Table 2: Summary of Stakeholder Representation at Forums, Focus Groups and Interviews

Category per PEI Guidelines	Organization / Agency / Individuals
Underserved Communities	Latino Outreach Council, People's Self Help Housing, Sojourn - disability services, Tri-Counties Regional Center, GALA, juvenile offenders, Latino English-language learners, Rural Assistance, Adult Services Policy Council, County Commission on Aging, Grizzly Academy cadets, Latino teens, Vision Unida Latino Leadership program
Education	Cal Poly Children's Center, Atascadero High School, Cuesta Community College, Head Start, Teen Academic Parenting Program, First 5 Commission, Grover Beach Elementary, Independent Living Program, Lucia Mar School District, Paso Robles Unified School District, Early Start, Special Education Local Plan Area, San Luis Coastal Unified School District, San Luis Obispo County Office of Education, a speech pathologist for preschools, Ms. Sue's Reading and Art Porch, private and public preschool providers
Individuals with Serious Mental Illness and/or their Families	Teens, adults and older adults with mental illness, parents with minor and adult children with mental illness, foster parents with children with mental illness, T-MHA Family Advocates, County Mental Health Advisory Board
Providers of Mental Health Services	Community Counseling Center, EOC Child/Youth/Family Services, Kinship Center, Martha's Place, County Mental Health Services, MFT/private practice, Psychologist/private practice, SAFE System of Care, Pediatric Therapy Solutions, Sexual Assault Recovery Program, Transitions-Mental Health Associations
Health	Alzheimer's Association, Best Home Health Care, Children's Medical Services, Drug and Alcohol Services, Public Health Department, County Health Commission
Social Services	Department. of Social Services, 211 Hotline, Area Agency on Aging, Aspira Foster Care, Creative Mediation, Drug and Alcohol Services, Economic Opportunity Commission, Family Care Network, Independent Living Program, Kinship Center, SAFE, SLO Child Abuse Prevention Council, Transitional Food and Shelter, Inc, Tri-Counties Regional Center, West Coast Housing, Adult Services Policy Council
Law Enforcement	Probation Department, District Attorney's Office-Victim/Witness, all City Police Chiefs, County Sheriff, Juvenile Justice Commissioners, patrol officers, sheriff deputies, County Jail correctional officers
Community Family Resource Centers	Community LINK, SAFE, North County Connection, North County Women's Resource Center, Paso Robles Unified School District Student Resource Center
Employment	Independent Living Program, Community LINK - TeenWorks, CalWORKs

Table 3: 2008 PEI Awareness and Survey Distribution Activities

Awareness and Survey Distribution Activity	Date
Survey released - hard copy and on-line. More than 15,000 surveys and informational postcards distributed throughout the county during input period.	March 7
Print advertising for survey website and telephone number – Tribune (countywide), New Times (free weekly), Mustang Daily (college paper)	March – April
Press release – all print, radio, TV outlets	March 10
Letter to Editor – to all print outlets. Ran in six publications	March 17
Shaken Tree film showing at Film Festival – distributed surveys and survey postcard notices; 120 in audience	March 10
SLO Chamber of Commerce – postcard distribution – 300 audience	March 27
Public Health Week Fair – MHSA booth	April 11
Oceano Day of the Child – MHSA booth	April 27
SLO Farmers' Market – surveys and PEI information at TMHA and GALA's booths	March/April
Survey Link on GALA's website	March/April
Survey Link on Verdin INK blog	March/April
Survey Link on SLO County Medical Society's web site	March/April
Survey/postcards distributed at: • MHS clinics • DAS sites • Community Health Centers • EOC clinics • Senior centers, countywide • Libraries • Police Station lobbies, all cities • Health Department sites • SAFE sites • Atascadero LINK, a family resource center • School District offices • Cal Poly Health Center • Cal Poly Counseling Center • Kennedy Fitness Centers • Head Start sites – staff and families • County Jail inmates • California Men's Colony inmates • Prado Day homeless center • Maxine Lewis Homeless Shelter • United Way membership • San Luis County Community Foundation membership • Churches • MECHA and Chicana Studies classes, Cal Poly • Adult offender groups, Probation Dept. • Community recovery centers	March/April
Community Collaboration Forum – survey in Participant Materials – 200 participants	March 27-28
Childcare Providers: survey mailed to private childcare providers, 480	week of March 24
Businesses: survey mailed to 1500 county workplaces including County staff	week of March 24
Primary care providers: survey faxed to 475 primary care offices; emailed to 130 physicians	week of March 24
Private mental health providers – surveyed mailed	March
Service Clubs throughout county	March
NAMI members	March
Staff – SLOBHD, Planning Team agencies, police departments, Sheriff's Department, all school districts	March/April
Children's Services Network members - 100+	March/April
Latino Outreach – community groups, churches, school clubs, sports clubs	March/April
Cal Poly – Health Center, Multicultural Center, Student Community Services, Dorms, Counseling Center, professors	March/April

Table 4: Sources and Demographics of PEI Community Input

Input Source	Total Participants/ Respondents	Persons with Mental Illness	Family Members	Providers	Latino	Teens (13-18)	Gender F	Gender M
County Demographics	257,005 (2006 est.)	~ 9%	Unknown	Unknown	18%	~7%	49%	51%
Focus Groups (25 sessions)	350	17% 69	32% 125	47% 192	40% 184	20% 83	63% 291	37% 172
Provider / Subject Expert Forums (4 sessions)	152							
Written Survey- Online and Hard Copy English and Spanish *	2,246	6% 109	22% 426	56% 1,083	22% 505	8% 159	74% 1,346	26% 474
Combined Totals **	2,748	8% 178+	24% 551+	54% 1,275+	25% 689+	10% 242+	72% 1,637+	28% 646+
		+ demographic info not collected from all – listed values will be less than actuals						
* Survey: Spanish-only Subset	294	5% 15	11% 30	5% 13	100% 275	8% 23	52% 144	35% 97

These data should be viewed in the context that the most current population estimates for San Luis Obispo County (2006 U.S. Census estimates) are: 74% White; 18% Latino; 3% Asian, 2% Black and 1% American Indian.

***Totals are greater than 100% due to respondents belonging to more than one category.*

Phase II Publicity Campaign
The publicity campaign was conducted to announce and inform the general public and targeted groups about the MHSA, the uniqueness of the PEI component, increase broad stakeholder input by guiding them to the survey website, join a Workgroup, and to reach underserved populations and those providers not known to SLOBHD. It also provided an excellent opportunity to spotlight encouraging information about coping with or living with mental illness and to reduce stigma.

The publicity campaign included:

- Market analysis and strategy assistance from award-winning public relations firm.
- Radio interviews (3) – including a featured segment to kick off the input gathering phase on the day the survey was released. That radio show has an audience of at least 20,000 countywide.
- Print advertisements published in two countywide papers (over 100,000 circulation) and two regional papers, including the Cal Poly University's paper and a Spanish-language paper.
- Letters to the Editor and press releases in six (6) regional papers encouraging community input and mental health awareness and support.
- Information booths at health fairs and children's fairs.
- "Fax Blast," endorsed by the Medical Society, to 475 primary care physicians.
- Television and radio PSAs, including Spanish-language radio.
- Presentations to various agencies and organizations.
- Surveys and informational postcards distributed throughout county, including via community health centers, Chambers of Commerce, Head Start sites, senior centers, community coalition groups, and recovery centers.

Phase II, the input gathering process, concluded with the closing of the survey period and completion of the stakeholder focus groups. The Community Planning Team reviewed who had contributed input and it was agreed that key populations and groups had been well-sampled or the attempt was well-made and reasonable.

Phase III: Data Analysis; Priorities and Strategy Identification (May - August 2008)
This phase of the Community Program Planning Process began with the planning consultant synthesizing the collected data. On May 5, 2008, the Community Planning Team received the compiled community input and reports on key findings.

Stakeholders were now charged with review and analysis of the community's desires, determine the key community needs to respond, and narrow priority populations to targeted groups (1,003 distinct groups were suggested as priority). From there, the stakeholders would review the strategies that were appropriate for the needs and populations as well as matched community recommendations (592 viable PEI strategies were submitted). They then began combining ideas that would ultimately lead to final programs and projects.

The Planning Team formulated criteria it would use to prioritize options, (such as the balance between prevention and early intervention programming, serve a few groups more in depth rather than many groups but "lightly"), and adopted guiding practices that

would be universal to the all the PEI projects. These included cooperative and coordinated services, easy access, utilize existing strategies before starting something new, maximize existing natural relationships, serve whole family units rather than just the "problem" individual," and vary services to be culturally aware and appropriate (these were themes from the community at large.).

Workgroups

In order to gain from the wisdom and diversity of more stakeholders, three age-specific Workgroups were created: Children/Youth; TAY/Adult; and Older Adult. (Groups were combined because many of the "same players" serve the "overlapping" age groups in our relatively-small county and we were conscious of the time commitment asked of the participants. By combining we were able to maximize time as well as integrate programming ideas between age groups).

Workgroup membership included public and private members coming from the Planning Team and focus group and provider forum participants, as well as the community at large responding to promotional ads. Seventy-four individuals participated amongst the three Workgroups (some serving on all three), representing the following organizations and agencies:

- Alzheimer's Association
- Area Agency on Aging
- Aspira Foster Care
- Autism Spectrum Center
- Cal Poly Counseling Center
- Cal Poly Counseling Department
- Child Abuse Prevention Council
- Children's Services Network
- Commission On Aging
- Community LINK, FRC
- Consumers, Adults and Older Adults
- County Office of Education
- Drug and Alcohol Services
- EOC Homeless Services
- EOC, Child, Youth and Family Services
- Family Care Network
- Family Members
- First Five Commission
- Head Start
- Kinship Center
- Latino Outreach
- Lucia Mar School District
- Mental Health Board
- Mental Health Services youth treatment
- Mental Health Services Cultural Competency Committee
- MHSA FSPs - all ages
- NAMI
- North County Connection, a recovery center
- Probation Department, Adults and Juveniles
- Psychotherapists, private practice
- Public Health Nursing
- SAFE System of Care
- San Luis Coastal Unified School District
- School Counselors
- SELPA, special education
- Sheriff's Dept
- SLO County Community Foundation
- Sojourn Services, disability services
- Transitions-Mental Health Association
- Tri-Counties Regional Center
- United Way

Each Workgroup utilized the broad community input data, conducted research, and applied their own expertise and experience to determine specific needs, target groups and strategies that are most realistic, feasible and best use of PEI funds. They also

suggested operating details and models. Their recommendations would be brought to the full PEI Community Planning Team in order to develop the projects included in the final PEI plan.

Each Workgroups met a total of three times, once in May, June and August. Their time and commitment was invaluable and provided guidance in developing the plan.

Phase IV: Project Selection and Design (August - October 2008)
The Workgroups' recommendations were presented to the Community Planning Team on August 18, 2008 in the form of 17 potential programs or strategies. This began the final phase of the Community Program Planning Process: Project Selection and Design.

The Planning Team reviewed and debated the recommendations - and options and variations within - and went through several rounds of refining. The planning consultant presented possible programming details and groupings based on themes heard throughout the planning process. From these the first draft projects were selected. By mid-September, six working projects had been identified. The planning consultant and the internal SLOBHD work team developed the projects further, drafted budgets, and consulted with individual stakeholders to further project development. Significant progress was made on both individual projects and the overall plan in September and October.

On October 28, 2008, the Planning Team approved the five projects proposed herein, as well as provided SLOBHD administration direction where to increase or reduce funding if that was necessary as detailed internal budgeting began.

Stakeholders will continue to be involved through reviewing the proposed plan, and Workgroup and Planning Team members will be asked for their input on operating details of each program. The PEI Community Planning Team will have ongoing oversight of the general progress of the PEI effort once implemented.

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

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

San Luis Obispo County made a commitment to actively engage underserved target populations reflective of our county's demographics and service rates, specifically: low-acculturated Latino adults and youth; older adults in any area or of ethnicity; GLBTQ populations; and TAYs.

Strategies to increase Latino representation included:

- All personal-contact outreach and input gathering was conducted by bilingual/bicultural mental health professional.

- Utilized Latino community members and allies to recommend strategies.
- Six (6) focus groups conducted in Spanish at already-existing community gathering.
- Focus group for Latino youth.
- Engagement of Latino Outreach Council.
- Surveys (in Spanish and English) distributed at:
  - Churches. Priests and pastors encouraged congregation to complete them.
  - Public Health Department and community medical clinic.
  - Head Start site.
  - English-language classes.
  - Cal Poly Latino clubs and Multicultural Center.
  - Assistance provided for those unable to read/write.
- PSAs on Spanish radio station.
- Presentation to Visión Unida leadership classes (in Spanish and English
- Interviews with monolingual Spanish-speaking community members.
- Asked community representatives to participate on Planning Team and Workgroups.

Through these efforts we reached higher proportions of both high- and low-acculturated Latinos than are represented in the county's general population. Latino individuals are 18% of the county population, and constituted 40% of focus group/forum participants, 22% of survey respondents, and 9% of Planning Team membership.

Strategies to increase Older Adult representation included:

- Presentation to Commission on Aging and Adult Protective Services.
- Interviewed Adult Services Policy Council members.
- Direct contact and invitation to older adults and senor providers to participate in focus groups, provider forums, Workgroups and Planning Team.
- Surveys distributed to:
  - Churches.
  - Senior Centers.
- Offered assistance in completing surveys or attending meetings.
- Created Older Adult Workgroup.

Older Adults are 14% of the county population (based on those over age 64, per U.S. census data). In the PEI input process Older Adults constituted 9% of survey responders, but Adults 55 and over constituted 29%. Greater representation than county proportion were on the Planning Team at 15% being over 64, and on the Older Adult Workgroup at 33%.

Strategies to increase GLBTQ representation included:

- Consulted with GALA as to best ways to reach the population.

- Focus group participation.
- Survey and PEI information linked from GALA's website.
- PEI information, surveys and Workgroup announcement distributed at GALA's SLO Farmers' Market booth.
- Survey distributed directly to GALA and PFLAG membership.
- Outreach to Community Foundation's "Growing Together" membership.

While the actual number of stakeholders identifying themselves as GLBTQ is not known (the county's estimated population is 12%), community input showed a commitment to serving their needs. Members of these groups and advocates were helpful in expressing priorities and strategies that would be effective. Ultimately, this population was selected to be a priority population for targeted outreach in the awareness and stigma reduction project included in this plan. Local GLBTQ groups will be engaged to design best practices for that effort.

Strategies to increase TAY representation included:

- 6 TAY-only focus groups.
- Survey distribution to high school and college campuses, with incentives.
- Print ads in university new paper.
- Employed TAYs for input data processing, interviewed them about mental health issues and utilized their peer connections to promote the survey.

Transitional Age Youth (16-25 years old) constitute approximately 12% of the county population. They were deliberately over-represented in the planning process, resulting in 19% of the stakeholders in all input sources. Additionally, 70% of the Planning Team members represented providers that serve TAYs.

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.

Methods of involving diverse stakeholders have been described above. Further demographics are included in the following tables.

Table 5: Stakeholders, by Age:

	SLO County (2006 est.)	Survey Respondents	Focus Groups / Forums	Planning Team
< 18	19%	4%	20%	0%
18-24	16%	8%	2%	0%
25-34	12%	14%	12%	3%
35-44	14%	19%	24%	21%
45-54	14%	25%	19%	17%
55-64	11%	20%	19%	21%
Over 64	14%	9%`	4%	15%

Table 6: Stakeholders, by Gender:

	SLO County (2006 est.)	Survey Respondents	Focus Groups / Forums	Planning Team
Female	49%	74%	63%	50%
Male	51%	26%	37%	50%

Table 7: Stakeholders, by Race/Ethnicity:

	SLO County (2006 est.)	Survey Respondents	Focus Groups / Forums	Planning Team
White, non Hispanic	74%	72%	57%	85%
Latino, Hispanic	18%	22%	40%	9%
Asian	3%	2%	3%	3%
Black	2%	1%	2%	3%
American Indian	1%	3%	2%	3%

** totals in some categories may be greater or less than 100% due to individuals belonging to more than one group, or not all members providing information.*

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

At least 729 people with mental illness or family members participated in the Community Program Planning Process. The majority participated through focus groups, forums, interviews, and surveys. Additionally, persons with mental illness (including current and former clients of County Mental Health Services) and family members were members of the Community Planning Team and/or age-specific Workgroups.

Specific populations of persons with mental illness or family members that participated in focus groups included:

- NAMI members - adults with mental illness and family members.
- Young teens at Vicente day treatment school.
- Transition age youth at Vicente day treatment school.
- Adults in socialization / day treatment programs.
- Older Adults in socialization / day treatment programs.
- Family members at peer support groups.
- Adult Services Policy Council, includes client and family representatives.
- Foster parents of Seriously Emotionally Disturbed (SED) children.

Surveys were completed by current County Mental Health Services consumers, clients of community-based mental health programs, and mono-lingual Spanish-speaking persons with mental illness and family members. Surveys were also completed by persons with mental illness who were in custody at County Jail, as well as from people in the general population who have mental illness or their families, including those living in rural areas.

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**

Please refer to Question 1c above which includes detailed information about the diverse stakeholders involved in the process. Listed specially are the memberships of our Community Planning Team and the three age-specific Workgroups, which included all of the groups noted here in 3a.

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

All county SLOBHD staff, and many members of the Planning Team and the consumer, family member and provider stakeholder groups had previously participated in the CSS community planning process and had received training on MHSA and its principles and their role in the process. At its first convening in January 2008, the Planning Team received an extensive orientation to PEI and their roles, goals, and responsibilities, and each member was responsible for studying the Guidelines and reviewing the supplemental Resource Guide.

A PEI briefing paper was developed, distributed widely and included in the announcements of stakeholder activities. It defined prevention and early intervention as identified by the Institute of Medicine, distinguished between PEI and CSS, and included the specific community needs and priority populations that PEI plans must center around. Each focus group and forum began with an orientation to PEI, and all of the outreach presentations and media contacts were in fact trainings about PEI and the Community Program Planning Process.

Workgroup members were further trained in prevention strategies, and members were asked to teach each other about the evidence behind the programs or strategies they were advocating.

The survey included a cover page that briefly explained the MHSA and defined prevention and early intervention concepts and approaches.

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 varied strategies used during the 2005 CSS process to involve diverse stakeholders was on the whole very successful and relevant, with over 2,400 people participating, including 1,000 people with mental illness and family members, and over-representation from Latino groups (statistically underserved). The resulting CSS plan has been well-received and benefits many. However, the process did reveal lessons to be heeded during the PEI process.

CSS showed that strategies to reach Latino groups were successful, but other underserved populations such as TAY, Older Adults, and rural communities needed to be reached also, and that needed concentrated effort. This time, increased attention was given to find these populations' existing networks and advocates. The number of TAY and Older Adults involved increased, and rural community leaders were identified and contacted directly to seek input.

Consistent consumer participation on the Community Planning Team - the leadership group - was difficult to maintain during the CSS process. Several consumer members commented that the business and subject matter of the meetings (administrative, analysis, regulations, specific content-heavy, many documents), along with the demographics (a large group, agency personnel, "system" experts) did not fit for them. This feedback was not forgotten when setting up the PEI Community Planning Team. One improvement included setting better "upfront" expectations of what was needed from a team member and the nature of the work (thanks to having gone through CSS). Another improvement was creating the Workgroups which gave Consumers another option to have a greater role beyond just completing a survey or attending a one-time focus group, but were smaller in size and more open-forum in function. Consumers seemed more at ease with the Workgroups than the Planning Team, and participated more actively. Additionally, the planning consultant met one-to-one with Consumers on the Planning Team to solicit more input, but in a more comfortable environment. Future Consumer participation on the Planning Team could be further improved and a separate, standing "Consumer advisory" council has been suggested.

CSS showed that it is difficult and vitally critical to create a PEI Plan that has realistic time and cost estimates. Designing new programs, creating new positions, conducting RFP processes, hiring personnel and then launching a new initiative will take longer than expected. Administrative, personnel and operating costs can be difficult to accurately calculate when new programs are being designed. The SLOBHD internal team is budgeting time and funds conservatively and comparing estimates from other counties and sources.

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.

Large number of stakeholders involved. San Luis Obispo County's population is only 257,000 and yet over 3,000 individuals participated in this process. That in itself is a success. SLOBHD is greatly appreciative of the level of input it received, demonstrating a great interest from many caring community members.

Engagement of diverse stakeholders. As described above, the Community Program Planning Process involved representatives from all required and recommended sectors, and was successful at reaching underserved and underrepresented groups in significant numbers.

The proposed PEI Plan itself. The resultant plan is directly responsive to stakeholders' recommendations on the most important community needs to address, the priority populations to serve, and the types of services they know to be most needed and effective.

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

a. The date of the public hearing:

The public hearing was conducted by the San Luis Obispo County Mental Health Advisory Board on Wednesday, December 17, 2008. Mental Health Board members, including representatives of the County Board of Supervisors, mental health clinicians and program providers, educators, consumers, law enforcement, community advocates, and retirees conducted the Public Hearing. A presentation was made by Frank Warren, PEI Program Supervisor for SLOBHD outlining the projects put forth in the PEI Proposed Plan.

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.

Notice of the PEI Plan's availability for review and of the December 17, 2008 public hearing was sent to participants of the Community Program Planning Process, the MHSA e-mail list (a compiled list from the CSS Community Program Planning Process and other interested community members), County Board of Supervisors, all SLOBHD staff, and the SLO County Mental Health Advisory Board.

Notification flyers were posted at regional County Mental Health clinics, County Drug and Alcohol Services offices, and County libraries. A legal notice was published in the Tribune, the only countywide daily newspaper, and press releases were sent to more than 20 print, radio and television outlets. The PEI Plan and notice of the public hearing were posted on the SLOBHD website.

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

Public comments during the hearing were positive and supportive of the PEI Plan as written. No substantive recommendations for revisions were brought forth. The Mental Health Board voted unanimously to recommend the PEI Plan be submitted to DMH.

d. The estimated number of participants:

Approximately thirty individuals attended the public hearing.

County: San Luis Obispo

Project 1: Mental Health Awareness and Stigma Reduction
Date: 11/17/2008

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

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

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

The devastating effects of stigma, discrimination and a mental illness going undiagnosed are, sadly, too well-known. More than 2,200 SLO County community members participated in the PEI planning survey and "undetected mental health problems" or "problems not being identified" early ranked as *the most important issue* for PEI programs to address; and "difficulties accessing care due to stigma and not knowing about services" ranked as the second most important. Additionally, 27% of survey respondents stated stigma and discrimination related to mental illness is a critical problem in our county.

Stakeholders knew that everyone in our community is impacted by these significant issues and the community-at-large should be the focus of this project.

Furthermore, 91% of the focus groups, including persons with mental illness, family members, transitional age youth (TAYs), older adult advocates, and low-acculturated Latinos, requested that PEI funds be allocated to an awareness campaign dedicated to community education about mental illness, signs, symptoms, available local resources, wellness, and stigma reduction.

Eighty-eight percent of focus groups desired specific training to be dedicated to teachers, students, and parents. Stakeholders, through the survey, selected people of all ages exposed to traumatic events, particularly abuse, domestic violence and homelessness, as priorities to receive targeted focus.

However, in spite of the community's interest and strong support for mental health awareness and stigma reduction efforts, very little programming or activities currently exist. The National Alliance for the Mentally Ill's (NAMI) peer-run "In Our Own Voice" has operated at a limited capacity, but nothing on a large, coordinated, countywide, school-infused, bi-cultural scale has ever been undertaken.

Research has been clear in addressing the impact stigma and discrimination have on people accessing services. According to a report by the President's New Freedom Commission on Mental Health, "some people may not recognize or correctly identify their symptoms of mental illness; when they do recognize them, they may be reluctant to seek care because of stigma (Mojtabai, 2002; Sussman, 1987)."

Based on the consistent community request and strong support for a general, countywide effort, the lack of anything else like it, and the full range of priority populations who would benefit, our Community Planning Team has made this a priority for local PEI funding. In addition, the project described here will compliment the State's efforts to reduce stigma and disparity issues which threaten the health of all Californians. The programs described below will benefit all PEI priority populations within the general public as well as trauma-exposed populations that receive specific focus.

3. PEI Project Description

The President's New Freedom Commission on Mental Health's recommendations outlines the following tenets which serve as the foundation of the project being described below:

- Targeted public education can increase awareness about the effectiveness of mental health services and can encourage people to seek treatment, thus reducing the stigma and discrimination associated with mental illnesses.
- Media-oriented and other types of mental health awareness campaigns can inform the public about *where* and *how* to obtain help.
- Campaigns should use a multi-faceted approach that includes various public education strategies, as well as direct, consumer-to-target audience, interpersonal contact methods, such as dialog meetings and speakers' bureaus.

The President's New Freedom Commission on Mental Health, 2003

A. Description of Proposed PEI Project

The Mental Health Awareness and Stigma Reduction project is a multi-faceted approach to building community capacity in understanding and addressing mental health issues. This project focuses on three areas: Social Marketing; Campus-based Mental Health Education; and Parent/Caregiver Outreach and Education. This project aims to create awareness of mental illness, its signs, symptoms, and treatments, amongst the general population; address and dissolve the beliefs and attitudes which create internalized self stigmatization, and externalized discrimination towards those in need of services; and educate those populations most at risk for mental illness and those most capable of building resiliency.

This project creates social marketing for the general population, and education for schools, students, and parents throughout the county. It also addresses disparities in access to services by providing outreach to individuals from underserved and trauma-exposed high-risk groups identified in the Community Program Planning Process. The PEI Community Planning Team selected this as an effective strategy that would address the top ranked community needs across age and ethnic groups to impact the outcomes described above. This project includes three core components described below:

1.1 Social Marketing Strategy: This program will increase awareness of mental health issues and resources, decrease stigma, and help people seek more effective strategies for dealing with distress.

a. Media Advocacy: Using both traditional, and innovative strategies, this program will feature media messaging, PSA's, and campaigns which promote positive mental health while providing information to the public regarding the signs, symptoms, and potential treatment of mental illness.

- Traditional methods of marketing will include TV, radio, mass mailing, and print marketing which will include utilizing available campaign materials, as well as the creation of local messaging. This effort will be divided between mental health promotion and stigma and discrimination reduction messages.
- Innovative techniques for social marketing will include web presence; both new online capacity as well as the expansion of the County's Network of Care website which features fact sheets, articles, and local resources. Other innovations may include strategic marketing in school newspapers, yearbooks, programs, community fliers, and trade publications.
- This information dissemination strategy will help promote other PEI project activities including Depression Screenings, speakers' bureau events, and parent education opportunities.
- The Media Advocacy program will be provided through a community contractor selected through the County's formal PEI Request for Funding process.
- All marketing and outreach will be provided and conducted in English and Spanish.

b. Community Outreach and Engagement: This social marketing program will also utilize both traditional and innovative approaches to provide interpersonal mental health awareness, education, and stigma reduction information to populations identified as at risk for mental illness and prioritized through the Community Program Planning Process. Community events, one-to-one engagements, and a speakers' bureau made up of consumers, family members, and other mental health advocates will be utilized to deliver key information regarding the signs, symptoms, and care options for mental illness to underserved and high-risk populations.

This program includes two elements currently funded through the MHSA Community Services and Supports (CSS) Plan. With further definition and development of the MHSA Prevention and Early Intervention component, San Luis Obispo County is transferring the *In Our Own Voice* awareness program and the homeless outreach and engagement elements in the Outreach and Education Campaign from CSS to PEI as required per DMH Notice 08-23.

- Utilizing the aforementioned Media Advocacy program provider, community events and services organized by the County and its community partners, including CSS programs, will be promoted to expand the presence of positive mental health messaging throughout the county. These events and services include depression and anxiety screenings, parent education forums, and consumer and family support groups.
- *In Our Own Voice,* a client-led educational presentation on living with and the realities of mental illness will be transferred from CSS. The presentations will be promoted through Project component 1.1a to expand its presence throughout the county.
- PEI funds will be used to employ 1.5 full time Community Outreach workers (including a .5 FTE being transferred from CSS) to make direct contact with

the following high-risk target populations: Homeless individuals and families; veterans; and those identifying themselves as gay, lesbian, bisexual, transgender or questioning (GLBTQ). These interactions will focus on assessing needs, resource referrals, and risk factor-specific education.

- This targeted social marketing will allow direct one-to-one, personal contact with trauma-exposed and underserved individuals at risk for depression, other mental illnesses, and suicide, who may currently be increasing unhealthy behaviors such as substance abuse, drinking in isolation, or violence. The interactions provided by the Community Outreach workers will include information dissemination, referrals, and screening and support resources.
- The Community Outreach workers will also provide concentrated training to target group support systems, including those who work directly with homeless, veterans, and GLBTQ communities. These trainings will provide awareness and build the capacity of support services to respond to the mental health needs of these underserved groups.
- All marketing and outreach will be provided and conducted in English and Spanish.

1.2 Campus Initiative: Teacher and Student Mental Health Education: This initiative will increase awareness of mental health and illness, including warning signs, symptoms, and treatment; and increase capacity amongst school communities to intervene, make referrals and assist those seeking care through two collaborative programs.

a. Teacher Education: This program will be piloted for two years, using unexpended (Fiscal Year 07-08) funds, and potentially serve 65 school campuses across the County.

- PEI funds will be used to create one full time Mental Health Educator position to provide a wide array of services to the County's elementary, middle, and high schools. This Educator will be available to each campus for staff presentations, information dissemination, one-on-one contact with faculty, and formal curriculum training per the individual school's specific needs and available time.
- This Educator will be responsible for increasing the capacity of school faculty and other staff (i.e. yard duty, front-desk, coaches, etc.) to understand, identify, and provide support for those needing mental health resources; as well as to reduce stigma and discrimination towards those needing support.
- The Educator will use existing materials, and curricula such as *Parents and Teachers As Allies,* to provide training and information to school personnel.
- The Educator will provide training for interested schools and trainers to conduct *Parents and Teachers As Allies* themselves in order to sustain mental health education for teachers beyond this pilot project.
- The Educator will also be responsible for collecting materials and resources for teachers and parents to access via a lending/resource library.
- In the second year of the project the Educator will provide classroom education to Cal Poly State University San Luis Obispo's Teacher Education

program in order to build the capacity of future teachers to understand and address mental health needs on K-12 campuses.

b. Student Education: This program will be ongoing, and will potentially serve 65 campuses focusing on upper elementary grades (4, 5, and 6), middle and high schools across the County.

- PEI funds will be used to create one full time Student Mental Health Educator position to provide classroom teaching in the County's elementary, middle, and high schools. This Educator will rotate through all interested local schools.
- The goal of this program will be to provide youth in schools with accurate, culturally competent information regarding mental illness, awareness of signs and risk factors, the reduction of stigma, and most importantly, resources that a student may access for support - either for their self, or for a friend.
- For those campuses interested in adopting a mental health awareness curriculum, there will be two means of delivery:
    1. The Student Mental Health Educator will provide an evidence based curriculum, such as *Breaking the Silence* (BTS), within standing courses such as Health or Science; or
    2. A school can send their trainer(s) to a train-the-trainer conducted by the Student Mental Health Educator. The BTS curriculum (or other chosen curriculum) will be taught and made available at no-cost to any school attending. The Educator will continue to be available for technical support as the site trainer rolls out the curriculum.

1.3 Parent/Caregiver Mental Health Education: This program will increase awareness of mental health and illness, including warning signs, symptoms, and treatment; and increase capacity amongst parents, extended families, and caregivers to intervene, seek referrals and access care.

This program will be piloted for two years using unexpended (FY 07-08) funds, and potentially serve hundreds of local parents and caregivers each year.

- PEI funds will be used to create one full time Parent Mental Health Educator position to provide targeted awareness education events and educational groups using an approved curriculum, such as *Parents and Teachers As Allies.*
- The parent education events will be promoted by schools and campus community organizations (i.e. PTA's) and will be held in evenings with food and childcare provisions to maximize attendance. Spanish language presentations and materials will be available for monolingual populations.
- This Parent Mental Health Educator will also conduct an awareness campaign specific to parents and caregivers by creating mass mailings and electronic messaging for all school districts to provide to parents. This material will cover mental health promotion, awareness of signs and symptoms, information on accessing care, and strategies for working with youth with emotional or mental health problems.

- The duties of this position will be blended after two years into the Student Mental Health Educator's (1.2) responsibilities.
- The three Parent Mental Health Educators identified in this initiative will work in close collaboration to maximize effectiveness, coordinate activities, and share resources.

B. Implementation Partners and Service Delivery

The Mental Health Awareness and Stigma Reduction Project's components will be conducted in a variety of venues most conducive to promoting positive mental health and awareness. Each component of the project will be provided by an agency or Community Based Organization (CBO) experienced in and most appropriate for the type of service being delivered. An RFP process will be undertaken following state approval of funding.

The daily operating leadership for each component will be provided by agencies or CBO's identified in the RFP process and SLOBHD, with the PEI Community Planning Team involved in quarterly project review. Each PEI provider will be required to meet the County's requirements for cultural competence, accessibility, evaluation and innovation.

The media advocacy and general public outreach pieces of the Social Marketing Strategy will be provided by a local business or CBO which can best achieve the goals and objectives put forth in this plan. Qualifying agencies will be able to create and disseminate material which is accessible to the majority of the general population, as well as utilize innovative means to engage the public in reducing stigma and discrimination. The new Community Outreach worker will be provided by an agency which can support the training and qualifications required to address mental health concerns with the stated targeted priority population sub-groups.

The Campus Initiative and Parent/Caregiver Education components will be provided by individuals, an agency, or CBO which can support the training and qualifications required to address mental health awareness in educational settings, and on campus communities. By providing services on school campuses the county will have the greatest access possible to youth, and by extension, their parents. Schools will be the main target to host Parent Education events as they are often seen as community centers with positive neighborhood relations. However, other settings convenient for parents/caregivers (e.g. churches, community centers, workplaces) can be utilized. Spanish language presentations and materials will be required of providers, so personnel will need to reflect capacity for bilingual/bicultural staffing.

C. Target Community Demographics

The Mental Health Awareness and Stigma Reduction Project will serve the entire population of San Luis Obispo County (est. 257,000), primarily through the Social Marketing Strategy which will employ universal prevention and broad mass media

approaches to provide information to the public. Because this is a county-wide universal project, in effect *all* PEI priority populations will be touched.
Students in K-12, who make up approximately 15% of the County's population, and their teachers, will be provided formal education and training which will build awareness of mental illness and promotion of mental health, while building capacity in school systems to respond to youth and families in need of care.

Targeted groups who are at high risk of developing serious mental illness include: homeless individuals and families (approximately 2,500 individuals or 10% of the population) veterans (12% of county population) and the GLBTQ communities (12% of county population). These underserved cultural populations will be given focused attention as part of this project in the form of outreach, education, and support for accessing care. (See Project 4 for targeted service to underserved Latino populations, which is 18% of the County's population.)

This project will target the entire geographic spread of San Luis Obispo County. Outreach, education, media services and parent trainings will be provided to all County regions.

D. Highlights of New or Expanded Programs

To date, San Luis Obispo County has not made a comprehensive, community-articulated effort to affect the population's understanding of, and capacity to, respond to mental health issues as is being proposed herein. Prior efforts have not been as thoughtfully coordinated or as well-funded as proposed through this Mental Health Awareness and Stigma Reduction Project. This comprehensive countywide strategy is new to San Luis Obispo County.

Existing local outreach efforts have been centered on the consumer-led speakers' bureau, *In Our Own Voice*, which was expanded as part of the CSS process. That effort to raise awareness of the issues faced in dealing with mental illness, will be now be complemented via prevention and early intervention promotion under the proposed project.

E. Action Plan

Components	Strategies	Objectives: Frequency and Duration
1.1 Social Marketing Strategy To increase awareness of mental health issues and resources, decrease stigma, increase seeking of care	**Media Advocacy**	A minimum of four TV/Radio marketing pieces produced annually to target 100,000 residents.
		A minimum of eight print ads, including newspapers, flyers, billboards, yearbooks, and others to target 50,000 residents annually.
		The development of a new web based mental health and illness awareness site, including ongoing updates, to be linked in expansion of the County Behavioral Health and Network of Care

		web presence.
		A minimum of four print or electronic mailings addressing the Veterans and GLBTQ target groups.
	Community Outreach and Engagement	The promotion of a minimum of 8 community awareness and stigma reduction events including parent education forums, Speakers Bureau presentations, including media releases, print ads, and broadcast PSA's.
		In Our Own Voice will provide 25 presentations and serve an audience of 500 annually.
		A minimum of 50 contacts with individuals and groups representing each target population: homeless, veterans, GLBTQ; annually (150 total).
		A minimum of three collaborative education forums annually to raise the awareness of and build capacity with support workers who serve the identified target groups.
1.2 Campus Initiative Teacher and Student Mental Health Education MH/mental illness awareness, warning signs, referral, intervention	**Teacher Education** This is a pilot program funded for two years.	A minimum of 30 K-12 school's faculty and staff per year will be provided with education and curricula support. 900 teachers, administrators and support faculty will be provided information annually.
		In second year, four Cal Poly Teacher Education presentations will be made, addressing 100 future teachers and ten higher education faculty members.
		Conduct at least two "Train the Trainers" events each year for school personnel in evidence based program such as *Parents and Teachers As Allies*. 15 new trainers to be certified annually.
		Create and house one lending/resource library available to school staff and parents. This library may be located at County Office of Education.
	Student Education	Deliver evidence based curriculum, such as *Breaking the Silence* for ten K-12 schools annually, targeting 300 students.
		Conduct at least two "Train the Trainers" events each year for school personnel in evidence based program such as *Breaking the Silence*. 15 new trainers to be certified annually.
		Provide 30 schools annually with materials necessary to conduct evidence based program such as *Breaking the Silence*.

1.3 Parent/Caregiver Mental Health Education MH/mental illness awareness, warning signs, resources	**Parent Education** This is a pilot program funded for two years.	Provide 12 targeted awareness education events and groups annually using an approved curriculum, such as *Parents and Teachers As Allies*. These events will target 240 parents and caregivers annually.
		The Educator will conduct an awareness campaign specific to parents and caregivers by creating mass mailings and electronic messaging for all school districts to provide to parents. This will result in contact with over 10,000 families in the two year project period.

F. Key Milestones and Timeline

Key Milestones	Target Date
Develop RFP and begin procurement process for program providers. • Includes collaboration with PEI Planning Team to design RFP which meets the proposed program requirements	Upon DMH Approval (January 2009)
Transfer currently-operating CSS programming outlined in project description, including: • *In Our Own Voice* awareness program • Community Outreach worker (.5 FTE) targeting homeless population	Upon DMH Approval (January 2009)
Procurement process	Feb. ’09 – April ’09
SLOBHD and PEI Planning Team will establish sub-group to review and select RFP applicants to provide project services • RFP awardees may include agencies currently participating in the county mental health programming	Feb. ’09 – April ’09
Program start-up, including recruitment, hiring and training of staff, and program/infrastructure development	April ’09 – July ‘09
Program implementation of each new component	April ’09 – July ‘09
Provider quarterly reporting to County	July ’09 and ongoing

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through		Number of months in operation through June 2009
	Prevention	Early Intervention	
Media Advocacy	Individuals: 100,000 Families: 11,000	Individuals: Families:	Three
Community Outreach and Engagement	Individuals: 250 Families:	Individuals: 50 Families:	Six
Teacher Education	Individuals: 250 Families:	Individuals: Families:	Three
Student Education	Individuals:75 Families:	Individuals: Families:	Three
Parent Education	Individuals:60 Families: 2,500	Individuals: Families:	Three
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 100,635 **Families**: 13,500	**Individuals:** 50 **Families**:	

5. Linkages to County Mental Health and Other Providers

A. Linking PEI Participants to Services

The Mental Health Awareness and Stigma Reduction Project seeks to reduce stigma and discrimination in the population that is not necessarily connected to current mental health and primary care services, and to provide people who are at risk for mental health issues increased knowledge about how best to access mental health services. Stigma associated with mental health issues is a serious barrier to seeking services. The project will provide anti-stigma and discrimination education to the general public which may need services, have neighbors or family members in need, work with, or provide support to those in need.

All marketing materials will have a telephone number and e-mail that will link respondents to further assistance, such as being connected to the community-based Resource Specialists (Project 5) who can answer questions and refer to local services, including community resource centers, NAMI, or counseling, or to more intense care through County Mental Health. The Community Outreach worker will have expertise in connecting the target populations with appropriate services. The whole objective of the outreach effort is to help recognize problems and link those in need to existing resources.

In order to reduce stigma and create a more welcoming environment for local citizens at risk of mental health issues, it will be important to provide awareness on school campuses where attitudes and behaviors are shaped. This project also promotes the services which exist throughout the county for those in need of assessment, treatment, or support. This awareness will promote the benefits of taking charge of one's mental health, thereby increasing consumer utilization of available services.

Project partners will provide outreach to parents, teachers, support providers, and high-risk groups to help them identify the early signs of serious mental health problems, and take intervention steps early. Parents and schools will be given information and resources which build capacity for assessing a child's need for services and support.

B. Linking PEI Participants to Non-Traditional Services

In addition to accessing traditional mental health services, the reduction of both internalized and external stigma and discrimination will enable people at risk for, or not as yet identified as having, mental illness and their families to more readily access community resources. These resources include community support groups, as well as educational, employment, housing, substance abuse, domestic/sexual abuse, and faith/culturally-based services.

Each component provider will need to demonstrate the capacity to understand and engage the target populations and the ability to promote the benefits of accessing key community mental health services. The materials developed as part of the strategies will

list available community resources, as appropriate. This will be assured by the requirements set forth during the procurement process

Management of the SLO County PEI projects will include oversight by the SLOBHD's Drug and Alcohol Services Division (DAS). This expertise will be critical to move prevention services beyond traditional mental health clinics and treatment providers and to ensure integration within the current service delivery system.

C. Sufficiency to Achieve Outcomes

The SLOBHD engaged community leaders and service providers to provide research on local and comparable county programs to ensure that the budget and program design for this project includes programs and activities which provide a cost benefit to achieve the stated PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, component providers will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes.

Key policies and capacities will include cultural competence, staff training and accountability, evaluation tools, and evidence-based practices. All proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

6. Collaboration and System Enhancements

A. Relationships, Collaborations and Arrangements

The SLO County PEI projects were developed in partnership between the SLOBHD, and stakeholders represented on the PEI Community Planning Team and the age-specific community workgroups (those members are fully described in Part II above).

Critical to this project is the collaboration between the County and schools, including the support of the County Office of Education; and media outlets which have been working closely with the with MHSA project planner since 2005, and with the Drug and Alcohol Services Division to promote prevention for many years. These relationships will be key to launching the Social Marketing Strategy and the Campus Initiative.

Another key ally in the implementation phase for engaging at-risk and underserved communities will be the partnership with the Economic Opportunity Commission (EOC). The EOC has been at the forefront of developing awareness and responses for dealing with the growing homelessness issue. Other organizations, including Cal Poly, GALA, Pride Alliance (GLBTQ), Parents, Families and Friends of Lesbians and Gays (PFLAG), and the San Luis Obispo County Veterans Administration, have each worked with SLOBHD in various capacities, and will be critical to the success of the strategies included in this project.

B. Building Upon the Mental Health and Primary Care Systems

Mental health is key to overall physical health (Fawzy, et. al., 1993). Improving services for individuals with mental illnesses requires paying close attention to how mental health care, general medical care, and other critical systems interact. In assessing community opinion and needs, focus group stakeholders emphasized the need to provide mental illness awareness and sensitivity training to primary care providers.

When stigma and discrimination are decreased, people at-risk for, as yet not identified with, or have a mental illness will be more apt to readily access both mental and primary health services. Strategically, this project seeks to decrease the stigmatizing attitudes of all citizens which would include local primary health providers who may have stigma towards people with mental illness. (See Project 4 for further efforts to target primary care providers.)

This will result in more welcoming environments and more effective treatment. It is an important byproduct outcome of this project that persons with mental illness will be treated with respect and their choices will be honored. Ideally, within the primary care system, the physical complaints of a person with mental illness will be addressed rather than dismissed as part of their mental health problem; and conversely, mental health problems would not be overlooked due to lack of knowledge or discomfort in discussing the symptoms. Decreasing stigma and discrimination will both result in better health for people with mental illness, but also a stronger mental and primary health care system.

C. Leveraging Resources

Each component of the Mental Health Awareness and Stigma Reduction Project will rely on community partnerships which can maximize the benefits of each planned service. For many years the local media agencies in the county have supported public health initiatives, prevention, and education and it is expected that their involvement in this project will continue to demonstrate that commitment to public wellness. This support will result in access to airtime, print space, and broadcast opportunities.

All component providers will be expected to generate supports and leverage resources. Support may include distribution of materials, outreach to their respective members to attend educational events and provide in kind resources. In kind resources may include space, equipment, staff and volunteer time, consultation and referrals. Component providers will be asked to describe their plan for leveraging additional resources and/or funding during the RFP procurement process.

D. Sustaining the PEI Project

The Teacher and Parent Mental Heath Awareness are two-year pilot programs. Teacher awareness will be sustained by expanding the capacity of each school-site to provide its own teacher education and training through train the trainers and other technical assistance provider by the Teacher Educator during the pilot term. Parent mental health

awareness training will continue beyond the pilot term as the Student Educator position will absorb these duties after the program has been developed and standardized

The project's other components will be sustained through continued MHSA funding. As part of implementing the project, SLOBHD will assess the organization and capacity of each provider to fiscally manage and sustain its components. SLOBHD will assign a Program Supervisor and an Administrative Services Officer to monitor the project and each provider's ability to achieve outcomes and meet fiscal requirements at the awarding of the contract. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability, effectiveness of programs, and progress in achieving goals.

7. Intended Outcomes

The San Luis Obispo County PEI Community Planning Team reviewed priority needs relating to stigma and discrimination, unidentified mental illness and lack of knowledge about local services and supports that were identified through the Community Program Planning Process. The Planning Team worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Components: **1.1: Social Marketing Strategy** **1.2: Campus Initiative Teacher and Student Mental Health Education** **1.3: Parent/Caregiver Mental Health Education**
Individual Outcomes
• Increased knowledge of signs and symptoms of mental health problems and the experiences of those living with mental illness. • Increased knowledge of risk and protective factors amongst target populations. • Enhanced resilience and protective factors, including hope and self empowerment. • Increased knowledge of local mental health resources.

System and Program Outcomes
• Reduced internalized/externalized stigma and discrimination, particularly among under/ inappropriately served communities, and those trained in support to those populations. • Increased number of consumers will more readily utilize mental health PEI and other needed services because of the reduction of personal stigma, as well as the reduction of community stigma and discrimination. • Schools will improve systems and policies which support mental health screening, assessment, and access to care. • Reduced stigma and discrimination and increased knowledge of signs/symptoms will lead more teachers, parents and caregivers to seek appropriate referrals and supports. • Community members will be more likely to assist persons experiencing mental health issues in accessing mental health and other services after being exposed to anti-stigma and awareness educational messages.
Methods/Measure of Success
• Media tracking tools to measure capacity and numbers exposed to information in all formats of Social Marketing Strategy. • Pre and Post Test instruments to measure the effectiveness of Education sessions with teachers, students, and parents. • Surveys for target populations assessing baseline attitudes and beliefs, as well as documenting any changes. • Focus group and key informant studies to evaluate outcomes of each component over time. • Rosters, feedback surveys, and other program documentation.

A. Long Term Outcomes

The overarching goal of San Luis Obispo County's PEI Plan is to "help build the capacity of the community to increase resiliency by decreasing risk factors, and increasing the protective factors which promote positive mental health and reduce the negative impact of mental illness." The Mental Health Awareness and Stigma Reduction Project seeks to reduce stigma and discrimination in the population that is not necessarily connected to current mental health and primary care services, and to provide people who are at higher risk for mental health issues increased knowledge about how best to access mental health services.

Ultimately this will result in San Luis Obispo County being an environment where stigma and discrimination toward those with mental health issues and delays in accurate diagnosis and care no longer exists. Potential long term outcomes include:

- The general population, including those impacted by mental illness, will see a reduction in the negative effects of stigma and discrimination. This would be demonstrated by the empowerment of people with mental illness achieving equal access to education, housing, jobs and community resources, and embraced fully by the community.
- Mental health problems will be identified early, thus the impact of the illness - both in terms of suffering and cost - will be lessened.
- Consumers will increase service utilization and the community will document a decrease in psychiatric hospitalizations, the needs for higher levels of care, and other negative impacts of stigma and discrimination.
- Schools, community organizations serving high risk populations, and primary care providers will improve access to mental health services and supports through an increase in the level of knowledge of mental health issues and risk factors.
- All County residents, including those identified with mental illness, will achieve improved resiliency, personal wellness and recovery.

8. Coordination with Other MHSA Components

A. Coordination with CSS

System transformation is a goal of MHSA and one of the key fundamental concepts is service integration and community collaboration. Several CSS components have great collaboration opportunities with this PEI project including the *Family to Family* program, which is a mentoring and support program sponsored by NAMI, and incorporating PEI programs and information through the *Network of Care*, a website funded by CSS. This website provides information and links to community resources for the general public.

In addition, through this effort, individuals from the community at large may be newly identified with varying degrees of mental illness. Based on these individuals expressed needs as consumers, individuals may be referred to one of the many components of

CSS ranging from an educational presentation, to co-occurring services, or to one of the highly intensive FSP programs.

B. Intended Use of WET Funding

San Luis Obispo County's Workforce Education and Training (WET) Taskforce is planning to develop Career Pathways programs that will promote recovery and illness management, a wellness and strength-based curriculum in schools and colleges, increased hiring of consumer employees, and diversification of the mental health workforce to more closely reflect our community.

C. Intended Use of Capital Facilities and Technology Funds

At this time no Capital Facilities and Technology funds have been identified for this project.

9. Additional Comments (optional)

None at this time.

County: San Luis Obispo

Project 2: School-Based Student Wellness Project
Date: 11/17/2008

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

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

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

The community survey ranked two top priority populations: “Children/Youth in stressed families and at high risk for behavioral or emotional programs, or mental illness;” and “Children/youth at risk for school failure due to unaddressed emotional, cognitive or behavioral problems”. Youth, 13-17 years old, and Children, 0-5 years old, ranked as first and second choice as priority for PEI services. Upon further analysis, the Planning Team determined that serving the younger end of the youth spectrum would have the greatest impact.

Stakeholders were clear in stating what types of services best meet the needs of the priority populations. The most unanimous program requests from the comprehensive Community Program Planning Process were for school-based services in general, and those which increase the number and availability of counselors on campuses. One hundred percent of all focus groups (49 separate input groups) stated school based services were the key to effective prevention and early intervention care. Additionally, 60% of survey respondents want help for early mental illness to be available “at settings such as school.”

Stakeholders also strongly supported the provision of school-based wellness programming that gives students the support and skills to deal with emotional or behavioral issues, and develop healthy living, communication and coping skills. The survey respondents ranked this as the second best use of PEI funds; and 79% of focus groups want this type of programming formally and consistently implemented. Local youth survey results indicate rising alcohol and drug use coupled with one-third of high school students reporting feelings of sadness and hopelessness for long periods of time (CHKS, 2007).

Research supports the stakeholder’s recommendations for early childhood and school-based prevention programming. Strong school mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores (Jennings, 2000). Mental health issues or emotional disturbance that occur before the age of six can interfere with critical emotional, cognitive, and physical development, and can predict a lifetime of problems in school, at home, and in the community (Lynch, 1996). Because early childhood is a critical period for the onset of emotional and behavioral impairments (Shonkoff, 2000), this project will address the needs of the community’s youngest students, and those most at risk for developing mental illness.

The programs within Project 2 integrate all of the stakeholder input noted above. The project’s universal prevention elements will touch all of the children/youth priority populations noted in the PEI Guidelines, and the selective prevention and early intervention programs will specifically target the two priority populations noted above.

3. PEI Project Description

The recommendations of the President's New Freedom Commission on Mental Health outline the following tenets which serve as the foundation of the project being described below:

- Schools are in a key position to identify mental health problems early and to provide a link to appropriate services.
- Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school.
- Strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary pain and suffering, and help ensure academic achievement.

The President's New Freedom Commission on Mental Health, 2003

A. Description of Proposed PEI Project

The School-Based Student Wellness Project is a comprehensive, multi-age approach to building resiliency among all service recipients. The project responds to the universal population of children and youth, and youth who exhibit risk factors for mental illness utilizing the following programs: Positive Development with pre-Kindergarten-aged children; Comprehensive Middle School programming for higher-risk schools; Student Wellness programming; and Sober School Enrichment.

This project uses Universal and Selective prevention, and early intervention principles to address all youth including those at risk for school failure, those exposed to trauma, and those with heightened risk for juvenile justice involvement, depression, and suicide. Strategies include youth development and life skills training, Student Assistance Programs, on-campus counseling and support, evidence-based curriculum for key target age groups, and enhanced school-based responses for parents and youth seeking access to care, including resources for more intensive mental health issues. All services will be conducted primarily on campuses and in facilities where students and families are comfortable and welcomed, thus increasing reducing stigma and disparities which often inhibit youth access to care.

The primary goal of this project is to build resiliency and identify mental health issues early. Research supports life skills development as critical to building resiliency in youth. The County has developed strong youth development prevention responses to substance abuse issues, and these strategies will be expanded here to create a similar approach to mental health promotion and the reduction of risk for mental illness. Each program will utilize evidence-based approaches to reduce risk factors and develop protective factors among individuals, and by extension, families and systems. This project includes four core programs that are described below:

2.1 Positive Development Program: This county-wide effort will target the youngest population identified by the Community Program Planning Process. Children, ages 3-5, attending small, private pre-schools and daycare facilities, and their parents, will have access to a Child Development Specialist and evidence-based curriculum which builds problem-solving skills, self-esteem, social, emotional and behavioral control competencies and, ultimately, skills which prepare participants for grade school.

- As a universal prevention approach, this program will target private pre-K schools and daycares which traditionally do not receive dynamic training on mental health or other resiliency and prevention principles.
- A Child Development Specialist position will be created to make contact with and provide side-by-side facilitation of a chosen curriculum to the targeted childcare facilities with the capacity to engage children and their parents in need of boosting social development.
- An evidence-based curriculum, such as *I Can Problem Solve* will be purchased as part of this program and provided to each participating pre-K school.
- The curriculum will help parents, pre-K teachers and other staff address behavioral and anxiety issues, as well as to help develop the early identification of more severe issues.
- If a child is identified as needing further intervention, the Child Development Specialist will assist teachers and/or parents in connecting to available resources.

2.2 Middle School Comprehensive Program: San Luis Obispo County's middle schools are in need of strategies to support youth who are at a developmental age ripe with insecurity, physical and emotional upheaval, and increased exposure and risk for substance abuse, sex and relationship issues, along with the declining parental involvement that comes with increased independence.

This program provides a new approach to this target population by establishing comprehensive student assistance programs across the county on middle school campuses that demonstrate the need for services and the capacity to support this innovative and integrated approach. Schools will be selected through an application and review process based on documented need (i.e. high academic failure rates, disciplinary referrals, high incidents of violence or gang involvement, high numbers of English-language learners, etc.) *and* their capacity to support the tenets of this program.

The program has three distinct elements:

a. Student Support Counselors: Most districts do not have the means to have counselors trained in behavioral health issues located on campus. This program will utilize PEI funds to provide six schools in the county with specialists who will be located on site.

- Three full time Student Support Counselors will be placed at six middle schools. Each Counselor will provide approximately 20 hours per week of service to two schools. School assignments will be static in order for individual counselors to build relationships and an on-going presence.

- The Student Support Counselor will serve all students by providing easy access, short term counseling for any issue with which a student feels s/he needs support, training faculty and staff on recognition of mental health risks and symptoms, developing a referral and screening process for youth to be seen (including by self-referral), and supporting school staff by facilitating youth development programming.
- The Student Support Counselor will conduct regular, selective prevention groups for youth identified at risk for mental illness; as well as indicated short-term, low intensity interventions with those youth experiencing more serious mental health problems. Services will include referrals to treatment when appropriate. Groups may include risk processing including issues of divorce, GLBTQ, domestic violence, grief, etc.
- The Student Support Counselor will work in coordination with the Resource Specialist and Youth Development Programming providers (described below) to ensure all youth on campus have access to mental health promotion and prevention opportunities and that services are integrated, non-duplicative, and meeting the greatest needs of each specific campus.
- To better address the whole family in reducing risk and building protective factors, the Student Support Counselor will be available to all campus parents. The Student Support Counselor will be available for any parent seeking more information, resources, or guidance for supporting a student dealing with mental health risk factors.

b. Resource Specialists: Repeatedly and vigorously expressed throughout the Community Program Planning Process was the importance of dedicated personnel to serve as system navigators to assist youth and others at risk for or struggling with mental health issues to access available resources, obtain basic living needs, and to support resiliency. This component will provide one-to-one linkage services for each of the six middle schools participating in this program. Resource Specialists (also known as Family Advocates or Consumer Partners) are highly valued in other human services agencies and school systems throughout the county and often considered the key to a person's success in overcoming difficult times or situations. The duties outlined below are modeled on proven success experienced by our stakeholders, including CSS program providers.

- The Resource Specialist on each campus will provide support to all students (and their families, as appropriate) by responding to faculty, staff, parent, and self-referrals which identify a student in need of supports such as clothing, food, school supplies, medical and dental care, transportation, mental health or drug and alcohol assessment and treatment, educational support, public aid and assistance, governmental services navigation, and employment support. The Resource Specialist may be needed for a "one time" issue that if resolved would prevent or minimize stress and trauma, or may need to provide longer-term case management to the child and family until the difficulties have resolved and stability is reached. Meeting basic daily life needs removes barriers to school success and reduces stressors linked to

behavioral problems, family violence, substance abuse and mental health issues.

- The Resource Specialist will team with the Student Support Counselor and have a reciprocal relationship. The Resource Specialist may identify a child as needing emotional and developmental assistance and refer to the Student Support Counselor; and the Student Support Counselor will identify students and families in need of daily supports and an overall "helping hand." The Resource Specialist and Student Support Counselor will partner to create wellness plans for each student they share and will support each other in ensuring overall program success.
- The Resource Specialists will be employed by a community provider who, through the procurement process, can assure the organizational capacity to train, monitor, and evaluate the staff; develop cultural competence (including the culture of adolescents) and demonstrate an understanding of and ability to engage an array of local services which build protective factors against the negative impact of mental illness.

c. Youth Development Programming: Youth Development, the "ongoing process in which young people are engaged in building the skills, attitudes, knowledge, and experiences that prepare them for the present and the future (Pittman, 1990)" is a key in building resiliency which reduces the risk of mental health issues. In this component each participating middle school will strengthen its school-based assets by launching or expanding evidence-based youth development opportunities.

- Each of the six middle schools will integrate an evidence-based youth development curriculum, such as Botvin's *LifeSkills Training*, or Friday Night Live *Mentoring*, which build core competencies in a universal prevention model. The curriculum chosen will address esteem, communication, understanding of alcohol or other drug (AOD) issues and other risk factors, and exploration of the students' leadership skills and peer-relations capacity.
- One full time Health Educator position will be created to serve the six middle school sites, and will be on each campus at least once per week. This Health Educator will deliver the evidence-based curriculum.
- Each middle school will be allowed to choose the youth development approach which best suits their population. PEI funds will provide each site with resources to purchase curriculum and activity materials.
- Targeted assistance programming will be made available at each campus for youth exhibiting problem behaviors and attitudes and experiencing negative consequences. Youth Development groups and activities will be conducted by the Student Support Counselor described previously.

2.3 Student Wellness Strategy: This innovative youth development program creates a continuum of prevention services across grades, and offers resiliency-building and risk-decreasing activities to all county middle schools.

a. 5th Grade Initiative: During the Community Program Planning Process**,** the Children and Youth Workgroup, including mental health professionals, educators,

and child development experts, indicated the need for universal prevention approaches that address key developmental stages. Fifth grade students were selected as a target population due to risk factors compounding at this age (including the emerging adolescence, emotional development, and the lack of DARE or other substance use education). Fifth grade students are demonstrating risk indicators such as alcohol use (according to the most recent California Healthy Kids Survey). Additionally, it was recommended to provide prevention programming at one developmental stage and then repeat it at a later stage - thus the 5th grade build up, followed by the middle school reinforcement component described within this program. This component was developed in concert with research supporting 5th grade youth development interventions.

The goals will be to "teach students that stress is normal and that resiliency and prevention are effective ways to deal with stress;" and to "teach students the importance of communication and asking for help."

- All 5th grade classes across the county (approximately 39 schools) will receive an evidence-based curriculum, such as Botvin's *Life Skills Training: Promoting Health and Personal Development* or NCTI's *Crossroads*. These curricula have demonstrated success in building capacity in youth to see that "mental health is positively correlated with self-efficacy beliefs." And that "personal and academic competency is operationalized by identifying and achieving short and long-term goals. "
- One full time Health Educator position will be created to rotate through the county's schools to conduct the curriculum and provide training to staff throughout the year. The Educator will be trained in prevention education, have youth development experience, and will be able to demonstrate cultural competence.
- The Health Educator will be selected either through a RFP procurement process, or assigned to SLOBHD staff meeting the requirements identified above.

b. Middle School Initiative: In order to reach students in those middle schools (approximately 8) not participating in the Middle School Comprehensive Program described above (Program 2.2), this initiative will provide universal prevention by infusing evidence based practices amongst each of the remaining campuses.

- PEI funds ($5,000) will be provided to each school site to deliver an evidence-based youth development program of the school's choice. (Will select from programs approved by SLOBHD).
- Schools with in-school and after-school health programming will be encouraged to enhance student development by addressing the key competencies and skills at the root of research-based prevention strategies including those listed above.
- This component will result in all middle schools having at least some level of formal, consistent universal or selective prevention programming. Currently,

some schools currently have no programming. Other schools will have the opportunity to expand from targeted to universal activities, or vice-versa.

2.4 Sober School Enrichment: San Luis Obispo County's Office of Education launched a Sober School for students 14-18 years old as part of its Community School programs in 2007. The school provides a comprehensive and challenging academic program for youth committed to remaining clean and sober. Students apply to the program voluntarily. The school's population is fifteen, with additional students enrolling each year.

During the PEI planning process, youth with substance abuse problems were consistently identified as a population in great need for mental health prevention and early intervention services. This program will expand services to this high-risk population by placing a Student Support Counselor at the Sober School along with wellness and youth development activities focusing on sobriety and recovery.

- A Student Support Counselor specializing in substance abuse and dependence and with experience in youth development and prevention will be placed on campus. The Counselor will conduct selective prevention groups for youth whose chemical abuse and dependence puts them at risk for a co-occurring disorder; as well as indicated short-term, individual interventions with those youth experiencing crises, trauma, or a particularly difficult period. Services will include referrals to more intensive behavioral health treatment when appropriate.
- The Student Support Counselor will also provide youth development opportunities and training for the whole school population. The opportunities may include peer mentoring, outdoor programs, leadership and community service, and life skill development and exploration. This includes linking students to positive activities, and asking providers of such to come on campus to engage students personally.
- The Counselor will be placed on campus for ten hours/week.

B. Implementation Partners and Service Delivery

The School-Based Student Wellness Project's programs will be conducted in the venues most conducive to promoting resiliency and reducing the risk factors associated with mental illness amongst youth: schools. Each program will be provided by either a team of providers or individuals qualified to provide quality prevention and early intervention within the targeted populations. Each component of the project will be provided by an agency or CBO experienced in and most appropriate for the type of service being delivered. An RFP process will be undertaken following state approval of funding. Daily operating leadership will be a partnership–between the participating schools, selected providers, and SLOBHD. The PEI Community Planning Team will participate in quarterly project review. Each PEI provider will be required to meet the County's requirements for cultural competence, accessibility, evaluation and innovation.

The **Positive Development Program** will be provided by an agency or CBO which can best achieve the goals and objectives put forth in this plan. Qualifying agencies will be able to recruit, train, monitor, and evaluate a Child Development Specialist who can outreach and interact with private pre-K's throughout the county. The providing agency will also be able to document the training and qualifications required to address mental health concerns with the stated high-risk population sub-groups within a procurement process.

The **Middle School Comprehensive Program** involves a multiagency collaborative. The **Resource Specialists** will be provided by an agency or CBO which can best achieve the goals and objectives put forth in this plan. Qualifying agencies will be able to recruit, train, monitor, and evaluate Resource Specialists who can interact with schools and health and wellness resources throughout the county. The provider agency will also be able to document the training and qualifications required to address mental health concerns with the stated high-risk population sub-groups within a procurement process.

Student Support Counselors and **Health Educators** will be provided either by an agency or CBO which can best achieve the goals and objectives put forth in this plan. This may include expansion of the SLOBHD's Drug and Alcohol Services school prevention and counseling programs. **Youth Development** programming will be selected by schools from agencies and CBOs which can demonstrate use of evidence-based practices, trained staff with cultural competence (including adolescent culture) and the capacity to engage youth.

C. Target Community Demographics

The School-Based Student Wellness Project will serve distinct target populations identified as either at higher risk for developing mental illness or developmentally appropriate for receiving prevention and mental health wellness services according to research and prioritized though the PEI Community Program Planning Process. The project builds competencies in each of the target individuals, as well as in the school systems.

- The **Positive Development Program** will target small, private providers of daycare and pre-school which comprise 39% of all childcare in the County. These providers are often untrained or unlicensed (only 35% of all childcare in the county is licensed), lack resources for training and materials, and lack curricula for behavioral health issues, and the expertise to identify mental health issues, or are unable to support parents in need of mental health education or training. This program will serve 50 sites per year, and approximately 500 children and their families.
- The **Middle School Comprehensive Program** will target schools in the northernmost and southernmost parts of the county where higher rates of poverty and crime, along with cultural and socioeconomic disparities create

added risk factors amongst the student populations. Approximately 625 youth will be served.

- The **Student Wellness Strategy** will target the remaining middle schools, and each of the county's 39 fifth grades. This universal approach will target all risk demographics listed above. Approximately 3200 youth will be served countywide.
- **The Sober School Enrichment Program** addresses a targeted demographic at high risk for co-occurring disorders based on each student's history of substance abuse or dependence. Currently the school hosts 15 youth, with planned expansion of 10% each year.

D. Highlights of New or Expanded Programs

Each program in the School-Based Student Wellness Project features innovative programming new to SLO County schools and students. In some instances services may take advantage of existing partnerships, resources, or staff, but each program implements a highly-desired, but previously unavailable, strategy.

The San Luis Obispo Economic Opportunity Commission supports private daycare providers countywide with training and licensure activities, but the institution of a prescribed mental health curriculum focusing on skill building is new. The County has had great success with substance abuse prevention and youth development programs such as Friday Night Live, and FNL Mentoring, while community organizations like 4-H, YMCA Youth In Government, and Healthy Start After School programs have been in partnership with schools and districts for many years. However, these opportunities have not been available to each of the schools targeted in the project, nor has there been a concentrated mental health wellness focus. This project provides much-needed school-based counseling and resource support to several more schools and thousands more young people.

E. Action Plan

Programs	Strategies	Objectives: Frequency and Duration
2.1 Positive Development Program	**Private Preschool Outreach and Education**	50 private providers of daycare will be targeted each year to be trained in identifying mental health issues and conduct evidence-based social, emotional and behavioral skills and parenting curriculum.
		500 youth and a majority of their parents/caregivers will be engaged through curriculum activities.
2.2 Middle School Comprehensive Program	**Student Support Counselors**	Six public middle school sites will be selected to receive a half-time School Support Counselor to implement comprehensive prevention programming.
		Counselor will conduct at least four groups per

Integrated program for middle school youth.		week, for 8-15 youth, including Youth Development groups for selective populations at high risk (a minimum of 96 youth per school annually)
		Counselor will conduct 10-20 individual sessions weekly, including low intensity, short term interventions (a minimum of 50 youth not engaged in groups per school annually).
		Counselor will develop a school-based assessment and referral tool for faculty and provide staff with training.
	Resource Specialists	The Resource Specialist will provide direct linkage to resources and system navigation supports for a minimum of 50 youth and their families at each site annually.
	Youth Development Programming	Each school site will be provided with the services of a Health Educator to conduct evidence based Youth Development (YD) curriculum, serving approximately 480 youth per year.
		Each site will be provided with funds to support evidence based YD opportunities serving approximately 600 youth each year.
2.3 Student Wellness Strategy Education and activities for all students at key transitional ages.	**5th Grade Initiative**	39 elementary schools will have access to the services of a Health Educator to deliver evidence based life skills curriculum, serving up to 2400 youth annually.
	Middle School Wellness	Eight middle school sites not participating in Program 2.2 will be provided with funds to support evidence based YD opportunities serving approximately 800 youth each year.
2.4 Sober School Enrichment High-risk subgroup services.	**Student Support Counselor and YD Activities**	Counselor will hold at least three groups per week, for 8-15 youth, including sobriety support, relapse prevention, anger management, building positive peer relationships, and YD alternatives for selective populations at high risk.
		Counselor will conduct 5-10 individual sessions weekly, including low intensity, short term interventions for mental health issues.

F. Key Milestones and Timeline

Key Milestones	Target Date
Develop RFP and begin procurement process for program providers. • Includes collaboration with PEI Planning Team to design RFP which meets the proposed program requirements • Includes selection of school sites for implementation. Schools will be selected during a separate Request for Qualification process to determine need, and system capacity to carry out Middle School Comprehensive Program.	Upon DMH Approval (January 2009)
Procurement process	Feb. ’09 – April ’09
SLOBHD and PEI Planning Team will establish sub-group to review and select RFP applicants to provide project services • RFP recipients may include agencies currently participating in the county mental health programming	Feb. ’09 – April ’09
Program start-up, including recruitment, hiring and training of staff, and program/infrastructure development	April ’09 – July ‘09
Program implementation of each component	April ’09 – July ‘09
Provider quarterly reporting to County	July ’09 and ongoing

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through		Number of months in operation through June 2009
	Prevention	Early Intervention	
Positive Development Program	Individuals: 125 Families: 70	Individuals: Families:	Three
Middle School Comprehensive Program	Individuals: 120 Families: 12	Individuals: 36 Families:	Three
Student Wellness Strategy	Individuals: 800 Families:	Individuals: Families:	Three
Sober School Enrichment	Individuals: Families:	Individuals: 3 Families:	Three
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 1,045 **Families**: 82	**Individuals:** 39 **Families**:	

5. Linkages to County Mental Health and Other Providers

A. Linking PEI Participants to Services

This project will provide children and youth (and their parents) increased knowledge about the mental health and support services available locally, and provide personnel to ensure that they are directly linked to community providers and services. Stigma associated with mental health issues is a serious barrier to seeking services.

The provider schools and parents involved in the Positive Development Program will be given information and resources which build capacity for assessing a child's need for services and support.

Overall, this project includes critical life skill building which increases protective factors and resilience, thus making participants more apt to engage in services to get their needs met. The Student Support Counselors, Health Educators and Resource Specialists will be well-poised to help participants identify and articulate their needs, and will have the capacity to connect them to appropriate services beyond their care.

B. Linking PEI Participants to Non-Traditional Services

The provision of Resource Specialists will enable students and their families to more readily access alternative community resources. Resource Specialists, who know the vast and varied resources available throughout our county, including the over 500 human services non-profits, will navigate a person through the community's system of supports. These resources could include community support groups, as well as basic living needs, educational, employment, housing, substance abuse, domestic/sexual abuse, and faith/culturally-based services.

This will be assured by the requirements set forth during the procurement process. Each provider in this project will need to demonstrate the capacity to understand and engage the target populations and the ability to promote the benefits of accessing key community mental health and other services.

Management of the SLO PEI projects will include oversight by the Drug and Alcohol Services Division. This expertise will be critical to move prevention services beyond traditional mental health clinics and treatment providers.

C. Sufficiency to Achieve Outcomes

The SLOBHD engaged community leaders and service providers to provide research on local and comparable county programs to ensure that the budget and program design for this project includes programs and activities which provide a cost benefit to achieve the stated PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, service providers will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes.

Key policies and capacities will include cultural competence, staff training and accountability, evaluation tools, and evidence-based practices. All proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

6. Collaboration and System Enhancements

A. Relationships, Collaborations and Arrangements

This project was developed in partnership between the SLOBHD, and stakeholders represented on the PEI Community Planning Team and the Children and Youth community workgroups (those members are fully described in Part II of this plan).

Critical to the Middle School Comprehensive, Student Wellness, and Sober School Enrichment programs is the collaboration between the County and schools, including the support of the County Office of Education; and school districts which have been working closely with the Drug and Alcohol Services Division to promote prevention for many years.

The Positive Development Program is dependent on engaging private day care providers through partnerships with agencies such as the Economic Opportunity Commission (EOC), Cal Poly, and the school psychologists. The community's EOC has been working with private daycare providers in licensing and training programs for many years, and other stakeholders as part of the PEI Community Planning Team will provide key planning and oversight.

B. Building Upon the Mental Health and Primary Care Systems

Each component of this project links education, programs and services within and across systems. Students and their families are connected to behavioral health education, programs, and services. When appropriate, key personnel will make referrals to medical care and longer duration or more intensive therapeutic services. The School-Based Student Wellness Project develops new partnerships with schools and delivers services in settings which are nonthreatening/ non-stigmatizing to students and families.

Easily accessible, on-campus mental health counseling and wellness support effectively interrupts the progression to more serous issues. Early identification and referral to appropriate community resources will assure that the local mental health and primary care systems will have an opportunity to intervene early, which will reduce the number of "intensive" or "severely ill" burdening the system, and help the system be more effective and provide more proactive, rather than reactive care.

Teaching development skills for children and youth and training parents can mitigate stigma commonly associated with mental illness and could help these group identify or admit problems earlier.

Distressed children and adolescents place high demands on caregivers and schools, straining resources. By providing development skills, counseling, early intervention, and linkages to necessary care, gaps in services can be closed to prevent significant harm to children and the community.

C. Leveraging Resources

The School-Based Student Wellness Project will rely on community partnerships which can maximize the benefits of each planned service. For many years school districts and campuses in the county have worked in concert with agencies promoting public health initiatives, prevention, and education, and it is expected that their involvement in this project will continue to demonstrate that commitment to public wellness. This support will result in access to space, students, faculty, and parents.

All providers in this project will be expected to generate support and leveraged resources. Support may include distribution of materials, outreach to their respective members to attend educational events and provision of in kind resources. In kind resources include things such as space, equipment, staff and volunteer time, consultation and referrals. Component providers will be asked to describe their plan for leveraging additional resources and/or funding during the procurement process.

D. Sustaining the PEI Project

It is the intention of the SLO PEI Community Planning Team that this project will be sustained through continued MHSA funding, and leveraged and in-kind resources provided by the partners.

SLOBHD will assess the organization and capacity of each provider to fiscally manage and sustain this program. SLOBHD will assign a Program Supervisor and an Administrative Services Officer to monitor the project and its providers' ability to achieve outcomes and meet fiscal requirements at the awarding of the contract. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals.

7. Intended Outcomes

The San Luis Obispo County PEI Community Planning Team reviewed priority needs relating to student risk, resiliency, and wellness that were identified through the Community Program Planning Process. The Planning Team worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to the desired outcomes.

Programs:

2.1: Positive Development Program

2.2: Middle School Comprehensive Program

2.3: Student Wellness Strategy

2.4: Sober School Enrichment

Individual Outcomes
• Increased knowledge of social, emotional, and behavioral issues amongst target populations, and improved behavior (i.e. self-control, peer relations, anger, and compliance). • Decreased risk factors amongst target populations. • Enhanced resilience and increased protective factors, including social and life skills competencies. • Increased successful follow through on linkages/referrals. • Reduction in number of suspensions. • Increased grade promotion/attendance rate. • Improved parenting skills (pre-K program). • Improved coping with emotional, behavioral or social problems through voluntary counseling.
System and Program Outcomes
• Increase in number of prevention programs and early intervention activities in schools. • Increased number of students who will more readily utilize mental health and other needed services due to the reduction of personal stigma, as well as the increase in school-based assessment and response systems (i.e. procedures to improve access for referred individuals and families). • Increase in number of individuals and families identified as needing early intervention services. • Increase in number of individuals and families identified who receive prevention programs and early intervention services.

Methods/Measure of Success
• Standardized tools such as the California Healthy Kids Survey to track risk behaviors, attitudes, and resilience ratings. • Pre and Post Test instruments to measure the effectiveness of the youth development programming. • Surveys for target populations assessing baseline attitudes and beliefs, as well as documenting any changes. • Focus group and key informant studies to evaluate outcomes of each component over time. • Rosters, feedback surveys, and other program documentation. • Mental health screenings performed by Student Support Counselors.

A. Long Term Outcomes

The School-Based Student Wellness Project contributes to the overarching goal of San Luis Obispo County's PEI Plan to "help build the capacity of the community to increase resiliency by decreasing risk factors, and increasing the protective factors which promote positive mental health and reduce the negative impact of mental illness." The project builds resiliency and utilizes science-based approaches to reduce risk factors and develop positive protective factors among individuals, and by extension, families and school systems. Potential long term outcomes include:

- The county's student population will have lower incidences of behavioral problems and mental health issues.
- Children and youth with mental health problems will be identified earlier and be provided with increased access and assistance to treatment and support.
- Youth will increase overall wellness and resilience.
- Schools will report increased attendance, grade promotion, and graduation rates.
- Schools, including those serving high risk populations, will improve access to mental health services and supports through an increase in the level of knowledge of mental health issues and risk factors, and more services provided.
- The community will demonstrate reduced suicide rates.

8. Coordination with Other MHSA Programs

A. Coordination with CSS

There are risk factors in each of the targeted populations that may contribute to various mental illnesses. Through this project, children and youth identified as SED would be referred to appropriate CSS programs, such as the children and TAY FSP programs, co-occurring programs, or the Latino treatment program.

Staff in these particular PEI projects will be oriented to all CSS activities, in addition to all other Behavioral Health and community-based programs outside of MHSA, in order to develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

B. Intended Use of WET Funding

The Workforce Education and Training Taskforce is currently considering Carrier Pathways programs that will address career exploration for High School seniors. Staff in these PEI programs will be oriented to educational and vocational resources available for youth.

C. Intended Use of Capital Facilities and Technology Funds

At this time, no Capital Facilities and Technology funds have been identified for this project.

9. Additional Comments (optional)

None at this time.

County: San Luis Obispo

Project 3: Family Education, Training and Support
Date: 11/17/2008

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

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

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

This project addresses numerous important community issues, and meets the needs of several priority populations through universal and selected prevention and early intervention approaches. This project provides parents throughout the county with evidence based parent training, one-to-one coaching, and resource coordination.

During the Community Program Planning Process it was reiterated that the true key to eliminating many of the risk factors associated with mental illness was to strengthen families through impacting parents.

The community ranked domestic violence, homelessness, school failure, suicide, prolonged suffering or trauma (including abuse), and removal of children from their homes within the top ten most important issues for PEI programs to address. All of the subject matter age-specific Workgroups and the Community Planning Team agreed that improving parenting behaviors and skills may prevent these issues in the first place, or reduce the impact of these stressors when they do occur.

Focus groups, including teens with mental illness, parents with adult children with mental illness, low-acculturated Latinos, educators, therapists, and child abuse and addiction experts, all agreed that a significant commitment should be made to improve parenting skills and provide parenting training, “whole family” approaches, and readily-available interventions, through a project that includes both prevention and intervention approaches. Eighty-five percent of focus groups recommended that PEI funding be used to improve parenting skills.

Priority populations were selected based on surveys, focus groups, the subject matter expert age-specific Workgroups, and the Planning Team. Children/youth in stressed families (includes families where there’s substance abuse, violence, depression) was selected as the top priority population by the community at large. While the parent is the service recipient, both parent and child are the service beneficiaries, and both are the priority for this project’s selective prevention and early intervention programs. Additional priority populations include: parents of children at risk of school failure or juvenile justice involvement, trauma-exposed parents or children; and underserved cultural populations, including low-acculturated Latino parents.

3. PEI Project Description

Parent training is a proven strategy for reducing the risk and negative impacts of mental health issues for children and adolescents. Results of multiple studies indicate that protective factors such as family cohesion, emotional cohesion, and warmth appear to be consistent factors associated with positive post-trauma adjustment and reduction in mental health problems (Gorman-Smith, 2004).

Studies have found that in cases of juvenile offenders who had been arrested an average of three times by age 14, having the parents undergo behavioral parent training

reduced the rate of incarceration by 64% in the first year. Another study found that even after age 14 years, children whose parents took the training were much less likely to be arrested and jailed as adults (Henggeler et al., 1997).

The President's New Freedom Commission recommends the following tenets which serve as the foundation of the project being described below:

- Educational efforts can help a greater number of parents learn about the importance of the first years of a child's life and how to establish a foundation for healthy social and emotional development.
- Addressing the mental health of young children may also involve providing information, supports, and treatment for parents.

The President's New Freedom Commission on Mental Health, 2003

A. Description of Proposed PEI Project

The Family Education, Training and Support Project is a multi-level approach to building the capacity of all county parents and other caregivers raising children. This includes parents and caregivers in "stressed families" living with or at high risk for mental illness, trauma, substance abuse and domestic violence; as well as those parents/caregivers who are doing well and wishing to maintain stability. This project will improve skills, and build capacity and resiliency in both parents and their children by utilizing the following programs: Coordination of Existing Parenting Programs; Parenting Training and Education; and Coaching to Parents and Caregivers.

This project uses Universal and Selective prevention and early intervention approaches available to all parents/caregivers including those with children at risk for school failure, those exposed to trauma, and those with heightened risk for juvenile justice involvement, depression, and suicide. Strategies will include multi-systemic skills training, information dissemination, and one-on-one and group parent support and guidance.

Research supports behavioral parent training as critical to reducing the risk for mental health problems including school failure, violence, depression, and substance use. Over the years county providers have built excellent parenting courses for various demographics. However, very few programs address the risk and protective factors which affect positive mental health.

The goals of this project are to build competencies and skills in parents and caregivers, decrease parent-induced trauma or the impacts of situational trauma, and better respond to the urgent needs of parents in stressed families at risk for abuse.

This project includes three core programs that are described below:

3.1 Coordination of County's Existing Parenting Programs: This program provides an innovative service to the county by establishing a coordinated, proactive web-based, outreach-oriented parent resource center to disseminate information and referrals. The Community Program Planning Process revealed that many parenting classes and resources do exist in SLO County; however there is no central clearing house for the information or a master calendar. Offerings are not consistent. Schedules are uncertain; pre-notice is often short, and parents most in need are often unaware of classes currently being offered. Recently, the local Child Abuse Prevention Council has been attempting to list parenting classes on its website. However, they have limited resources and state that many resources are still untapped, uncataloged and that there has been no proactive efforts to connect with parents, schools and other providers to promote the classes and trainings.

- A half time Education Coordinator position will be created to serve parents countywide in providing outreach, referrals, coordination, and promotion of the various parenting classes and resources offered throughout the community.
- The Education Coordinator will gather information, and track and monitor existing programs by maintaining a web-based portal for community members and providers to access parenting classes and resources. Links to this portal will be placed on hundreds of school, city, social and human services, and other providers' websites, including the CSS-sponsored *Network of Care* site.
- The Education Coordinator will assist schools and agencies by creating and distributing parent education resources, including providing training and outreach.
- The Education Coordinator will identify needs and expand services for parents and caregivers countywide.

3.2 Parent Educator: The Community Program Planning Process clearly identified several parenting education and training needs, including:

- Parent education and training needs to strengthen parenting competencies and decrease the effects of stress and trauma.
- Need to improve the consistency and accessibility of available classes.
- Need to increase the number of fathers participating.
- Need to increase the number of courses available in Spanish.

One full time Parent Educator will be created to thoroughly meet these needs by providing both universal and selective prevention parenting programs, designed and delivered strategically throughout the county to a diverse population of parents.

a. Universal Parent Prevention Programs: Evidence based curriculum will be delivered to English and Spanish-speaking parents throughout the county. Core competencies for families will increase, including communication, goal-setting, stress reduction, relationship building, trust, and structure.

- The Parent Educator will provide at least three courses per year using evidence-based curricula such as *Strengthening Families*, *Nurturing Parent*, *Parent Participation Program*, or *Positive Parenting Program*.

- These courses will address responsibility, communication and listening skills, safe and effective discipline, encouraging and building self-esteem, and understanding the stages of child development.
- The Parent Educator will utilize the findings of the Education Coordinator to determine the best delivery options and curriculum based on parent and school input, the regions that should be served first and the best ways to leverage community resources to maximize the number of parents/caregivers that can benefit, including ways to encourage fathers to participate. The Education Coordinator will promote the courses provided by the Parent Educator.
- The Parent Educator will collaborate with the Mental Health Educators (Project 1) to coordinate training deliveries as much as possible, integrate learning needs, and refer parents to the services of each other's programs. Classes will be held at convenient hours and locations, which may include weekends, on school sites, at churches, and in conjunction with other activities that already have parents in attendance.

b. Selective Parent Prevention Programs: For parents with children and adolescents who are difficult or out of control, trainings and skill sessions will be offered that address building effective skills in parents facing destructive behaviors, stressed homes, trauma, and children entering juvenile justice systems.

- The Parent Educator will conduct four behavioral parent training courses annually using curricula such as *Parent Project*, or *Loving Solutions*, in both English and Spanish.
- The courses will teach parents to substitute systematic for arbitrary discipline. Parents will learn how to set rules and define the consequences for disobeying them. They will also learn how to negotiate with older children, how to follow through on warnings, and how to identify early signs of trouble and talk to children about these problems. At the core of behavioral parent training is the establishment of positive praise, love, and trust-building.
- A concentrated effort will be made to include father participation, and the Parent Educator will team with the Education Coordinator (Project 3.1) and the Mental Health Educators (Project 1) to assist with this, as well as the families' other community supports such as teachers, pastors, therapists, probation officers, social services, and case managers. As applicable, the Student Support Counselors and Resource Specialists in Project 2 will encourage the fathers they interface with to participate.
- The Parent Educator will collaborate with the Mental Health Educators (Project 1) to coordinate training deliveries as applicable, integrate learning needs, and refer parents to the services of each other's programs.
- Referrals to these classes can come from the parents themselves or others involved with the family, such as the school, churches, Social Services, Drug and Alcohol Services, Mental Health, EOC, Probation, etc.

3.3 Coaching for Parents/Caregivers: This project's efforts to build parenting capacity will be enhanced by the creation of a team of parent coaches to provide "on-demand" guidance and support for parents in "stressed families" or environments of abuse. Coaches will provide brief interventions when there is an acute difficult situation with a child – offering parents/caregivers someone to assist them through the steps to deescalate the issue and assist in preventing the parent from acting out in frustration, which could make matters even worse.

The Coaches: A team of coaches will provide "on-demand" guidance, feedback and support to parents in "stressed families" or environments of abuse. Parents and caregivers who find themselves in need of advice, counsel, or brief interventions will be able to access one of the coaches for one-on-one telephone and, when possible, in-home coaching.

This is a new and innovative approach to a concern from many agencies and community services which report limited resources for responding to parents in need; other than referring them to classes which may not begin for weeks or months from the time of crisis.

- The Parent Educator will serve as the lead coach as well as recruit, develop and manage a team of at least five coaches.
- The Parent Educator will provide training for coaches including the use of evidence-based curricula listed above and other strategies such as *Incredible Years* and *Parent-Child Interaction Therapy*.
- Unexpended PEI funds (FY 07-08) will be used to recruit and train college interns, volunteers, retired childcare and teaching professionals, AmeriCorps members, or MFT and LCSW interns who will be able to provide coaching services to parents in need.
- At least one coach will be bilingual/bicultural.

The Coaching Approach:

- The Parent Educator will establish a hotline, in collaboration with the Education Coordinator, and a triage system to provide one-on-one and group coaching interventions.
- Coaching will consist of assessment of stressors and risks, training and skill building with parents/caregivers to ameliorate immediate concerns while building competencies for future parenting challenges.
- Coaching interventions may include linkage for parents seeking other community resources, understanding of child welfare, law enforcement and legal systems for youth, and immediate responses necessary to provide safety and a calm environment to address stressors.
- Coaching Team members will be located throughout the county and will have both established office/phone hours and time in the field to conduct in-home and group coaching.
- Coaches will make appropriate referrals to law enforcement, Child Welfare Services, social services providers, primary and behavioral health care when appropriate.

B. Implementation Partners and Service Delivery

The Family Education, Training and Support Project's components will be conducted in venues most conducive to information dissemination, promoting resiliency and building strong parenting skills through active classes. Locations may include school sites, churches, libraries, community centers, and agencies that are conveniently located to groups of parents, or facilities that are already holding events that parents are attending.

The project's programs will be provided by an agency or CBO experienced in and most appropriate for the type of service being delivered. An RFP process will be undertaken following state approval of funding. The daily operating leadership for each component will be provided by agencies or CBO's identified in the RFP process and SLOBHD, with the PEI Community Planning Team involved in quarterly project review. Each PEI partner will be required to meet the County's requirements for cultural competence, accessibility, evaluation and innovation.

The **Coordination of the County's Parenting Programs** will be provided by an agency or CBO which can best achieve the goals and objectives put forth in this plan. Qualifying agencies will be able to track, monitor, store, disseminate, and promote information regarding existing parenting courses and resources throughout the region. The provider will be required to create and maintain a "clearing house" web site which will house information accessible to parents, caregivers, schools, professionals, and the general public.

The **Parent Educator** and **Coaching for Parents/Caregivers** programs will be provided by an individual, CBO or agency which can provide specific professional responses to this innovative project. The Parent Educator and Coaching Team will be required to have the training and qualifications required to address mental health concerns with the stated general and high-risk population sub-groups of parents.

C. Target Community Demographics

The Family Education, Training and Support Project's components will serve both general and targeted parent populations and distinct parent populations with need for improved understanding of their impact on their child's emotional and mental health and the risk and protective factors associated with mental illness; as well as address those parents and caregivers in stressed families who need skills and competencies to reduce trauma, anxiety, and abuse.

- The **Coordination of the County's Parenting Programs** will serve all parents and caregivers in the community, as well as the CBO's, schools, agencies and grass roots organizations which provide and promote parent resources, education, and training. There are over 30 CBO's with a child/youth-focus and 11 school districts in the County. The information collected and maintained by the Coordinator will be available to the 28,000 families in the county with a target goal of 2,800 (10%) contacts annually.

- The **Parent Educator** will serve the general population in universal prevention efforts by conducting three 6-to-12-week courses annually, with at least one session provided in Spanish. Approximately 90 parents/caregivers will be served.
- The **Parent Educator** will also serve a selective prevention population made up of parents and caregivers from "stressed families" and those experiencing trauma and exacerbated factors placing them at high risk for violence and abuse. The Parent Educator will provide four 6-to-12 week courses annually, with at least one session provided in Spanish. Approximately 120 parents/caregivers will be served.
- The **Parent Coaching** program serves families which are experiencing acute stressors and are at high risk for violence and abuse by establishing a hotline and triage system to provide one-to-one and group coaching interventions. Protective factors are built for both children and parents. Approximately 10 contacts per week will be made with a target goal of 500 families served in a year.

D. Highlights of New or Expanded Programs

The Coordination of the County's Parent Programs is an expansion of the efforts that have been undertaken by the SLO County Child Abuse Prevention Council (SLOCAP). The Council has provided a model and advice as to what new elements should be added, what new regions to serve and how to expand from a passive to active effort.

The Parent Educator and the Parent Coach programs are both new.

E. Action Plan

Components	Strategies	Objectives: Frequency and Duration
3.1 Coordination of the County's Parenting Programs	**Education Coordinator** This is a 3-year pilot program	100 agencies, CBO's, schools, churches, and grassroots groups will be contacted to collect information on parenting courses, tools, workshops, and other resources.
		2,800 parents/caregivers will be engaged through coordination web site, promotion materials, and outreach.
3.2 Parent Educator Strengthen parenting competencies.	**Universal Parent Prevention Programs**	3 courses annually, with at least one session provided in Spanish. Approximately 90 parents/caregivers will be served.
		Open to any interested parent.
	Selective Parent Prevention Programs	4 courses annually, with at least one session provided in Spanish. Approximately 120 parents/caregivers will be served.

3.3 Coaching to Parents/Caregivers "On demand" interventions for "parents in stressed families" or at risk for abuse	**Coaching Team**	Parent Educator establishes hotline and triage system to provide 1:1 and group coaching interventions. Approximately 10 contacts per week will be made with a target goal of 500 families served in a year.
		Recruit, train, and supervise minimum of five parent coaches. At least one coach will be bilingual/bicultural.

F. Key Milestones and Timeline

Key Milestones	Target Date
Develop RFP and begin procurement process for program providers. • Includes collaboration with PEI Planning Team to design RFP which meets the proposed program requirements	Upon DMH Approval (January 2009)
Procurement process	Feb. '09 – April '09
SLOBHD and PEI Planning Team will establish sub-group to review and select RFP applicants to provide project services • RFP recipients may include agencies currently participating in the county mental health programming	Feb. '09 – April '09
Program start-up, including recruitment, hiring and training of staff, and program/infrastructure development	April '09 – July '09
Program implementation of each component (not including CSS programming)	April '09 – July '09
Provider quarterly reporting to County	July '09 and ongoing

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through		Number of months in operation through June 2009
	Prevention	Early Intervention	
Coordination of the County's Parenting Programs	Individuals: 700 Families:	Individuals: Families:	Three
Parent Educator	Individuals: 53 Families: 53	Individuals: Families:	Three
Coaching to Parents/Care givers	Individuals: Families: 125	Individuals: Families:	Three
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 753 **Families**: 178	**Individuals:** **Families**:	

5. Linkages to County Mental Health and Other Providers

A. Linking PEI Participants to Services

The Family Education, Training and Support Project's programs will provide parents and caregivers with awareness, skills, and competencies which will increase their knowledge of mental health, signs and symptoms, and services available for families. Through working with the Parent Educator and/or Parent Coaches, parents and caregivers of youth with elevated risk for mental health issues will gain increased knowledge about how best to access both the County's Mental Health Services and other community providers' services.

B. Linking PEI Participants to Non-Traditional Services

The promotion of parenting classes and resources will enable parents, including those with children at risk for emotional disturbance, to build assets and be more apt to access community resources. These resources include community support groups, educational, employment, housing, substance abuse, domestic/sexual abuse, and faith/culturally-based services.

The Parent Educator and Parent Coaches can conduct a needs assessment with parents in order to make referrals to appropriate services. Referrals will be made for, but not limited to: mental health treatment and support providers; substance abuse prevention and treatment; community, family or sexual violence prevention and intervention; and basic needs (food, housing and employment). Assistance in connecting to the resource will be conducted by the Educator and Coaches, or the Resource Specialists in Project 1 and Project 5 may be utilized.

Management of this project will include oversight by the DAS. The agency's expertise in family-based services will move prevention services beyond traditional mental health clinics and treatment providers.

C. Sufficiency to Achieve Outcomes

The SLOBHD engaged community leaders and service providers to provide research on local and comparable county programs to ensure that the budget and program design for this project includes programs and activities which provide a cost benefit to achieve the stated outcomes at the individual/ family, program/system and community levels. Through the procurement process, project providers will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes.

Key policies and capacities will include cultural competence, staff training and accountability, evaluation tools, and evidence-based practices. All proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

6. Collaboration and System Enhancements

A. Relationships, Collaborations and Arrangements

This project was developed in partnership between the SLOBHD, and stakeholders represented on the PEI Community Planning Team and the Children and Youth and Adult subject-matter expert Workgroups (those members are fully described in Part II of this plan).

The concept for the coordination of the county parenting programs expands on the work by the SLOCAP in collecting and distributing information on local parenting resources. SLOCAP was part of both the CSS and PEI Community Program Planning Processes. The Latino Outreach & Engagement program in Project 4 will assist in increasing Latino parents' awareness of the parenting classes and needs, as well as refer parents to the appropriate programs.

B. Building Upon the Mental Health and Primary Care Systems

This project provides linkages for families to access behavioral health supports, programs, and services. When appropriate, the Educator and Coaches will assist families in connecting and contacting law enforcement and legal entities, social services, and the mental health and primary care systems. Educators and Coaches will make referrals to professional assessment and counseling, as well as to Resource Specialists in Projects 1 and 5 who can assist with more in depth service linkage.

Through the educational classes, the resource and referral services, and the coaching contacts, it is anticipated that some parents and children will be identified as needing more intensive therapeutic services. As a relationship will have been forged between the parent and the Coordinator, Educator or Coach, it is assumed the parent will be more willing to pursue the necessary care.

The Family Education, Training and Support Project will provide culturally competent information and deliver services in settings which are nonthreatening/ non-stigmatizing to parents and caregivers. This should help increase parents/caregivers' comfort in utilizing the core services of the traditional mental health and primary care systems if needed, particularly with the Educator or Parent Coach serving as an ally.

C. Leveraging Resources

All providers in this project will be expected to generate support and leveraged resources. Support may include distribution of materials, outreach to their respective members to attend educational events and provision of in kind resources. In kind resources may include space, equipment, staff and volunteer time, consultation and referrals. Providers will be asked to describe their plan for leveraging additional resources and/or funding during the RFP/procurement process.

D. Sustaining the PEI Project

It is the intention of the SLO PEI Community Planning Team that this project will be sustained through continued MHSA funding, and leveraged and in-kind resources provided by the partners

The Parenting Program Coordination program is designed as a three-year pilot and uses unexpended funds from FY 07/08. The provider will be charged with building a system that is self-sustaining, such as creating a web-portal to which any provider can

post (using a Wikipedia-type model) and leveraging other staff or volunteer resources to promote the existing resources.

SLOBHD will assess the organization and capacity of each provider to fiscally manage and sustain this program. SLOBHD will assign a Program Supervisor and an Administrative Services Officer to monitor the project and its providers' ability to achieve outcomes and meet fiscal requirements at the awarding of the contract. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals.

7. Intended Outcomes

The San Luis Obispo County PEI Community Planning Team reviewed the priority needs and populations that were identified through the Community Program Planning Process. The Planning Team determined the desired individual and system level outcomes and developed the strategies that would lead to these desired outcomes.

Programs:

3.1: Coordination of County's Parenting Programs

3.2: Parent Educator

3.3: Coaching to Parents/Caregivers

Individual Outcomes

- Parent and caregiver participants will demonstrate improved skills in responding to the social, emotional and behavioral issues related to mental health.
- Families will demonstrate increased responsibility, communication and listening skills, safe and effective discipline, increased self-esteem, and reduced stressors and trauma.
- Parents and caregiver participants will demonstrate increased successful follow through on linkages/referrals.
- Children of participants will demonstrate increased school attendance; reduced behavioral problems; increased compliance; decreased risk factors.
- Children of participants will report decreased involvement with juvenile justice system.
- Parents and caregivers will report decreased contact with CWS.

System and Program Outcomes
• Increased number of parenting and caregiver resources including training and education throughout the county. • Increased number of families who will more readily utilize community supports, including mental health care, because of increased awareness and personal support, and the reduction of stigma. • Increased number of parents and caregivers seeking universal and selective prevention programming. • Decreased number of families seeking mental health treatment due to a reduction of family stress and discord
Methods/Measure of Success
• Pre and Post Test instruments to measure parent education program effects • Surveys for target populations assessing baseline attitudes and beliefs, as well as documenting any changes. • Focus group and key informant studies to evaluate outcomes of each component over time. • Web contact counts. • Rosters, call logs, feedback surveys, and other program documentation.

A. Long Term Outcomes

The overarching goal of San Luis Obispo County's PEI Plan is to "help build the capacity of the community to increase resiliency by decreasing risk factors, and increasing the protective factors which promote positive mental health and reduce the negative impact of mental illness." The Family Education, Training and Support Project builds resiliency and utilizes science-based approaches to reduce risk factors and develop positive protective factors among parents and caregivers, and by extension, their children, whole family systems, and communities. Potential long term outcomes include:

- The county's children and youth population will have lower incidences of mental illness issues; and in the future they will raise healthier children
- Families will increase overall wellness and resilience.
- Community organizations providing parent and caregiver support will improve access to mental health services and supports
- The community will demonstrate reduced rates of child abuse, domestic violence, substance abuse, and suicide
- The general population will obtain earlier access to mental health treatment and services thus preventing the need for higher levels of care at a substantial increased cost.

8. Coordination with Other MHSA Components

A. Coordination with CSS

In working with a sweeping and broad range family population, there will undoubtedly be identified risk factors that may contribute to various mental illnesses. The Parent Educator, the Education Coordinator, and Coaches in these this project will be oriented to all CSS activities, in addition to all other Behavioral Health programs outside of MHSA, in order to develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services. Parents identified with serious mental illness or children serious emotional disturbances may be enrolled in a CSS program such as a Full Service Partnership, the co-occurring disorders program, or the Latino treatment program.

The Latino Outreach and Engagement Specialists and CSS Mental Health Therapists will be available for families in need of monolingual and/or bilingual and bicultural services.

B. Intended Use of WET Funding

The Parent Educator, Education Coordinator and Coaches will have information and resources to refer parents, youth and TAYs that they are serving, to programs in Workforce Education and Training, as it fits their expressed desire to enhance their educational and/or vocational goals, and meets the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

At this time, no Capital Facilities and Technology funds have been identified for this project.

9. Additional Comments (optional)

None at this time.

County: San Luis Obispo

Project 4: Early Care and Support for Underserved Populations
Date: 11/17/2008

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

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

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

This project is dedicated to providing prevention and early intervention services to three of our county's most underserved populations: Transition-aged youth (TAYs) emancipating from foster care or graduating from Community School; isolated Older Adults; and low-acculturated Latinos.

The importance of providing PEI services to underserved populations is found in much of the literature promoting improved mental health systems. Our community echoed that locally by ranking underserved cultural groups as one of the top four priority populations to receive PEI programming.

From our 2005 CSS Community Program Planning Process and Mental Health Services' prevalence rates, we know that Older Adults are the most unserved and underserved age group in the mental health system. And at 90% *unserved* (not just *under*-served), they are the least served of any demographic, including gender or racial/ethnic group. It is known that stigma, isolation and the complex issues of aging all play a role in making it difficult for many Older Adults to seek care for mental health problems or ask for help to mitigate factors that lead to greater issues. The PEI Older Adult Workgroup reviewed data to refine the local focus. According to Merck Institute on Aging and Health, the Older Adult suicide rate is 19% (compared to 11% U.S. average), 20% have a mental disorder (depression is most prevalent), and 90% of those with depression get no treatment. Additionally, risk factors for depression - isolation, chronic disease, substance abuse, caregiver stress, loss of spouse - are common and easily identified but often ignored and/or services are lacking. Serving *isolated* seniors was our community's top ranked Older Adult priority population (72% of survey respondents).

Consultation from the SLO County Commission on Aging and geriatric specialists revealed increasing cases of caregiver depression and a great need for depression screening in non-traditional settings along with early intervention, increasing social contacts, and improving primary care providers' knowledge about depression. Stakeholders agreed it was imperative that Older Adults at risk for depression be a priority population, with a focus on isolated elders.

Transition-aged Youth (TAY) are the second least well-served group in County Mental Health Services (after Older Adults). The PEI community survey selected young adults who "abuse substances, have experienced traumatic events and/or are leaving the foster care system" as the priority TAY populations to serve. Research supports these groups as a priority noting that when youth involved with service systems such as special education, child welfare, and juvenile justice age out of their respective youth system they are often ignored or neglected in the transition period to adulthood (Davis, 1997). The TAY/Adult Workgroup considered the broad community input, data and options and recommended creating a program that targeted TAYs aging out of foster care, graduating from Community School and/or having been a Ward of the Court, as that focus would encompass a group with common situational characteristics that matched the identified priorities. Sadly, as many studies tracking former foster care youth have shown, these populations represent a vulnerable group at exceptionally high

risk for self-sufficiency failure as adults, addiction, domestic violence, criminal activity, homelessness, and developing mental illness.

There is a system-wide overarching need for services to the Latino population, especially low-acculturated and impoverished sub-groups. County Mental Health Services prevalence data reveals that Latinos are the least well-served ethnic group. In 2005, stakeholders supported MHSA CSS programming to be developed to respond to this disparity for both Latinos with severe mental illness and to the Latino population in general through a culturally-appropriate, community-based treatment and outreach and engagement program. With PEI funding now available, the outreach and engagement portion of the current CSS project will be operated under this plan. This priority population and service transfer was recommended by the PEI Planning Team.

Through surveys, focus groups and interventions, stakeholders repeatedly expressed their desire to serve these three very specific, distinct and vulnerable cultural groups. Each group's high incidence of risk factors for mental illness and low representation in current service delivery systems supports their selection as priority populations.

This project provides these populations with innovative, culturally appropriate, and evidence-based responses to meet the need for prevention and early intervention services.

3. PEI Project Description:

The President's New Freedom Commission on Mental Health's recommendations outlines the following tenets which serve as the foundation of the project being described below:

- To develop culturally competent treatments, services, care, and support, mental health research will include these underserved populations. In addition, providers will include individuals who share and respect the beliefs, norms, values, and patterns of communication of culturally diverse populations.
- Schools and local mental health agencies could improve their collaboration and use of evidence-based practices to develop transition-to-work services so that children with emotional disorders can move successfully from school to employment or to post-secondary education.
- Implement systematic screening procedures to identify mental health and substance use problems and treatment needs in all settings in which youth, adults, or older adults are at high risk for mental illnesses or in settings in which a high occurrence of co-occurring mental and substance use disorders exists.

The President's New Freedom Commission on Mental Health, 2003

A. Description of Proposed PEI Project

The Early Care and Support for the Underserved Populations Project is a multi-focus effort to address the mental health prevention and early intervention needs of three distinct underserved populations identified during the PEI Community Program Planning Process. The populations include:

1. Transitional Age Youth (TAYs) aging out of foster care, Wards of the Court and/or those graduating from Community School;
2. Older Adults, with focus on isolated seniors; and
3. Low-acculturated Latino individuals and families.

Three individual programs are proposed to reduce risk factors or stressors, build protective factors and skills, increase support, detect early signs of mental health issues and reduce stigma and other barriers to care, and provide low-intensity intervention: The Successful Launch Program for At-Risk TAYs; The Older Adult Mental Health Initiative; and Latino Outreach and Engagement (currently funded under SLO County's CSS Plan). These three programs are described below.

4.1 Successful Launch Program for At Risk TAYs: This program seeks to increase self sufficiency and success of TAYs who are emancipating from foster care, former Wards of the Court, or graduating from Community School. Emphasis is on providing development opportunities and providing support to ensure that as these high risk youth turn 18 and are on their own, they are stable, have housing, have momentum for school or work, and are able to adequately cope with life's challenges and demands.

> *Given the developmental tasks of exploring opportunities for housing, employment, school, and social relationships, the process of discovering interests, dreams, strengths and values is the key to establishing an adult identity and making life-course decisions* (Clark, 2003).

The two components of this program are:

a. Expand Independent Living Program (ILP): ILP is a collaborative program coordinated by Cuesta Community College in partnership with the San Luis Obispo County Department of Social Services. The program's mission is to "empower youth through Education, Life Skills Training, Advocacy, Workforce Development, and Community Collaboration." ILP currently serves foster youth ages 16-24 providing skill development, case management, and career exploration in order to prepare them for self-sufficiency once they leave the foster care system. Research supports the effectiveness of the program to "develop leadership, perseverance and integrity as participants establish lifelong connections that mentor self-sufficiency, independence and permanency in all aspects of family and community."

- PEI funds will be used to enhance ILP by adding new, more in depth and more-frequently offered life skill building classes and practical training for the current ILP TAYs. More classes will be available to serve an increased number of foster youth.

- ILP will expand to serve non-foster care TAYs that are in their last year at Community School or as a Ward of the Court, and then follow them for a year after independence to ensure stability. These TAYs have common situational characteristics with those in foster care (including low success rates as young adults), yet have not been eligible for ILP's valuable services and supports due to funding restrictions limiting the programming to only foster youth.
- Case Managers will be added and their roles expanded to "life coaches" who provide system navigation, assistance with establishing housing, college application, courts, managing daily tasks and responsibilities, and other services critical to successful early adulthood.
- The life coaches will remain in contact with each participant for at least one year following "launch" (i.e. after age 18) to monitor, support, and maintain stability.
- Enhanced and new life skills classes will include: decision making skills; building healthy relationships; budgeting and banking; cooking; computer studies, scholarship opportunities, career exploration, college awareness, automotives, employment education, and housing information. Other topics will be added as requested by the TAYs.
- ILP will develop a peer support network with older and former participants to provide mentoring and skill building with newer TAYs.
- ILP will serve approximately 40 TAYs emancipating foster care, and 80 youth graduating from San Luis Obispo Community School or eligible Wards of the Court.

b. Vocational Development: Employment development is a critical component of any mental health prevention effort with TAYs. The Adult/TAY Workgroup and PEI Planning Team articulated the necessity of improved access to vocational training, development, and on-site experience for youth in foster, court, and Community School systems.

- ILP's current vocational program will be enhanced and expanded to begin serving non-foster TAYs as described above and provide new emphasis on practical, specific job skills, coaching, and shadowing.
- One additional full time Employment Specialist will be created. Employment Specialists work with youth to build job placement skills, career exploration, assist TAYs in creating employment "portfolios" to manage their job search, and "hit the streets" with the youth in search of jobs, transporting them to various businesses, assisting them in follow up, and then supporting them once employment is obtained (attendance, commitment, scheduling, etc).
- Funds (up to $1,000 per business) will be made available annually to local businesses providing vocational mentoring to ILP participants. The vocational mentoring will include a 12-weeek on-site placement, job skills training, interview preparation and practice, and performance evaluation.

4.2 Older Adult Mental Health Initiative: The Older Adult Workgroup, utilizing hundreds of community recommendations and their own expertise, yielded the following as best practice prevention strategies and early interventions for the priority populations. The program's two components will provide formalized, methodical, and vigorous outreach and screening specific to those at high risk for depression and anxiety while increasing access to preventive and early intervention care.

a. Screening and Connection: Screening for depression amongst the general population of older adults is recommended by current research on mental illness and co-occurring disorders. Older adults are at risk of developing both depression and substance dependence as this phase of the life cycle has new risk factors for both of these disorders (Commission on Mental Health, 2003).

The county's effort will focus on depression screening and access to treatment for the general population of older adults, with initial focus on rural areas and regions with large concentrations of mobile home parks and senior communities. Additionally, as 75% of older adults that commit suicide had seen their physician within the last week of their lives (Area Agency on Aging,) a concentrated outreach effort to educate and encourage general practitioners to provide depression screenings to their patients will be developed.

- The Senior Peer Counseling Program, a non-profit mental health care provider with expertise and proven success in serving seniors in SLO County, will expand its programming to create a Mental Health Screening and Resource Specialist to travel countywide and perform outreach, depression education, and screening to older adults.
- Using a recognized standard instrument, such as the Geriatric Depression Scale, screening will be conducted at EOC's well-known and well-attended monthly health fairs, mobile home parks, churches, senior and community centers, and other natural gathering places for seniors in a given community. Focus is on rural communities and neighborhoods, and outreach to isolated seniors.
- The Screening and Resource Specialist will have expertise in discussing positive findings with individuals and connecting with them in order to ensure that follow up care and supports are given. No individual will receive screening results and be left with nowhere to go for help or no one to assist them.
- Caregivers will also be screened and provided with linkage to community based supports and County-operated programs, as 43% of familial caregivers have undiagnosed depression (Merck Institute, 2004).
- The Screening and Resource Specialist will also provide outreach to General Practitioners to increase capacity in private health facilities to perform mental health screening. This will include educating providers on the prevalence of depression, its risk factors and the ease of screening. The Screening and Resource Specialist will also provide training on how to broach the subject with patients, and provide the screening tool and resource and referral support.

b. Social Support and Counseling for Isolated Older Adults: Isolation and reluctance to seek help or the inability to access care are major risk factors for Older Adult depression and suicide. Providers in SLO County offer both in home "friendly visitor" programs to isolated seniors and peer-led, easy-access counseling to seniors needing early intervention support for a mental health problem. Both services are successful and well-respected, yet serve very limited numbers due to funding. Stakeholders highly supported expanding these existing services to population groups and regions not currently served.

SLOBHD will partner with Wilshire Health and Community Services, Inc. to expand its "Caring Callers" and "Senior Peer Counseling" programs.

- Caring Callers make in-home visits to seniors, aged 60 and over, who are isolated and at high risk for developing mental illness based on depression, anxiety, and trauma related to aging, physical health, substance dependence, grief, and family stress. The visits are designed to provide resources to withdrawn community members and facilitate access to key services and supports.
- Caring Caller volunteers help alleviate the isolation and loneliness that many seniors face. Volunteers of all ages make homes visits and may play cards, board games, take walks or drives, go out for lunch or simply enjoy good conversation.
- The Senior Peer Counseling Program provides emotional and psychological counseling and supportive services to those individuals age 60 and over, who are experiencing emotional distress involving such issues as health problems, grief, care-giving, depression, anxiety, loss, or family difficulties.
- Peer Counselors are trained and supervised by licensed mental health professionals.
- Volunteers for both programs live in the communities where they provide services, building a cultural competence that is friendly, warm, and welcoming for seniors.
- Bilingual/bicultural Caring Callers and Peer Counselors are available, and recruitment efforts will target increasing these numbers.
- Through this component, additional outreach and intake coordinators, volunteer supervisors, and resource connectors will be added to the programs, increasing the number of Older Adults served by at least 50%.

4.3 Latino Outreach and Engagement: This Latino Outreach and Engagement program is currently funded by our MHSA CSS Plan. With further definition and development of the MHSA Prevention and Early Intervention component, San Luis Obispo County is transferring the awareness and outreach elements of this program to PEI as required per DMH Notice 08-23.

This program provides targeted outreach to populations in underserved Latino communities, particularly to identified pockets of poverty in the north and south areas of the county, and rural residents in Shandon, San Miguel, Oceano and Nipomo, and limited English speakers.

- Two bilingual/bicultural Outreach and Engagement Specialists will provide services in the north and south county areas, which have the largest low-acculturated Latino populations and disparate access to mental health awareness information, prevention activities, and services.
- These Specialists will work in coordination and provide a continuum of care with the CSS-funded Latino Treatment Team.
- The outreach efforts will be coordinated with existing Latino interest groups and allies and advocates trusted by the community.
- Activities will include grassroots outreach to all age groups and genders, including community presentations, booths and individual connections at community events, health fairs, school sites, churches and networking Latino advocacy organizations, and print and radio advertisements in Latino-oriented publications and other media.
- Outreach efforts will emphasize awareness and education about mental illness, wellness and health living skills, protective and risk factors, increase awareness of signs and symptoms of mental illness, decrease stigma, and highlight the availability of services.

B. Implementation Partners and Service Delivery

The Early Care and Support for Underserved Populations Project will be conducted by individuals, agencies, and organizations most equipped to provide quality, culturally competent mental health prevention and early intervention services to the target populations. All services will be conducted in venues most conducive to outreach, engagement, information dissemination, skill development, screening, and strengthening access to care.

In each program, leadership will be provided by the partner agency or CBO providing personnel and programming and SLOBHD. The PEI Community Planning Team will participate in quarterly project review.

Each contracted provider will be required to meet the County's requirements for cultural competence, accessibility, evaluation and innovation.

The **Successful Launch Program** will be conducted by the Independent Living Program (ILP) at Cuesta Community College. This innovative program strengthens SLOBHD's partnership with the foster care system, Department of Social Services, Probation, and the County Office of Education's alternative schools. The TAY participants will have access to vocational training at local businesses, and increase their community connections. ILP will be required to create and maintain documentation of the specific expanded and enhanced services being delivered.

The **Older Adult Mental Health Initiative** programs will be provided by the non-profit Wilshire Foundation, the sponsor of the Caring Callers and Senior Peer Support Counseling programs. The Mental Health Screening and Resource Specialist, a new position within Senior Peer Support Counseling, will work in partnership with the entire

Caring Callers and Senior Support Counseling programs. The volunteers providing the direct services will be required to have the training and qualifications necessary to address mental health concerns with the stated sub-groups of isolated older adults.

The **Latino Outreach and Engagement** program will be conducted by County Mental Health Services staff currently assigned to these efforts as this program is being transferred to PEI from the County's CSS plan. These Outreach Specialists are bilingual and bicultural with the necessary expertise and experience to engage low-acculturated Latino residents with limited access to services due to language, cultural and geographic barriers. This program has been and will continue to be culturally competent through the employment of exclusively bilingual/bicultural staff to execute strategies and deliver services.

C. Target Community Demographics

- The **Successful Launch Program** will be available to targeted TAYs (16-21) within and exiting from the foster care system, San Luis Obispo Community School 12th graders, and those designated as Wards of the Court who are within six months of turning 18. ILP will expand to provide services to between 100 and 120 youth annually.
- The **Older Adult Mental Health Initiative** will conduct 480 screenings year, provide counseling to 50 new Senior Peer Counseling clients, and provide social support to 48 new Caring Caller participants.
- The **Latino Outreach and Engagement** program will continue to serve universal and selective prevention populations of Latino children, youth, TAYs, adults, and older adults – monolingual Spanish speakers, those from "stressed families" and those experiencing trauma and heightened risk factors such as violence and abuse. Approximately 3,000 community members will be served.

D. Highlights of New or Expanded Programs

This project represents innovative, new, and expanded programming.

The **Successful Launch Program** has both new and expanded components. In addition to partnering with the existing ILP program to expand and boost its skill building for foster-care TAYs, PEI funds create new programming to expand ILP's programs to different, previously unserved target populations.

New programs include additional service populations, the creation of a vocational mentoring program, peer mentoring, and life coaches who will remain in contact with TAYs at least one year after their "launch" into independent living.

The **Older Adult Mental Health Initiative** creates a new depression screening and outreach program - none has ever existed with screening and outreach as its sole focus and a concentrated, structured approach. The program expands on the successes of the Caring Callers and Senior Peer Counseling Programs to target specific priority populations and new regions.

E. Action Plan

Programs	Strategies	Objectives: Frequency and Duration
4.1 Successful Launch Program for At-Risk Transitional Age Youth	**Expansion of Independent Living Program**	100 – 120 TAYs emancipating from the foster care system, graduating from Community School, or designated as a Ward of the Court will be enrolled in the Program.
		ILP program will provide life skills curriculum targeting social, emotional, and intellectual factors which increase the protective factors buffering TAYs from mental illness and ensuring self sufficiently.
		At least one new case manager/"life coach" will be added to the ILP staff. The case manager will assist 30 TAYs in linking to school, agencies, and peer support. The case manager will remain in contact with each TAY for one year after graduation or turning 18.
	Vocational Development	ILP will add at least one Employment Specialist to the staff. The Specialist will assist a minimum of 40 TAYs in building employment skills and obtaining a job.
		ILP will offer at least five businesses stipends of up to $1,000 to place TAYs in jobs and receive training, support, and evaluation.
4.2 Older Adult Mental Health Initiative	**Screening and Connection Initiative**	Using a standardized depression screening instrument a Mental Health Screening Specialist will travel countywide and conduct screenings with individuals, groups, and at events. 480 older adults will be screened.
		Specialist will contact 50 private primary care providers annually and provide information, education, and resources to increase screening within general practice.
	Social Support and Counseling for Isolated Older Adults	By increasing the provider's capacity to recruit, train and support volunteers, 50% more seniors will be served, at least 98 per year.
4.3 Latino Outreach and Engagement	**Latino Outreach and Engagement** This strategy is being transferred from CSS.	The program will provide countywide outreach activities. Approximately 3,000 community members will be served.

F. Key Milestones and Timeline

Key Milestones	Target Date
Develop contracts and agreements for sole-source program providers. • Includes collaboration with PEI Planning Team to design contractual program requirements	Upon DMH Approval (January 2009)
Transfer and continue CSS programming outlined in project description, including: • Latino Outreach and Engagement Program	Upon DMH Approval (January 2009)
Program start-up, including recruitment, hiring and training of staff, and program/infrastructure development	January '09 – July '09
Program implementation of each component	January '09 – July '09
Provider quarterly reporting to County	July '09 and ongoing

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through		Number of months in operation through June 2009
	Prevention	Early Intervention	
Successful Launch Program for At-Risk Transitional Age Youth	Individuals: 50 Families:	Individuals: Families:	Six
Older Adult Mental Health Initiative	Individuals: 240 Families:	Individuals: Families:	Six
Latino Outreach and Engagement	Individuals: 750 Families: 750	Individuals: Families:	Six

	Proposed number of individuals or families through PEI expansion to be served through		
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 1,040 **Families**: 750	**Individuals:** **Families**:	

5. Linkages to County Mental Health and Other Providers

A. Linking PEI Participants to Services

This project will provide the targeted underserved populations with information, and linkages to county mental health supports and providers. The populations described in this project are less likely to recognize mental health issues, their mental health needs (or the needs of a family member or friend), or be willing to access the County's Mental Health Services or private services. This project will provide recipients with both the opportunity to increase their knowledge and resilience while, offering a personal contact and one-to-one assistance to encourage people towards needed services.

B. Linking PEI Participants to Non-Traditional Services

The strategies in this project will enable individuals and families to receive personal and focused education, screening, and skill building. For community members at risk for mental illness these techniques will be critical to make recipients more apt to access community resources. Resources include community support groups, as well as educational, employment, housing, substance abuse, domestic/sexual abuse, and faith/culturally-based services. Additionally, the providers of this project's programs are non-traditional themselves, as they are community and school-based, and offer many peer-led services.

In each program referrals will be made (but not limited) to mental health treatment and support providers; substance abuse prevention and treatment; community, family or sexual violence prevention and intervention, and basic needs (food, housing and employment). If needed, assistance in connecting to the resource will be provided by the staff and volunteers in each program.

C. Sufficiency to Achieve Outcomes

The SLOBHD engaged community leaders and service providers to provide research on local and comparable county programs to ensure that the budget and program design for this project includes programs and activities which provide a cost benefit to achieve the stated outcomes at the individual/ family, program/system and community levels. Through the procurement process, program providers will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes.

Key policies and capacities will include cultural competence, staff training and accountability, evaluation tools, and evidence-based practices. All proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

6. Collaboration and System Enhancements

A. Relationships, Collaborations and Arrangements

The SLO PEI projects were developed in partnership between the SLOBHD and stakeholders represented on the PEI Community Planning Team and the age-specific community Workgroups (those members are fully described in Part II above).

Critical to this project is the collaboration between the County, Cuesta Community College, and the County Office of Education; both have been supportive of prevention initiatives in the community for many years. Wilshire Health and Community Services, Inc., the provider for the Older Adult Mental Health Initiative Program, has extensive cooperatives and coordination with all of the county's public entities and CBO's that serve older adults.

Latino Outreach activities have been supported in CSS by local Latino groups including the Bilingual Network, the Rural Legal Assistance League, which sponsors programs for Latinos in economically depressed areas, and the Latino Outreach Council. These organizations continue to be collaborators. Outreach efforts will continue to be coordinated with SAFE System of Care as well other traditional Latino providers, including the Economic Opportunity Commission and religious organizations. Engagement efforts will also include the Latino media.

B. Building Upon the Mental Health and Primary Care Systems

The Mental Health Screening Specialist will have a significant impact on bridging the mental health and primary care systems through the new outreach and education effort to general practitioners. The link between positive mental health and physical well-being is clearly stated in all literature and research which supports mental health initiatives for

older adults. By increasing General Practitioners' willingness and ability to screen for and discuss depression with their patients, the avenues for referral and understanding between mental health providers and the medical community are increased.

Good mental health is linked to improved quality of life for those with physical illness. When considering older adults who have general medical illnesses - such as heart disease, stroke, cancer, and arthritis - about 25% also have depression (Beekman, et. al., 1995). Furthermore, Hispanic Americans bear a disproportionately high burden of disability from mental disorders, stemming from receiving less care and poorer quality of care (Surgeon General, 2001). Increased awareness on caring for this group's mental health will decrease the impact on both the mental health and primary care system.

C. Leveraging Resources

All program providers in this project will be expected to generate support and leveraged resources. Support may include distribution of materials, outreach to their respective members to attend educational events and provision of in kind resources. In kind resources may include space, equipment, staff and volunteer time, consultation and referrals. Program providers will be asked to describe their plan for leveraging additional resources and/or funding during the procurement process.

D. Sustaining the PEI Project

It is the intention of the SLO PEI Community Planning Team that this project will be sustained through continued MHSA funding, and leveraged and in-kind resources provided by the partners

SLOBHD will assess the organization and capacity of each provider to fiscally manage and sustain this program. SLOBHD will assign a Program Supervisor and an Administrative Services Officer to monitor the project and its providers' abilities to achieve outcomes and meet fiscal requirements at the awarding of the contract. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals.

7. Intended Outcomes

The San Luis Obispo County PEI Community Planning Team reviewed the priority needs and populations that were identified through the Community Program Planning Process. The Planning Team determined the desired individual and system level outcomes and selected the strategies that would lead to these desired outcomes.

Programs:

4.1 Successful Launch Program for At-Risk TAYs

4.2 Older Adult Mental Health Initiative

4.3 Latino Outreach and Engagement

Individual Outcomes

- TAYs will have housing and demonstrate self-sufficiency after they have left foster care or begin living independently
- TAYs obtain jobs and retain employment after they have left foster care or begin living independently
- TAYs demonstrate a decrease in destructive and unhealthy behaviors.
- Older Adults receive early identification for depression and assistance with accessing care.
- Older Adults remain healthy and happy in their homes due to visitors and counseling, and demonstrate improved protective factors.
- Latino individuals and families increase knowledge of risk and protective factors related to mental health issues and demonstrate increased knowledge of community services and supports.

System and Program Outcomes

- Increased number of families who will more readily utilize mental health PEI and other needed services because of increased awareness and the reduction of stigma.
- Decreased in the number of Older Adults seeking intensive mental health treatment due to early identification and intervention of depression and mitigation of risk factors.
- County systems will report a decrease in criminal activity and need for public assistance amongst TAYs as they become self sufficient and self supporting.

Methods/Measure of Success
• Pre and Post Test instruments to measure program effects. • Surveys for target populations assessing baseline attitudes and beliefs, as well as documenting any changes. • Focus group and key informant studies to evaluate outcomes of each program over time. • Rosters, attrition rates, feedback surveys, and other program documentation.

A. Long Term Outcomes

The overarching goal of San Luis Obispo County's PEI Plan is to "help build the capacity of the community to increase resiliency by decreasing risk factors, and increasing the protective factors which promote positive mental health and reduce the negative impact of mental illness." The Early Care and Support for Underserved Populations Project builds resiliency and utilizes science-based approaches to reduce risk factors and develop positive protective factors among underserved TAY, older adults, and low-acculturated Latino populations. Potential long term outcomes include:

- The county's TAY population will have lower incidences of mental illness issues.
- Latino individuals and families will increase overall wellness and resilience.
- Older adults will report less depression and anxiety.
- TAY, older adults, and low-acculturated Latinos will demonstrate reduced suicide rates.
- Older adults with depression and anxiety will exhibit earlier access to mental health treatment and services.
- Latinos identified with mental illness will exhibit earlier access to mental health treatment and services.

8. Coordination with Other MHSA Programs

A. Coordination with CSS

There are risk factors in each of the targeted populations that may contribute to mental illness. A participant may be identified as needing further assessment and intervention beyond the PEI program's purview. Staff in these PEI programs will be oriented to all CSS activities, in addition to other behavioral health programs, in order to develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

In the Latino Outreach and Engagement program, the Outreach and Engagement Specialists and CSS Mental Health Therapists will be working side by side. This

collaboration will ensure the provision of services for individuals needing more intensive mental health treatment in a seamless continuum of care.

Part of the Geriatric Specialist's duties in the Older Adult FSP program is to work closely with other older adult providers and services. The staff of this project's Older Adult Initiative will work with the Geriatric Specialist to maximize efforts, leverage resources, and to provide referrals to both programs.

In the Successful Launch program, it is expected that there will be opportunities for the ILP Employment Specialist to exchange job development referrals and resources with the CSS Supported Employment program.

B. Intended Use of WET Funding

The Workforce Education and Training Taskforce is currently considering Carrier Pathways programs that will address career exploration for High School seniors as well as a Wellness and Rehabilitation curriculum at both Cuesta Community College and Cal Poly University. Collaborating with the Independent Living Program (ILP) may assist in maximizing efforts, leveraging resources, and bridging the avenues of services to both programs.

C. Intended Use of Capital Facilities and Technology Funds

At this time, no Capital Facilities and Technology funds have been identified for this project.

9. Additional Comments (optional)

None at this time.

County: San Luis Obispo

Project 5: Integrated Community Wellness
Date: 11/17/2008

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

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

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

The individual programs contained within this prevention and early intervention project will ultimately serve all of the PEI priority populations by providing fundamental basic services applicable to the shared needs presenting in all of the groups.

SLO County survey respondents ranked the need to identify mental health problems early and to improve access to care as the top two issues to address with PEI funds. Respondents then selected children/youth in stressed families and those at risk for school failure, people facing trauma, and people who do not receive care because of lack of knowledge, stigma or other barriers as the priority populations.

Many individuals representing these populations participated in the Community Program Planning Process and provided insight into their lives, needs and strengths. As community focus groups and age-specific Workgroups discussed and analyzed situational characteristics and needs of the local priority populations, it was clear that the identified local priority populations fell into all of the prescribed DMH PEI populations, and many individuals belong to more than one population.

The County's Mental Health Services, and Drug and Alcohol Services, the Probation Department, the County Office of Education, the Economic Opportunity Commission, the Sheriff's Custody division and family resource centers provided information on the populations they serve, their demographics, characteristics, needs and changing demands.

All of the priority populations and provider stakeholders identified common themes that, if addressed, would have immediate results in helping prevent or reduce problems. These included the basic needs of easy-access, low-cost counseling, assistance in connecting with existing services, and help in crisis situations so problems do not get worse.

The Integrated Community Wellness Project incorporates the priority populations' and other stakeholders' input and responds to a broad range of individuals in need. By providing system navigators to link individuals to existing prevention and early intervention services and supports, providing therapeutic interventions, and responding to anyone in crisis, this project serves all of the prescribed PEI populations. To address disparities in access to mental health services, each program will focus on priority underserved populations which will benefit from targeted outreach and cultural competence.

3. PEI Project Description:

The President's New Freedom Commission on Mental Health recommends the following tenets which serve as the foundation of the project being described below:

- Interventions must be implemented, provided in multiple settings, and connected to treatment and supports.
- Early intervention should occur in readily accessible, low-stigma settings.
- When mental health problems are identified, children, youth, adults, and older adults should be linked with appropriate services, supports, or diversion programs.

The President's New Freedom Commission on Mental Health, 2003

A. Description of Proposed PEI Project

The Integrated Community Wellness Project maximizes the opportunities for a large number of diverse individuals to access prevention and early intervention mental health services, including short-term, low-intensity counseling and one-to-one assistance in navigating and accessing community resources. And as required by DMH, the project also transfers a proportion of SLO County's CSS-funded Crisis Response program as it provides care and support, including wellness and early interventions, to an array of individuals, including those who are seriously mentally ill or severely emotionally disturbed.

This project will improve early detection of and provide early intervention for mental health issues while increasing access to care by utilizing three programs: Community-based Therapeutic Services; Resource Specialists; and Enhanced Crisis Response. The goals of this project are to increase the availability of early interventions, provide direct, personal assistance to accessing an array of community resources, early detection of potential mental health issues, and referral to higher levels of care as appropriate.

This project is based on wellness and resiliency principles which build the capacity of participants to establish, maintain, and/or restore positive mental health. By integrating therapeutic intervention services with Resource Specialists, individuals dealing with trauma, stress, depression, and other potentially severe risk factors will be better served and more inclined to sustain wellness.

This project includes three programs that are described below:

5.1 Community-Based Therapeutic Services: During the community input process, persons with mental illness and their family members repeatedly stated that more and earlier counseling would have helped their illness be diagnosed earlier and prevented it from getting worse. They ranked providing more counseling - that is easily accessible by anyone in the community for any reason - as a priority for PEI funding. This was

repeatedly echoed by parents and high risk youth who stated that, “someone to talk to” would help when they had problems, as well as by the provider focus groups and all of the age-specific Workgroups.

This program will expand the amount of low-cost, community-based individual or group counseling services available to those in need of short-term, low intensity therapeutic interventions. Several community counseling centers operate in San Luis Obispo County that continually have waiting lists and are unable to serve many regions of the county. SLOBHD will partner with one or more of these proven organizations to expand screening, assessment, referral, and individual or group therapy sessions. Programs and services proposed in the other four PEI projects will link individuals identified as in need of short term, low intensity counseling to the providers identified in this program. It is anticipated that Project 1’s outreach and awareness efforts will result in many community members being receptive to speaking to a mental health professional and timely, available access must be assured.

Studies have supported the efficacy of timely counseling for preventing suicide and promoting recovery for individuals whose vulnerability and life stressors may have tipped them into an episode of crisis (McGory, 1994; DSM-IV, 1994). Therefore, any community member can utilize the services of this program.

- Approximately 4,000 new early intervention therapeutic counseling hours will be provided to populations and geographic regions not currently receiving services.
- Community-based therapeutic services will be located in welcoming, low-stigma environments and staffed by qualified, friendly practitioners with experience in early intervention, and the capacity for bilingual services.
- Services will be low or no-cost as needed.
- Hours of services will be accommodating, including evenings and weekends.
- The provider will establish drop-in capacity along with policies which reduce wait times, paperwork, and costs
- Therapists will conduct individual and group counseling, along with support groups for participants and their family members.
- Priority will be given to services for underserved communities, such as the rural regions of the county; and underserved populations referred to counseling as a result of other PEI program outcomes.

5.2 Resource Specialists: The Community Program Planning Process clearly identified the need for dedicated, knowledgeable personnel to assist those in need to navigate systems, link to resources, and reduce disparities and barriers caused by lack of knowledge, age, language, poverty, geography, and low self-efficacy. There is an array of services available in the county, but sadly, many are unaware of, or unable to access help.

Studies indicate that early detection and treatment of mental disorders can result in a substantially shorter and less disabling course of illness (McGlashan, 1999). However, some people may not recognize or correctly identify their symptoms of mental illness.

When they do recognize them, they may be reluctant to seek care because of stigma or other barriers (Mojtabai, 2002). Barriers to access are particularly challenging for older adults, ethnic and racial minorities, and residents of rural areas (Surgeon General, 2001).

Resource Specialists (also known as Family Advocates or Client Partners) are highly valued in other human services agencies and school systems throughout the county and are often considered the key to a person's success in overcoming difficult times or situations. The Resource Specialist model currently operates successfully in the county, mostly serving children and their families. This program will expand the number of community-based Resource Specialists to serve anyone in the priority populations, targeting those without minor children (and thus not served by a school's program), rural residents, older adults, and otherwise underserved who face disparities caused by limited cultural competency in existing care options.

Resource Specialists will provide services including, but not limited to: securing basic needs such as food, clothing, housing, health care, and transportation; accessing mental health, drug and alcohol, and other social services; employment assistance, navigating the legal system and courts, aid and relief, and educational services such as parenting training. They will help minimize stress, support wellness and resilience, and increase an individual's ability to follow through on referrals and care. Meeting basic daily life needs removes barriers to work and life success, and reduces stressors linked to behavioral problems, violence, substance abuse, and suicide.

Two full time Resource Specialists will be funded to provide linkage services for individuals and families needing support, resources, and system navigation.

- The Resource Specialists will be stationed in the communities with the highest need (to be determined through procurement process).
- Referrals to the Resource Specialists will be made through promotional activities by Project 1's Social Marketing Strategy, Project 4's screening activities, and via community-based therapeutic services like that of Project 5.1.
- This project's Resource Specialists will team with Project 2's school-based Resource Specialists to maximize capacity and share information, referrals and resources.
- Priority will be given to services for underserved communities, such as the rural regions of the county; and underserved populations not receiving services and referred to this program as a result of other PEI program outcomes.

5.3 Crisis Response: This Crisis Response program is currently funded by our MHSA CSS Plan. With further definition and development of the Prevention and Early Intervention component, San Luis Obispo County is transferring a portion of this program to PEI as required per DMH Notice 08-23.

This 24/7 mobile crisis program utilizes two responders that are regionalized in the north and south portions of the county. They intervene when mental health crisis situations occur in the field and after clinic hours. Responders provide in-home/in-the-field

intervention and crisis stabilization with individuals, families, and support persons. If the individual stays in the community, the responder makes a next day follow-up visit or telephone call to continue support and provide assistance in following through with referrals and appointments.

Crisis Response utilizes client-centered, strength-based, asset-focused short-term crisis management plans. These plans will promote resiliency by utilizing each individual's and family's assets in developing successful short term coping plans to work through crisis situations. Crisis Response providers are trained in cultural competence, and provide services in Spanish and English, reducing disparities for monolingual individuals and families.

Upon review of call records, 64% of individuals served by Crisis Response are not seriously mentally ill, and are most appropriately served with stabilization and then early intervention strategies. Because of this, the program is best managed for its early intervention and its aftercare services within both the PEI and CSS plans, respectively.

- A portion of Crisis Response's funding will be transferred from CSS to PEI sources.
- Elements of this program being absorbed by PEI will require specific deliverables and outcome reporting which meets the requirements set forth by SLOBHD and the PEI Planning Team.
- Staffing of this program is two trained crisis professionals, each available 24 hours daily.
- Crisis Response staff are mobilized throughout the county, serve males and females of all ages, and have bilingual capacity.
- Crisis response staff make appropriate referrals to CSS programs, law enforcement, Child Welfare Services, social services providers, primary and behavioral health care when appropriate.

B. Implementation Partners and Service Delivery

The Integrated Community Wellness Project's programs will be conducted countywide "on-demand" (Crisis Response) and in communities and environments most conducive to early detection, short term therapy, and responsive to community resource navigation. Crisis response will be in-home or in-the-field, and response calls will come mainly from agencies providing health and safety services. Community-based therapeutic service locations may include school sites, churches, libraries, community centers, and agencies located in or near underserved communities and populations. Resource Specialists will be stationed in areas where there are currently no other Resource Specialist-type providers.

Each program will be provided by an agency or CBO experienced in and most appropriate for the type of service being delivered. A RFP process for the community counseling and Resource Specialists will be undertaken following state approval of funding. Each program's daily operating leadership will be provided by the agency or CBO's awarded during the service contract process, and the SLOBHD. The PEI

Community Planning Team involved in quarterly project review. Each PEI provider will be required to meet the County's requirements for cultural competence, accessibility, evaluation and innovation. To address disparities in access to mental health services, each program will focus on priority underserved populations which will benefit from targeted outreach and culturally appropriate care.

The **Community-Based Therapeutic Services** will be provided by individuals, an agency, or CBO which can best achieve the goals and objectives put forth in this plan. Qualifying providers will be experienced in mental health assessment and treatment, as well as the provision of accessible, culturally appropriate, low intensity therapy.

The **Resource Specialists** positions will be provided by an individual, CBO or agency which can demonstrate an ability to engage an array of local services and resources for a variety of individuals' situations, and which can document the training and qualifications required to address mental health concerns with the target population and sub-groups – including the necessity for Spanish language services.

The **Enhanced Crisis Response** program is provided by a contracted community provided who has a proven record of success and has held the CSS contract since 2005. This provider has bilingual staff and the capacity to serve rural and otherwise underserved populations identified herein.

C. Target Community Demographics

This project will serve broad populations with need for increased access to services, early detection and intervention, and immediate crisis care. To address disparities in access to mental health services, each program will focus on priority underserved populations which will benefit from targeted outreach and cultural competence.

The proposed services will be available to all county residents (approximately 257,000) that are having situational circumstances that place them in the priority populations described by the PEI Guidelines. There is an expectation that activities outlined in the previous projects will increase awareness and sources of referral to take advantage of the improved access to care outlined in this project.

- The **Community-Based Therapeutic Services** will provide approximately 4,000 new hours annually of assessments; screenings and individual and groups counseling sessions for low intensity care. Priority will be focused on rural communities and other areas of the county where physical access to care is limited by the lack of transportation or other issues of culture or poverty.
- Each **Resource Specialist** funded in this program will serve approximately 360 individuals or families annually; including 300 referrals and 60 case-managed clients. Priority will be focused on rural communities and other areas of the county where physical access to care is limited by the lack of transportation or other issues of culture or poverty.
- The **Enhanced Crisis Response** program will serve individuals and families dealing with critical incidents of anxiety, stress and suicide brought on by

depression, trauma, or other threats to mental health and wellness. Based on estimates from the previous years of CSS operations, approximately 600 will be served. Priority will be focused on increasing services to trauma-exposed individuals and families in rural communities and other areas of the county where access to care is limited by the lack of transportation or other issues of culture or poverty.

D. Highlights of New or Expanded Programs

The **Community-Based Therapeutic Services** Program is an expansion of the community's network of care which currently has very limited low-cost or free behavioral health care for individuals needing early intervention and low intensity services. The expansion proposed in this plan creates a response service to unserved regions of the county and for individuals who have yet to be identified.

The **Resource Specialist** Program is an expansion of services currently being provided in limited capacity. The demand for resource linkage, system navigation and community support specialists has grown beyond the capacity of most agencies, and is projected to grow as PEI activities heighten awareness and reduce stigma associated with mental health. Services will be expanded to areas and individuals currently unserved.

E. Action Plan

Programs	Strategies	Objectives: Frequency and Duration
5.1 Community-Based Therapeutic Services Short term, low intensity intervention.	**Increase number of available therapists**	Therapists provide 4,000 new hours of assessments; and short-term, low intensity care annually.
		Therapists reserve space for and provide services for a minimum of 2,000 individuals or families to be referred from other PEI projects
5.2 Resource Specialists Assist individuals needing short-term help and prevent issues from becoming worse.	**Increase number of available Resource Specialists**	Each Resource Specialist will serve 300 individuals and families each year by referral, with 60 individuals (approx. 15 families) to be case managed.
		Each Resource Specialist will reserve space for and provide case management services for 10 individuals or families to be referred from other PEI projects

5.3 Crisis Response	**Crisis Response staffing** This strategy is being transferred from CSS.	Approximately 600 individuals or families will receive brief interventions to reduce crisis conditions annually.

F. Key Milestones and Timeline

Key Milestones	Target Date
Develop RFP and begin procurement process for program providers. • Includes collaboration with PEI Planning Team to design RFP which meets the proposed program requirements	Upon DMH Approval (January 2009)
Transfer and continue CSS programming outlined in project description, including: • Crisis Response for individuals diverted from hospitalization or in-patient care	Upon DMH Approval (January 2009)
Procurement process	Feb. ’09 – April ’09
SLOBHD and PEI Planning Team will establish sub-group to review and select RFP applicants to provide project services • RFP awardees may include agencies currently participating in the county mental health programming	Feb. ’09 – April ’09
Program start-up, including recruitment, hiring and training of staff, and program/infrastructure development	April ’09 – July ‘09
Program implementation of each component (not including CSS programming)	April ’09 – July ‘09
Provider quarterly reporting to County	July ’09 and ongoing

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through		Number of months in operation through June 2009
	Prevention	Early Intervention	
Community-Based Therapeutic Services	Individuals: Families:	Individuals: 250 Families: 250	Three
Resource Specialists	Individuals: 300 Families:	Individuals: 60 Families: 15	Three
Crisis Response	Individuals: Families:	Individuals: 300 Families:	Six
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 300 **Families**:	**Individuals:** 610 **Families**: 265	

5. Linkages to County Mental Health and Other Providers

A. Linking PEI Participants to Services

The Integrated Community Wellness Project will provide improved access to SLOBHD services by increasing assessment, early intervention, and linkages for individuals and families in need of mental health services countywide. Project providers identified in this project will work in partnership with the County and all community mental health and support services to provide persons dealing with crisis and risk for mental illness with smooth system transitions and navigation between providers and services.

Individuals identified to need higher levels of care beyond what is provided in this project will be referred and “warmly” guided to the appropriate County service, including the Mental Health, Drug and Alcohol, and Public Health divisions of the County Health Agency.

B. Linking PEI Participants to Non-Traditional Services

All of the services detailed in this project reflect best practices for engaging community members suffering from anxiety, depression, trauma, stress, and at heightened risk for suicide or other mental illness factors. By providing community-based counseling in non-agency facilities, individuals needing early intervention will have access to clinical care provided in non-traditional settings. This strategy allows counseling to take place outside of traditional clinic models, and counselors may utilize community centers such as schools, churches, and other neighborhood facilities.

Resource Specialists are experts in connecting people to non-traditional services. The Resource Specialists providing system navigation and engagement will also help clients develop self-efficacy to improve personal wellness and health. This will be done by linking individuals and families with community supports that provide assets, both inside the network of care, and through community service, clubs, recreational activities, civic events, and educational opportunities.

C. Sufficiency to Achieve Outcomes

The SLOBHD engaged community leaders and service providers to provide research on local and comparable county programs to ensure that the budget and program design for this project includes programs and activities which provide a cost benefit to achieve the stated outcomes at the individual/ family, program/system and community levels. Through the RFP procurement process, program providers will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes.

Key policies and capacities will include cultural competence, staff training and accountability, evaluation tools, and evidence-based practices. All proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

6. Collaboration and System Enhancements

A. Relationships, Collaborations and Arrangements

This project was developed in partnership between the SLOBHD and stakeholders represented on the PEI Community Planning Team and the Children and Youth, Adult, and Older Adult subject-matter expert Workgroups (those members are fully described in Part II of this plan).

B. Building Upon the Mental Health and Primary Care Systems

This project provides linkages for individuals and families to access behavioral health supports, programs, and services. Therapeutic services for people needing low intensity and brief interventions are in demand, as are on-demand response services for those in crisis. Linking individuals to these types of early detection and response services, and health and social support services, will assure an increase in earlier intervention and thus prevent situations from worsening. In turn, this will enhance the effectiveness of the mental health system, and result in improved health overall.

The Crisis Response program provides both increased access to critical care, as well as preventing further exacerbation of mental illness. This results in fewer hospital and psychiatric inpatient admissions.

C. Leveraging Resources

All providers in this project will be expected to generate support and leveraged resources. Support may include distribution of materials, outreach to their respective members to attend educational events and provision of in kind resources. In kind resources may include space, equipment, staff and volunteer time, consultation and referrals. Providers will be asked to describe their plan for leveraging additional resources and/or funding during the RFP procurement process.

D. Sustaining the PEI Project

It is the intention of the SLO PEI Community Planning Team that this project will be sustained through continued MHSA funding, and leveraged and in-kind resources provided by the partners.

SLOBHD will assess the organization and capacity of each provider to fiscally manage and sustain this program. SLOBHD will assign a Program Supervisor and an Administrative Services Officer to monitor the project and its provider's ability to achieve outcomes and meet fiscal requirements at the awarding of the contract. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals.

7. Intended Outcomes

The San Luis Obispo County PEI Community Planning Team reviewed the priority needs and populations that were identified through the Community Program Planning Process. The Planning Team determined the desired individual and system level outcomes and developed the strategies that would lead to these desired outcomes.

Programs:

5.1: Community-Based Therapeutic Services

5.2: Resource Specialists

5.3: Enhanced Crisis Response

Individual Outcomes

- Participants will demonstrate improved skills in responding to the social, emotional and behavioral issues related to mental health.
- Individuals will report improved health and wellness following brief interventions.
- Participants will demonstrate increased successful follow through on linkages/referrals.
- Adult counseling participants will demonstrate improved protective factors such as increased work attendance, and improved coping skills and behaviors,
- Youth counseling participants will demonstrate increased school attendance; reduced behavioral problems; decreased risk factors.
- Participants will increase engagement with support services for alcohol and drug abuse, domestic violence, child abuse, sexual assault/abuse, and reduced engagement with law enforcement.
- Individuals in crisis will decrease stress and suicidal thoughts, and will not require a higher level of care.

System and Program Outcomes
• Increase in number of individuals able to receive short term, low intensity therapeutic interventions. • Increased number of individuals and families who utilize community supports, because of assistance in accessing resources and systems. • Decrease in psychiatric inpatient, hospital and emergency primary care admissions for mental health crises. • Decrease in the number of individuals and families seeking mental health treatment due to a reduction of stress and discord.
Methods/Measure of Success
• Pre and Post Test instruments to measure counseling program effects. • Surveys for target populations assessing baseline attitudes and beliefs, as well as documenting any changes post program period. • Focus group and key informant studies to evaluate outcomes of each program over time. • Crisis call counts. • Rosters, call logs, feedback surveys, and other program documentation.

A. Long Term Outcomes

The overarching goal of San Luis Obispo County's PEI Plan is to "help build the capacity of the community to increase resiliency by decreasing risk factors, and increasing the protective factors which promote positive mental health and reduce the negative impact of mental illness."

The Integrated Community Wellness Project builds resiliency and utilizes science-based approaches to reduce risk factors and develop protective factors among the community at large, including individuals and families, people of all ages and genders, and underserved special populations. Potential long term outcomes include:

- County residents will increase overall wellness and resilience.
- The community will demonstrate reduced rates of school or work interruptions, substance abuse, child abuse, domestic violence ,
- The general population will obtain earlier access to mental health treatment and services.
- The county suicide rate will decrease.

8. Coordination with Other MHSA Components

A. Coordination with CSS

The Community Based Therapists, Resource Specialists and Enhanced Crisis Workers will be expected to work closely with many providers in the mental health field across the county, including CSS programs and personnel. Depending on an individual's expressed needs, referrals to programs will span the range from education and mentoring, to intensive FSP treatment for individuals suffering from SMI. The hope is that not only will the collaboration between the service delivery systems become seamless, but that true transformation will begin and bridging the gaps in mental health care will finally become a reality.

B. Intended Use of WET Funding

San Luis Obispo County's Workforce Education and Training (WET) Taskforce is planning to develop Career Pathways programs that will promote recovery and illness management. This project will include a wellness and strength-based curriculum in schools and colleges, increased hiring of consumer employees, and diversification of the mental health workforce to more closely reflect our diverse community. These key elements will support this PEI project by increasing workforce opportunities.

C. Intended Use of Capital Facilities and Technology Funds

At this time, no Capital Facilities and Technology funds have been identified for this project.

9. Additional Comments (optional)

None at this time.

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Project Budget Narrative

The project budgets in Form 6 represent a 3-month estimate budget for fiscal year 2008-09. This budget includes unexpended funding of $1,565,000. These funds are unexpended from fiscal years 07-08 and 08-09. The annualized project budgets are in Table 1 below.

Table 1: Annualized PEI Project Budgets

Project #	PEI Project	Annualized Budget
1.1A	Social Marketing Campaign - Media Advocacy	15,000
1.1B	Social Marketing Campaign - Outreach & Engagement	160,468
1.2/1.3	Campus Inititative - Teacher, Student & Parent/Caregiver Mental Health Education	100,000
2.1	Positive Development Program	80,000
2.2/2.4	Middle School Comprehensive Program, Sober School Enrichment	356,246
2.2A	Middle School Comprehensive Program - Resource Specialists	180,000
2.3	Student Wellness	121,178
3.1, 3.2, 3.3	Coordination of Parenting Programs, Parent Education, Coaching to Parents and Caregivers	94,500
4.1	Successful Launch Program for At-risk TAYs	
4.2	Older Adult Mental Health Initiative	170,000
4.3	Latino Outreach & Engagement	105,166
5.1	Community-based Therapeutic Services	
5.2	Resource Specialists	174,600
5.3	Enhanced Crisis Response	100,000
	Administration	232,297
	Total Cost	1,889,455

Expenditures

1. Personnel expenditures are estimated at $179,654 for FY 2008-09.
    a. Budgets for county staff positions are based on county position cost estimates for FY 2008-09. Benefits and taxes vary from 32-35% depending on the staff position.
    b. All recruitment and hiring will comply with San Luis Obispo County hiring policies, seeking culturally and linguistically diverse individuals.

2. Operating expenditures are estimated at $129,611 for FY 2008-09.
    a. Facility cost estimates are based on a percentage of total square feet per department.
    b. Other operating expenses are based on an average cost of 30% of Salaries and Benefits.

3. Subcontractors are estimated at $1,786,770 for FY 2008-09.
    a. Subcontracts are specific to each project plan.

b. Budgets for positions to be contracted are based on average salaries and benefits of existing community based program budgets.

Revenue

Revenue is estimated at $22,061 for FY 2008-09.

a. Medi-Cal/EPSDT revenue is estimated at $19,862.
c. Medi-Cal Administrative Activities (MAA) revenue is estimated at $2,187 which is conservative due to the County being in its first year of claiming MAA revenue.

Total Proposed PEI Project Budget

The total proposed PEI project budget for FY 2008-09 is $2,073,974. Unexpended funding makes up $1,565,000 of the total project budget.

Project Summary

1.1A. Social Marketing Campaign – Media Advocacy

Subcontracts/Professional Services

- $150,000 one-time contract for a social marketing campaign
- Ongoing marketing costs of $15,000 will be budgeted for future years.

1.1B. Social Marketing Campaign – Outreach and Engagement

Preliminary staffing for the proposed project includes:

- 0.50 FTE County Mental Health Therapist

Subcontracts/Professional Services:

- $3,020 contract for In Our Own Voice Presentations,
- $22,500 contract for a Community Health Worker.

1.2 Campus Initiative – Teacher and Student Mental Health Education / 1.3 Parent and Caregiver Mental Health Education

Subcontracts/Professional Services:

- One-time funds for two $200,000 two-year contracts for a teacher and student educator
    - 2.0 FTE Mental Health Educator

- $32,500 subcontract for a parent/caregiver educator
    - 1.0 FTE Mental Health Educator
    - $6,000 in start-up supplies

2.1 Positive Development Program

Subcontracts/Professional Services:

- $22,000 contract for 1.0 FTE Child Development Specialist

2.2 Middle School Comprehensive Program / 2.4 Sober School Enrichment Counselors and Educator

Preliminary staffing for the proposed project includes:

- 3.25 FTE Specialist II
- 1.0 FTE Specialist I

Project budget includes $15,000 in curriculum supplies, and $8,000 in start-up supplies. Medi-Cal and EPSDT revenue of $19,487 will be generated in FY 2008-09.

2.2A. Middle School Comprehensive Program – Resource Specialist

Subcontracts/Professional Services:

- $45,000 in professional service contracts for 3.0 FTE Resource Specialists.

2.3 Student Wellness

Preliminary staffing for the proposed project includes:

- 1.0 FTE Specialist I

Project budget includes $10,000 in curriculum supplies.

Subcontracts/Professional Services:

- $40,000 for eight $5,000 middle school grants

3.1 Coordination of Parenting Programs, 3.2 Parent Educator and 3.3 Coaching to Parents and Caregivers

Subcontracts/Professional Services:

- $105,000 in one-time funds for a three-year contract
    - 1.0 FTE Parenting Education Coordinator

- $24,500 contract for 1.0 FTE Parent Educator

Project budget includes $2,000 in start-up costs

- $18,750 for 1.0 FTE Parent/Caregiver Coach

4.1 Successful Launch Program for At-Risk TAY's

Subcontracts/Professional Services:

- One-time funds of $387,000 for a three-year Independent Living and Vocational Program

Project budget includes $2,000 in start-up costs

4.2 Older Adult Mental Health Initiative

Subcontracts/Professional Services:

- Sub-contract for $54,500 to provide depression screening and counseling

Project budget includes $12,000 in start-up costs

4.3 Latino Outreach and Engagement

Preliminary staffing for the proposed project includes:

- 1.0 FTE Mental Health Therapist

The outreach portion of this program was originally funded with Community Services and Supports (CSS) dollars.

5.1 Community-Based Therapeutic Services

Subcontracts/Professional Services:

- One-time funding of $400,000 for contracted community therapists

5.2 Resource Specialists

Subcontracts/Professional Services:

- $51,000 in professional service contracts for community-based resource specialists

Project budget includes $6,000 in start-up supplies

5.3 Enhanced Crisis Response

Subcontracts/Professional Services:

- $25,000 of the existing professional service contract will be paid with PEI funds in FY 2008-09.

The outreach portion of this program was originally funded with CSS dollars.

Administration

Salaries and Benefits are estimated at $48,053. Budgets for county staff positions are based on county position cost estimates for FY 2008-09. Benefits and taxes vary from 32-38% depending on the staff position.

Preliminary administrative staffing includes:

- 1.0 FTE PEI Coordinator
- 0.5 FTE PEI Program Supervisor
- 0.13 FTE Division Manager
- 0.5 PEI Intern

Operating Expenditures

- $2,237 in facility costs
- $25,805 in operating expenditures
- $12,000 in start-up costs

County Allocated Administration

- $2,055 in county overhead and administrative costs

Revenue - None
Total Administrative Funding Requirements $90,149
Total In-Kind Contributions - None

Form No. 4

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

1.1a Social Marketing Campaign - Media Advocacy

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 4. Stigma and Discrimination

Provider Name (if known):

Intended Provider Category: Other

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	133,000
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	133000
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Social Marketing Campaign	$0	$150,000	$150,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$150,000	$150,000
4. Total Proposed PEI Project Budget	$0	$150,000	$150,000
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$150,000	$150,000
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

1.1b Social Marketing Campaign

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 4. Stigma and Discrimination

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	300
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	300
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.5 FTE MH Therapist	$0	$8,720	$8,720
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ 32 %	$0	$4,104	$4,104
c. Total Personnel Expenditures	$0	$12,824	$12,824
2. Operating Expenditures			
a. Facility Cost	$0	$525	$525
b. Other Operating Expenses	$0	$16,865	$16,865
c. Total Operating Expenses	$0	$17,390	$17,390
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
In Our Own Voice	$0	$3,020	$3,020
Community MH Worker	$0	$22,500	$22,500
	$0	$0	$0
a. Total Subcontracts	$0	$25,520	$25,520
4. Total Proposed PEI Project Budget	$0	$55,734	$55,734
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$55,734	$55,734
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

1.2 Campus Initiative - Teacher and Student Mental Health Education / 1.3 Parent/Caregiver Mental Health Education

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 4. Stigma and Discrimination

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	7885
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	7885
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Teacher Education	$0	$202,000	$202,000
Parent/Caregiver Education	$0	$202,000	$202,000
Student Education	$0	$34,500	$34,500
a. Total Subcontracts	$0	$438,500	$438,500
4. Total Proposed PEI Project Budget	$0	$438,500	$438,500
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$438,500	$438,500
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

2.1 Positive Development Program

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. At-Risk Children, Youth and Young Adult Populations

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	335
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	335
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Child Development Specialist	$0	$22,000	$22,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$22,000	$22,000
4. Total Proposed PEI Project Budget	$0	$22,000	$22,000
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$22,000	$22,000
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

2.2a Middle School Comprehensive Program

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. At-Risk Children, Youth and Young Adult Populations

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	36
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	36
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Resource Specialists	$0	$45,000	$45,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$45,000	$45,000
4. Total Proposed PEI Project Budget	$0	$45,000	$45,000
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$45,000	$45,000
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

2.3 Student Wellness Strategy

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. At-Risk Children, Youth and Young Adult Populations

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	600
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	600
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
1.0 FTE Specialist I	$0	$10,841	$10,841
	$0	$0	$0
b. Benefits and Taxes @ 35 %	$0	$5,838	$5,838
c. Total Personnel Expenditures	$0	$16,679	$16,679
2. Operating Expenditures			
a. Facility Cost	$0	$1,050	$1,050
b. Other Operating Expenses	$0	$13,690	$13,690
c. Total Operating Expenses	$0	$14,740	$14,740
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$31,419	$31,419
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$31,419	$31,419
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

2.3 Student Wellness Strategy

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. At-Risk Children, Youth and Young Adult Populations

Provider Name (if known):

Intended Provider Category: PreK-12 school

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

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Middle School Grants	$0	$40,000	$40,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$40,000	$40,000
4. Total Proposed PEI Project Budget	$0	$40,000	$40,000
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$40,000	$40,000
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

2.2 Middle School Comprehensive Program / 2.4 Sober School Enrichment

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. At-Risk Children, Youth and Young Adult Populations

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	156
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	156
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
3.25 FTE Specialist II	$0	$48,690	$48,690
1.0 FTE Specialist I	$0	$3,140	$3,140
	$0	$0	$0
b. Benefits and Taxes @ 34 %	$0	$26,700	$26,700
c. Total Personnel Expenditures	$0	$78,530	$78,530
2. Operating Expenditures			
a. Facility Cost	$0	$4,463	$4,463
b. Other Operating Expenses	$0	$46,183	$46,183
c. Total Operating Expenses	$0	$50,645	$50,645
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$129,175	$129,175
B. Revenues (list/itemize by fund source)			0
Medi-Cal	$0	$10,707	$10,707
EPSDT	$0	$8,780	$8,780
		$0	$0
1. Total Revenue	$0	$19,487	$19,487
5. Total Funding Requested for PEI Project	$0	$109,688	$109,688
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

3.1-3.3 Family Education, Training and Support

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. Children and Youth in Stressed Families

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	1287
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	1287
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Parent Education Coordinator	$0	$105,000	$105,000
Parent Educator	$0	$24,500	$24,500
Coaching to Parents and Caregivers	$0	$18,750	$18,750
a. Total Subcontracts	$0	$148,250	$148,250
4. Total Proposed PEI Project Budget	$0	$148,250	$148,250
B. Revenues (list/itemize by fund source)			0
Medi-Cal	$0	$375	$375
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$375	$375
5. Total Funding Requested for PEI Project	$0	$147,875	$147,875
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

4.1 Successful Launch Program for At-risk TAYs

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 3. At-Risk Children, Youth and Young Adult Populations

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

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

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Independent Living & Vocational Program	$0	$387,000	$387,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$387,000	$387,000
4. Total Proposed PEI Project Budget	$0	$387,000	$387,000
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$387,000	$387,000
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

4.2 Older Adult Mental Health Initiative

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 5. Suicide Risk

Provider Name (if known):

Intended Provider Category: Olde adult service center

Proposed Total Number of Individuals to be served: FY 07-08 _____ FY 08-09 240

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

Total Number of Individuals to be served through PEI Expansion: FY 07-08 0 FY 08-09 240

Months of Operation: FY 07-08 _____ FY 08-09 _____

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Depression screening & Counseling	$0	$54,500	$54,500
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$54,500	$54,500
4. Total Proposed PEI Project Budget	$0	$54,500	$54,500
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$54,500	$54,500
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

4.3 Latino Outreach & Engagement

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	1500
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	1500
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
1.0 FTE MH Therapist	$0	$16,026	$16,026
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ 32 %	$0	$7,542	$7,542
c. Total Personnel Expenditures	$0	$23,568	$23,568
2. Operating Expenditures			
a. Facility Cost	$0	$1,050	$1,050
b. Other Operating Expenses	$0	$3,690	$3,690
c. Total Operating Expenses	$0	$4,740	$4,740
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$28,308	$28,308
B. Revenues (list/itemize by fund source)			0
MAA	$0	$849	$849
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$849	$849
5. Total Funding Requested for PEI Project	$0	$27,459	$27,459
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

5.1 Community-based Therapeutic Services

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 1. Trauma Exposed Individuals

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	1000
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	1000
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Therapeutic services	$0	$400,000	$400,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$400,000	$400,000
4. Total Proposed PEI Project Budget	$0	$400,000	$400,000
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$400,000	$400,000
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

5.2 Resource Specialists

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 1. Trauma Exposed Individuals

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	405
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	405
Months of Operation:	FY 07-08		FY 08-09	

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ %	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Resource Specialists	$0	$51,000	$51,000
	$0		$0
	$0	$0	$0
a. Total Subcontracts	$0	$51,000	$51,000
4. Total Proposed PEI Project Budget	$0	$51,000	$51,000
B. Revenues (list/itemize by fund source)			0
MAA	$0	$1,350	$1,350
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$1,350	$1,350
5. Total Funding Requested for PEI Project	$0	$49,650	$49,650
6. Total In-Kind Contributions	$0	$0	$0

Form No. 4

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

5.3 Enhanced Crisis Response

County Name: San Luis Obispo Date: 11/17/08

PEI Project Name: 1. Trauma Exposed Individuals

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08		FY 08-09	300
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	300
Months of Operation:	FY 07-08		FY 08-09	

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

Form No. 5

County: San Luis Obispo Date: 11/17/2008

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		1		$15,987	$15,987
b. PEI Support Staff					$0
c. Other Personnel (list all classifications)					$0
PEI Program Supervisor		0.5		$9,764	$9,764
Division Manager		0.13		$3,321	$3,321
Intern		0.5		$2,800	$2,800
					$0
d. Employee Benefits				$16,181	$16,181
e. Total Personnel Expenditures			$0	$48,053	$48,053
2. Operating Expenditures					
a. Facility Costs				$2,237	$2,237
b. Other Operating Expenditures				$37,805	$37,805
c. Total Operating Expenditures			$0	$40,041	$40,041
3.County Allocated Administration					
a. Total County Administration Cost			$0	$2,055	$2,055
4. Total PEI Funding Request for County Administration Budget			$0	$90,149	$90,149
B. Revenue					
1 Total Revenue			$0	$0	$0
C. Total Funding Requirements			$0	$90,149	$90,149
D. Total In-Kind Contributions			$0	$0	$0

Form No. 6

County:	San Luis Obispo
Date:	11/17/2008

		Fiscal Year			Funds Requested by Age Group			
#	List each PEI Project	FY 07/08	FY 08/09	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Mental Health Awareness and Stigma Reduction	$0	$644,234	$644,234	$161,059	$161,059	$161,059	$161,059
2	School-based Student Wellness	$0	$248,108	$248,108	$62,027	$62,027	$62,027	$62,027
3	Family Education, Training and Support	$0	$147,875	$147,875	$97,598		$50,278	
4	Early Care and Support for Underserved Populations	$0	$468,959	$468,959	$468,959			
5	Integrated Community Wellness	$0	$474,650	$474,650	$474,650			
	Administration	$0	$90,148	$90,148	$33,355	$26,143	$20,734	$9,916
	Total PEI Funds Requested:	$0	$2,073,974	$2,073,974	$1,297,647	$249,228	$294,097	$233,002

County: San Luis Obispo **Date: November 17, 2008**

PEI Project Name: School-Based Student Wellness

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

After thorough consideration of all the PEI projects, the School-Based Student Wellness Project has been selected as the project to be evaluated by San Luis Obispo County.

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

This project is focused on the healthy social emotional development of children aged 3 - 18. It was selected because:

- It has been developed in partnership with many of the organizations in San Luis Obispo County that focus on early childhood, youth development, and school-based issues.
- It will test innovative models of skill-building, resiliency development, and team-based support. Each program within the project is built upon collaboration between counselors, educators, specialists and supports both on and off school sites.
- The project's programs will be given sufficient resources in order to generate, collect, and analyze data which will provide a more comprehensive evaluation. Introducing evidence-based curriculum, youth development programming, specialists, educators, resource supports and counselors into three levels of the school system will build a dynamic set of outcomes. These outcomes will assist in future planning for the County, schools, and private providers, and possibly serve as a model for others.
- The outcomes projected in these programs have tremendous potential impact on the youth, families, schools, and communities served; as well as the county at large. Developing healthy, resilient children and youth will result in better students, self-sufficient adults, active citizens, and the reduction of negative impacts caused by unidentified and untreated mental illness.
- The San Luis Obispo County Behavioral Health Department, and particularly its Drug and Alcohol Services (DAS) division, have the capacity for evaluating youth and school prevention and early intervention programming. DAS evaluates youth development and school counseling programs at all grade levels as part of the State's Safe and Drug Free Schools and Communities programs and several other state and federal programs, including grants from the Substance Abuse and Mental Health Association (SAMHSA).

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

Person/family-level outcomes

- Increased knowledge of social, emotional, and behavioral issues amongst target populations, and improved behavior (i.e. self-control, peer relations, anger, compliance)
- Decreased risk factors amongst target populations
- Enhanced resilience and increased protective factors, including social and life skills competencies
- Increased successful follow through on linkages/referrals
- Improved parenting skills (Positive Development Program)
- Reduction in number of suspensions (Middle School and Sober School programs)
- Increased grade promotion/attendance rate (Middle School and Sober School programs)
- Improved coping with emotional, behavioral or social problems through voluntary counseling (Middle School and Sober School programs)

Program/system-level outcomes

- Increase in number of prevention programs and early intervention activities in schools, including pre-K programs
- Increased number of students who will more readily utilize mental health and other needed services because of the reduction of personal stigma, as well as the increase in school-based assessment and response systems (i.e. the development of procedures to improve access for referred individuals and families)
- Increase in number of individuals and families identified as needing early intervention services
- Increase in number of individuals and families identified who receive prevention programs and early intervention services

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

The following chart documents the projected unduplicated services being offered in this project. An unduplicated estimate of 5,440 recipients was calculated using projected service units, school records, and assumptions made based on capacity, attrition, and duplicative programming. Priority populations described in the PEI Community Survey Response, Question 2 (Appendix B), were used to calculate a baseline percentage of population for the targets in this project.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE	15%	11%	22%	17%	10%	12%	12%
African American 1.8%	14	11	20	16	9	11	11
Asian Pacific Islander 2%	14	11	20	16	9	11	11
Latino 28%	228	183	335	259	152	183	183
Native American .64%	5	4	8	6	3	4	4
Caucasian 63%	514	411	754	583	343	411	411
Other 3.7% Includes Filipino, multiple ethnicity, and no response in most recent California Basic Educational Data System (CBEDS)	40	85	59	47	27	33	32
AGE GROUPS							
Children and Youth (0-17)	771	565	1182	874	514	617	617
Transition Age Youth (16-25)							
Adult (18-59)	41	30	63	47	28	33	33
Older Adult (>60)	4	3	6	4	3	3	3
TOTAL	816	598	1251	925	544	653	653

Total PEI project estimated *unduplicated* count of individuals to be served 5,440
Estimate calculated using projected service recipients, with assumptions made regarding attrition, capacity to provide programming on campus, and ages of parents/caregivers.

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

Person/family-level outcomes

OUTCOMES	MEASURMENTS	WHEN WILL THEY BE MEASURED
Increased knowledge of social, emotional, and behavioral issues amongst target populations, and improved behavior (i.e. self-control, peer relations, anger, compliance)	• Scale of knowledge of issues including communication, self-worth, feelings, etc. • Scale of concern based on key risk indicators including self-esteem, anger, peer relations, and self-control	• Pre/post surveys including teacher/staff assessment tools reported after intervention • Teacher/staff observation reported after intervention
Decreased risk factors amongst target populations	• Reported and demonstrated improvements including reduced anxiety, reduced negative peer associations, reduced anger, etc.	• Pre/post surveys including teacher/staff assessment tools reported after intervention/annually • Teacher/staff observation reported after intervention
Enhanced resilience and increased protective factors, including social and life skills competencies	• Reported and demonstrated improvements including increased happiness, family and school bonding, grades, positive peer associations, etc.	• Pre/post surveys including teacher/staff assessment tools reported after intervention/annually • Teacher/staff observation reported after intervention
Increased successful follow through on linkages and referrals	• Demonstrated improvements in access to community resources	• Resource Specialist observation and report reported after intervention/annually • Service recipient self-reports
Improved parenting skills (Positive Development Program)	• Demonstrated improvements in understanding developmental stages of child, discipline, communication, etc.	• Child Development Specialist/staff observation and report reported after intervention/annually • Service recipient self-reports including pre/post reported after intervention

Reduction in number of suspensions (Middle School and Sober School programs)	• Decrease in suspension rate amongst school and youth engaged in services	• District and school site data reported annually
Increased grade promotion/attendance rate (Middle School and Sober School programs)	• Increase in graduation, grade promotion and attendance rates in each school and with individual participants	• District and school site data reported annually • Pre/post surveys including teacher/staff assessment tools reported after intervention/annually
Improved coping with emotional, behavioral or social problems through voluntary counseling(Middle School and Sober School programs)	• Demonstrated increase in capacities involving self-sufficiency, esteem, communication, family and peer relations.	• Pre/post surveys including teacher/staff assessment tools reported after intervention • Teacher/staff observation reported after intervention

Program/system-level outcomes

OUTCOMES	MEASURMENTS	WHEN WILL THEY BE MEASURED
Increase in number of prevention programs and early intervention activities in schools, including pre-K programs	• Number of PEI supported programs adopted on countywide school campuses including pre-K	• Measured rate of baseline school prevention and early intervention programs reported annually
Increased number of students who will more readily utilize mental health and other needed services because of the reduction of personal stigma, as well as the increase in school-based assessment and response systems (i.e. the development of procedures to improve access for referred individuals and families)	• Number of students engaged by PEI programs engaged in mental health or other social and behavioral health services and supports • Number of schools reporting developed, integrated, and utilized referral, assessment and delivery services	• Measured rate of service participation versus baseline reports by local providers as reported by Resource Specialists annually • School reports and staff observations reported annually.
Increase in number of individuals and families	• Number of individuals and families tracked in	• Measured rate of participants assessed for

identified as needing early intervention services	this project who are assessed and referred to early intervention services	need of early intervention, reported by program staff annually
Increase in number of individuals and families identified who receive prevention programs and early intervention services	• Number of participant individuals and families tracked in this project. • Number of individuals and families in prevention-only components of this project who access early intervention.	• Rosters and tracking documentation of participants reported quarterly. • Measured rate of universal prevention program participants engaging in early intervention, reported by program staff annually.

5. How will data be collected and analyzed?

Portions of this project will be coordinated and staffed by SLOBHD personnel while other staff will be employees of community based agencies that are successful in response to a RFP. All personnel (County or contractor) involved in implementation of the project's programs will be responsible for collecting data, through the use of tools and instruments developed by SLOBHD. The requirements for rosters and use of tools as outlined above will be part of the contractual responsibilities of agencies awarded in the RFP process.

SLOBHD will conduct the project evaluation using administrative and operations staffing experienced in data collection, analysis, and evaluation reporting. SLOBHD will convene school, agency and community representatives early in the implementation phase of the project to develop a detailed evaluation work plan with timelines. This group will be responsible for final selection of the tools to be used, the key elements of the collection instruments, and the timetable for submission of documentation.

SLOBHD will be responsible for collecting and analyzing the information and developing an annual report, and/or other reports required by DMH.

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

All programs and providers included in this project will have the capacity to provide culturally competent services to the wide variety of target recipients. A requirement of the RFP will be the ability to serve the ethnic and cultural populations that are currently underserved in the system, such as Latino and those distinguishing themselves as GLBTQ; as well as an ability to understand youth and adolescence culture. Program providers, including SLOBHD, will be responsible to have the language and cultural capacity to provide culturally competent services in the community that is being served.

The evaluation planning team described above will include representation from the community, to assure their engagement in and support for the evaluation process.

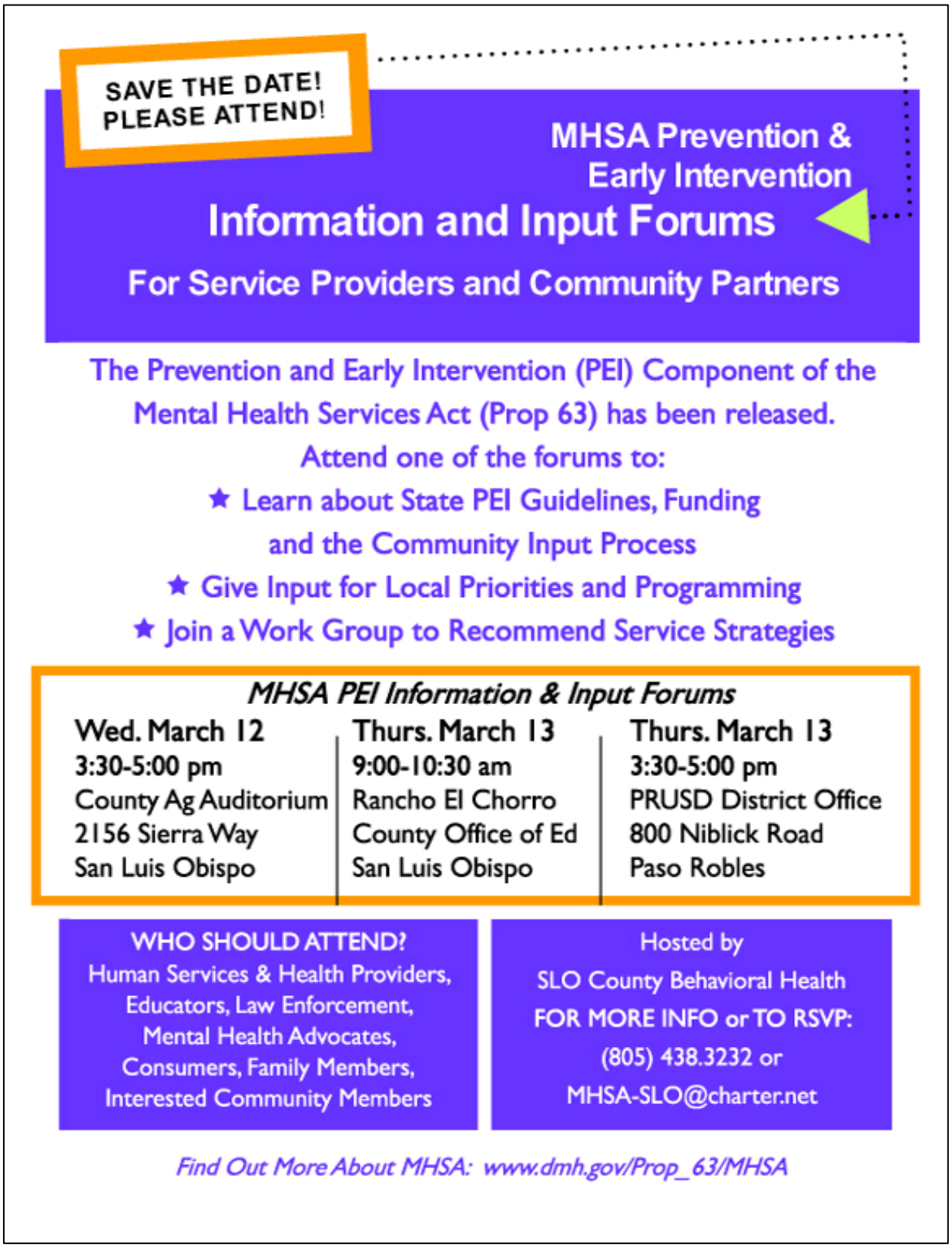
7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

The Positive Development Program, as well as the Youth Development and 5th Grade Initiative components will require the implementation of an evidence-based curriculum. Fidelity requirements for each curriculum will include proper training and monitoring of staff, including the outcome measurements described above. The RFP and contracts will outline details regarding fidelity to the models used.

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

SLOBHD will utilize the PEI Community Planning Team as well as countywide collaborative bodies such as the Prevention Alliance and Children's Services Network for disseminating PEI reports and information. In addition, key stakeholders in the selected schools and programs (including youth) will be invited to review and comment on the evaluation and the implications for next steps in the community.

APPENDIX A:
PEI OUTREACH and TRAINING MATERIALS



ADDITIONAL FORUM ADDED! NOT TOO LATE TO PARTICIPATE!

MHSA Prevention & Early Intervention

Information and Input Forum

For Service Providers and Community Partners

The Prevention and Early Intervention (PEI) Component of the Mental Health Services Act (Prop 63) is here.

Attend this Forum to:

- ★ Learn about State PEI Guidelines, Funding and the Community Input Process
- ★ Give Input for Local Priorities and Programming
- ★ Join a Work Group to Recommend Service Strategies

MHSA PEI Information & Input Forum

Thursday April 24

3:30 pm - 5:00 pm

South County SAFE Office

1086 Grand Avenue, Arroyo Grande

**This forum is a repeat of the series held in March. If you attended then, your input has already been recorded.*

WHO SHOULD ATTEND?

Human Services & Health Providers, Educators, Law Enforcement, Mental Health Advocates, Consumers, Family Members

Hosted by

SLO County Behavioral Health

PLEASE RSVP:

(805) 438.3232 or

MHSA-SLO@charter.net

TAKE THE PLANNING SURVEY: www.slocounty.ca.gov/health Deadline: April 15

More About MHSA at: www.dmh.gov/Prop_63/MHSA

MENTAL HEALTH SERVICES ACT PREVENTION & EARLY INTERVENTION – FACT SHEET

Spring / Summer 2008

PURPOSE

The intent of the PEI effort is to serve individuals prior to the development of serious mental illness or serious emotional disturbances, or alleviate the need for additional mental health treatment and/or extended mental health treatment.

Funding is to be used to achieve specific outcomes and to prevent mental health problems or to intervene early with relatively short duration and low intensity. It is not for filling gaps in treatment or recovery services for individuals who have been diagnosed with a serious mental illness or serious emotional disturbances and their families.

ESTIMATED FUNDS AVAILABLE FOR SLO COUNTY: $1,277,700 annually, beginning FY 08-09

- Must serve all four MHSA age groups: Children & Youth, TAY, Adults, Older Adults
- 51% must be dedicated to individuals 0-25 years old

DEFINITIONS *per PEI state guidelines*

Prevention involves reducing risk factors or stressors, building protective factors and skills and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and challenging circumstances.

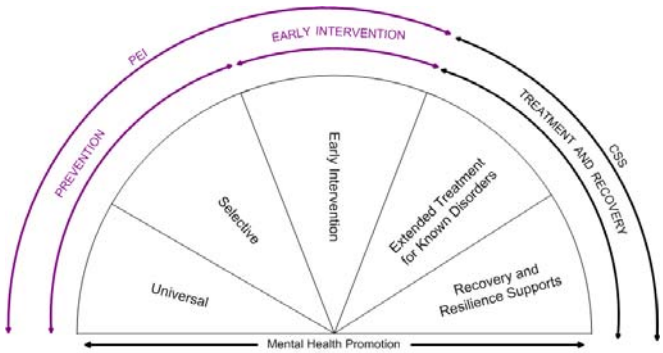
The **Prevention** element includes programs and services defined by the Institute of Medicine (IOM) as **Universal** and **Selective**, **both occurring prior to a diagnosis** for a mental illness.

Universal: target the general public or a whole population group that has not been identified on the basis of individual risk. *Examples include*: education for school-aged children on mental illnesses; gatekeeper training on warning signs for suicide and how to intervene; primary care provider training on social, emotional, behavioral issues.

Selective: target individuals or a subgroup whose risk of developing mental illness is significantly higher than average. *Examples include*: mental health consultation to support groups for older adults who have lost a spouse; screening women for post partum depression, or targeting children of parents with depression for intervention.

Early Intervention is directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse.

Examples include: interventions in child care environments; parent-child training for children with behavioral problems; anger management guidance; socialization programs with a mental health emphasis for home-bound older adults with signs of depression; screening individuals for confirmation of potential mental health needs.



OUTCOMES

- PEI is transformational
- PEI restructures the mental health system from “fail first” to “help first”
- Prevention can reach everybody and be everywhere
- PEI promotes wellness for individuals and the community, it is not treatment
- PEI done well will decrease the need for treatment

THE PLANNING PROCESS, *required by CA DMH*

- Identify and select Key Community Mental Health Needs and related Priority Populations for PEI programs
- Assess community capacity and strengths
- Select PEI strategies (programs, approaches, activities) to achieve desired outcomes.
- Develop PEI projects with timeframes, providers, staffing, budgets

Counties must select from the following, identified by MHSA Oversight & Accountability Commission

PEI Key Community Mental Health Needs	PEI Priority Populations
Disparities in Access to Mental Health Services reduce disparities in access due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services	**Underserved Cultural Populations** Projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of GLBTQ communities, etc.).
Psycho-Social Impact of Trauma reduce the negative psycho-social impact of trauma on all ages.	**Individuals Experiencing Onset of Serious Psychiatric Illness** Those identified by providers as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
At-Risk Children, Youth, and Young Adult Populations increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.	**Children/Youth in Stressed Families** Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults, rendering the children and youth at high risk of behavioral and emotional problems.
Stigma and Discrimination reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.	**Trauma-Exposed** Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
Suicide Risk increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.	**Children/Youth at Risk for School Failure** Due to unaddressed emotional and behavioral problems.
Projects State DMH will Administer Suicide Prevention Stigma and Discrimination Reduction Ethnically and Culturally Specific Programs and Interventions Training, Technical Assistance and Capacity Building Statewide Evaluation	**Children/Youth at Risk of or Experiencing Juvenile Justice Involvement** Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through CSS funding.

REQUIRED Groups to include in Planning Process	RECOMMENDED Groups to include in Planning Process
Underserved communities – particularly ethnic minorities, immigrants, GLBTQ; others specific to our county **Education** – K-12, higher ed, special ed, 0-5 **Individuals** with severe mental illness and/or their families **MH providers** **Health providers** – health clinics, older adult health, AOD treatment, emergency services, maternal/child health **Social Services** – DSS, CalWorks, APS, CWS **Law Enforcement** – courts, probation, sheriff/police	**Community Family Resource Centers** – FRCs, faith centers, youth clubs, parks & rec, senior centers, immigrant assistance centers **Employment** – workplaces, unions, rehab setting, employment centers

For more information, contact Dale Magee, PEI planning coordinator,
805.438.3232 or MHSA-SLO@charter.net

APPENDIX B:
Results of Public Input and Recommendations

- **Summary of Survey Response Report**
- **Focus Group and Input Report**
- **Summary of Workgroup Input**

MHSA Prevention and Early Intervention Community Program Planning, Spring 2008
SUMMARY OF SURVEY RESPONSES

Total number of respondents: 2,246
Not all respondents answered each question
Surveys completed on line and hard copy; in English and in Spanish
Responses collected March 7 – April 30, 2008

DEMOGRAPHICS

Respondents		Gender All		Age All		Race / Ethnicity All		City of Residence All	
Total	2,246							21 SLO Co cities represented	
		Female	74%	< 18	4%	African American	1%	SLO	27%
Special populations included:			26%	18-24	8%	Amer Indian	3%	Atascadero	16%
Persons with Mental Illness	6%			25-34	14%	Asian/Pacific Islander	2%	Paso	12%
Family Member of Person with MI	Male 22%			35-44	19%	Caucasian	72%	AG	8%
Self or family member has received care for a MH problem at sometime	55%			45-54	25%	Latino/ Hispanic	22%	Los Osos	7%
Service Provider	56%			55-64	20%			Grover	5%
Latinos with low acculturation (mono-lingual Spanish-speakers or limited English; immigrants)	13%			Over 64	9%			Morro Bay	5%
								Cambria and Nipomo	4%
								Templeton	3%
								Oceano and Pismo	2%
								Cayucos	1%
								Santa Margarita, San Miguel	1%
								Avila, Carissa Plain	<1%
								Creston, Shandon,	<1%
								Shell Beach, San Simeon	<1%

Q1. Community issues that are most important for mental health PEI programs to address in SLO County. (respondents

selected up to four) ***Subset responses by Special Populations***

	All Respondents Combined 1,956	Persons with Mental Illness 103	Family Members 412	Latinos, low acculturation 275	Latinos, hi acculturation 189
Percent % Count					
Undetected mental health problems/ not identified early	**54%** **1065**	**57%** **59**	**60%** **249**	26% 71	**51%** **96**
Difficulties and disparities in accessing care (due to stigma, not knowing about services, not the right services, not enough services)	**49%** **967**	**57%** **59**	**54%** **224**	31% 84	**43%** **81**
Domestic violence	**44%** **865**	23% 24	27% 113	**72%** **198**	**50%** **95**
Homelessness	**44%** **854**	**43%** **44**	**42%** **175**	20% 56	35% 67
School failure	37% 732	17% 18	26% 108	**50%** **137**	**42%** **79**
Suicide	28% 550	16% 16	23% 97	**41%** **112**	31% 58
Stigma/discrimination related to mental illness	27% 523	**33%** **34**	**34%** **142**	23% 62	28% 53
Prolonged suffering or trauma	26% 504	**33%** **34**	25% 102	36% 100	24% 45
Removal of children from their homes	22% 428	14% 14	20% 81	19% 52	24% 46
Arrest and detention in jail	21% 417	20% 21	19% 77	20% 54	23% 44
Unemployment	19% 373	15 15%	12% 49	**39%** **106**	25% 48
Notable Write-ins					
Substance abuse/addiction	2% 26				
Parenting problems/difficulties	Count = 12				
Autism disorders and needs	Count = 9				
Senior issues	Count = 6				

Q2. Priority populations that have the greatest need for mental health PEI services in SLO County.

(respondents selected up to four)

	All Respondents Combined	Persons with Mental Illness	Family Members	Latinos, low acculturation	Latinos, hi acculturation
Total times choice selected		*Not separated*	*Not separated*		*Not separated*
Children/youth in stressed families and at high risk for behavioral or emotional problems, or mental illness (e.g. placed out-of-home; in families where there's substance abuse, violence, depression or other mental illnesses).	1420			170	
Children/youth at risk for school failure due to unaddressed emotional, cognitive or behavioral problems.	1046			85	
People facing trauma (e.g., loss of a loved one, home, or employment; repeated abuse; domestic violence; refugees).	926			152	
People who don't receive care because of stigma, lack of knowledge, or other barriers (e.g., race/ethnicity, culture, language, or lifestyle).	784			88	
People who start to show signs of mental illness	769			79	
People with a family history of mental health problems and/or substance abuse.	769			117	
People who have attempted or might attempt suicide.	748			110	
Children/youth at risk of or have juvenile justice involvement.	635			108	
People at risk of being arrested or put in jail	309			54	

Q3. What are specific groups within the above populations that most need help?

1,003 responses received. Many responses relisted the choices above, or are choices offered in Questions 4 – 8.
See Appendix A, page 13, for the remaining suggestions for priority populations not represented in Questions 2, 4-8.

Q4. Highest Priority for Services: Children and Youth (respondents selected up to four)

	All Respondents Combined 1,695	Persons with Mental Illness	Family Members	Latinos, low acculturation 212	Latinos, hi acculturation 189
Percent % Count		*Not separated out*	*Not separated out*	*Different survey options*	
Children/youth with severe behavioral problems	**42% 707**				**33% 62**
Infants and very young children exposed to trauma	**41% 699**			**67% 141**	**24% 45**
Who are abused	**35% 598**			2% 5	**21% 39**
Whose parent(s) have a mental illness	**27% 452**			**5% 11**	**28% 53**
Who are violent/aggressive	23% 392				17% 33
Children/youth of first generation immigrants	21% 357			**68% 144**	20% 38
Whose parent(s) have drug and alcohol problems	21% 355			0	15% 29
Children/youth suspended, expelled, dropped out of school	19% 325				10% 19
Who are abusing substances	17% 288				10% 19
Living in foster care	13% 217				6% 12
Who are homeless	11% 190			2% 5	8% 16
Living in poverty	10% 171				9% 17
Youth who are isolated	10% 163				5% 10
Youth in jail, juvenile hall, on probation	8% 137				3% 6
Youth in gangs	4% 74				4% 7

Q5. Highest Priority for Services: Young Adults (respondents selected up to four)

	All Respondents Combined 1,084	Persons with Mental Illness	Family Members	Latinos, low acculturation	Latinos, hi acculturation 189
Percent % Count		*Not separated out*	*Not separated out*	*Not separated out*	
Who abuse substances	**63% 680**				**23% 44**
Who experience traumatic life events	**61% 656**				**27% 51**
Leaving foster care system	**51% 552**				17% 33
Persons who are homeless	**48% 525**				**20% 37**
Parents of out-of-control children	42% 452				16% 31
In jail, on probation	40% 436				14% 27
Persons living in poverty	30% 329				**18% 34**
Women who are pregnant	20% 222				12% 22
Persons living with a disability	19% 209				10% 19

Q6. Highest Priority for Services: Adults (respondents selected up to four)

	Respondents Combined 1,088	Persons with Mental Illness	Family Members	Latinos, low acculturation	Latinos, hi acculturation 189
Percent % Count		*Not separated out*	*Not separated out*	*Not separated out*	
Who abuse substances	**65%** **706**				**26%** **50**
Homeless	**62%** **674**				**24%** **45**
Who experience traumatic life events	**62%** **671**				**28%** **53**
Parents of out-of-control children/teens	**44%** **474**				17% 32
In jail, on probation	36% 395				12% 23
Persons living in poverty	35% 381				**17%** **33**
Unemployed, or have recently lost their job	31% 338				16% 31
Persons living with a disability	24% 256				10% 19
Women who are pregnant or post partum	16% 170				5% 9
All					

Q7. Highest Priority for Services: Older Adults (respondents selected up to four)

	All Respondents Combined 1,089	Persons with Mental Illness	Family Members	Latinos, low acculturation	Latinos, hi acculturation 189
Percent % Count		*Not separated out*	*Not separated out*	*Not separated out*	
Isolated Seniors	**72% 787**				**30% 57**
Victims of elder abuse or neglect	**65% 709**				**25% 47**
Persons who are chronically ill, or have a significant health problem	**47% 511**				19% 35
Persons who are homeless	**45% 490**				19% 35
Persons who abuse substances, including prescription medications	40% 432				13% 24
Persons living in poverty	39% 421				**20% 38**
Persons who experience traumatic life events	36% 397				12% 23
Persons who have lost a spouse, other loved one	34% 369				**20% 37**

Q8. Highest Priority for Services: Hard to Reach Populations (respondents selected up to four)

	All Respondents Combined 1,950	Persons with Mental Illness 103	Family Members 412	Latinos, low acculturation 275	Latinos, hi acculturation 189
Percent % Count					
Individuals experiencing domestic violence	**64%** **1241**	**50%** **52**	**60%** **249**	**66%** **181**	**54%** **102**
People who are homeless	**47%** **920**	**55%** **57**	**50%** **207**	**32%** **87**	**38%** **72**
Military personnel returning home	**40%** **777**	**41%** **42**	**50%** **205**	11% 29	**38%** **71**
People returning to the community from jail/prison	**37%** **713**	**39%** **40**	**37%** **154**	21% 58	26% 49
Immigrants, especially who do not speak English	33% 652	19% 20	21% 88	**62%** **170**	**51%** **96**
People who have experienced rejection over long periods	30% 587	32% 33	34% 139	25% 68	31% 59
People with developmental disabilities	26% 512	26% 27	25% 105	27% 73	26% 50
People with physical disabilities	18% 358	20% 21	15% 62	**39%** **108**	17% 33
Racial/ethnic/cultural groups who are underserved in the mental health system	18% 354	25% 26	22% 90	n/a	24% 45
Lesbian, gays, bisexuals, transgender, questioning (LGBTQ)	15% 298	14% 14	14% 56	11% 30	21% 39

Comparison Of Priority Populations Among Sub Sets
Top Four Responses Per Population As Reported By *All Respondents*

Children and Youth	**Young Adults**	**Adults**	**Older Adults**	**Hard To Reach Populations**
Children/youth with severe behavioral problems	Who abuse substances	Who abuse substances	Isolated Seniors	Individuals experiencing domestic violence
Infants and very young children exposed to trauma	Who experience traumatic life events	Homeless	Victims of elder abuse or neglect	People who are homeless
Who are abused	Leaving foster care system	Who experience traumatic life events	Persons who are chronically ill, or have a significant health problem	Military personnel returning home
Whose parent(s) have a mental illness	Persons who are homeless	Parents of out-of-control children/teens	Persons who are homeless	People returning to the community from jail/prison

Q9. Age Group Priority: Ranking of the children, youth and young adults age groups, 0-25 years old.

	All Respondents Combined 1,835	**Persons with Mental Illness**	**Family Members**	**Latinos, low acculturation 197**	**Latinos, hi acculturation**
Count		*Not separated out*	*Not separated out*		*Not separated out*
First Choice	Youth * 13-17 yrs old			Youth 13-17 yrs old	
Second Choice	Children * 0-5 yrs old			Children 6-12 yrs old	
Third Choice	Children 6-12 yrs old			Children 0-5 yrs old	
Fourth Choice	Young Adults 18-25 yrs old			Young Adults 18-25 yrs old	
	** only 2 percentage points between these two choices*				

Q10. The best mental health PEI activities for SLO County. (respondents selected up to four)

Compare to Focus Group responses

	All Respondents Combined 1,949	Persons with Mental Illness 103	Family Members 412	Latinos, low acculturation 275	Latinos, hi acculturation 189
Percent % Count					
Early screening, diagnosis, and help for mental illness at settings such as primary health care, school/college, child care, senior centers, and the workplace	**60% 1164**	**57% 59**	**59% 244**	42% 115	**63% 119**
Provide youth and families with support and skills for identifying and dealing with behavioral and mental health issues (includes school-based delivery)	**56% 1094**	**50% 52**	**56% 231**	**51% 139**	**50% 95**
Develop "one-stop" help centers, such as community resource centers or wellness centers	**53% 1033**	**43% 44**	**48% 196**	**60% 166**	**47% 88**
Education and support for parents, grandparents, and caregivers; offered at schools, community centers, churches, and other community settings	**44% 858**	38% 39	38% 156	**51% 139**	**45% 85**
Train teachers, law enforcement, emergency responders, and nursing home staff on early signs and response to mental illness	42% 813	**46% 47**	**47% 193**	29% 80	38% 71
Socialization programs for homebound seniors, isolated individuals, children with behavioral problems, etc.	36% 692	38% 39	35% 145	**43% 117**	34% 65
Resource and referral information at places easy to get to, such as primary health care, school/college, child care, church, nursing homes, and the workplace	35% 677	33% 34	31% 127	37% 103	34% 65
Resources to better help the prevention and early intervention needs of underserved groups (e.g. ethnic, racial, cultural, and LGBT communities)	26% 505	17% 18	18% 76	34% 93	38% 72
Incorporate prevention and early intervention into work-based programs (e.g., Employee Assistance Programs, Workplace Health)	19% 372	14% 14	16% 66	17% 46	29% 54

Q11. Specific PEI services and programs that should be funded. *See separate supplemental document*

Q12. Best ways to reach hard-to-reach populations and others most in need of mental health PEI services. (respondents selected up to four)

	All Respondents Combined 1,949	Persons with Mental Illness 103	Family Members 412	Latinos, low acculturation 275	Latinos, hi acculturation 189
Percent % Count					
Schools	**58%** **1134**	**39%** **40**	**44%** **183**	**57%** **156**	**57%** **108**
Community centers / family resource centers	**40%** **773**	32% 33	**36%** **147**	**39%** **106**	32% 60
Doctors' offices, medical clinics	**38%** **731**	**42%** **43**	**36%** **147**	**41%** **113**	**35%** **67**
Social service agencies	**35%** **679**	24% 25	**35%** **144**	22% 61	**42%** **80**
Mental health clinics (public, private)	28% 545	**36%** **37**	30% 124	17% 47	26% 49
Through radio, TV, newspaper or internet	28% 544	**37%** **38**	30% 122	28% 76	27% 51
Churches	27% 529	19% 20	21% 87	**42%** **116**	**33%** **62**
Jails, courts, Probation offices	24% 477	26% 27	28% 117	14% 39	20% 38
Infant and toddler programs	21% 403	11% 11	17% 68	17% 47	14% 26
In homes	16% 306	4% 4	10% 42	17% 46	21% 40
Unemployment / employment centers	16% 38	24% 25	19% 78	15% 41	16% 30
Workplace (e.g. presentations, employee assistance programs)	155 286	16% 16	16% 66	25% 68	13% 24
Grocery stores, markets	12% 228	10% 10	11% 45	11% 30	13% 24

Appendix A
Q3. What are specific groups within the above populations (Q2 listings) that need most help?

Verbatim responses for groups not already represented in Questions 2, 4-8. Responses have been left in list form to illustrate broad diversity of viewpoints for priority populations.

- 18-25 year old with no family support
- 20 to 40 year olds
- Adolescents and young adults who may not be able to advocate for themselves adoptees
- Adults with young children. it is vitally important to get help to these young families so that their children will be less likely to grow up needing help, too.
- All need help (x 2).
- all parties involved in a stressed family.
- anorexic young people
- Any one in the above groups that do not have some sort of support system in place, family, insurance, physicians in the area to treat them, mental health facilities in and out patient available in the county.
- Any person or their relative who has previously contacted (or been contacted by) the Mental Health, Criminal Justice, or Social Service systems concerning a behavioral health issue.
- Asian Americans
- at risk children who are bringing guns to school and killing others and themselves
- At risk teens and children at a fragile age for mental problems to develop
- Autism - Aspergers, PDD, high functioning autism
- Autism - children and families who are in the autism spectrum.
- Autism - Children borderline with high functioning autism or other mental illnesses who only may need services for a period shorter than others.
- Autism - Children that are not getting the early intervention that is need with Autism. Specifically, the behavioral treatment.
- Autism - children with aspergers syndrome or autism.
- Autism - Children with high functioning autism, PDD NOS, Aspergers that do not qualify for services through Tri Counties. Families are forced to "private pay".
- Autism - Families with Autistic Children that don't know how to get diagnosed or where to get help.
- Autism - high functioning autism
- Autism - High functioning autistic or Asperger's syndrome kids, kids with learning disabilities who are failing school, not getting the help they need, at risk for eventual legal problems.
- Autism - Kids with ASD, ADHD, Neurological Issues, Birth Trauma, Learning Disabilities. Families who are unaware they have an ADHD, learning disabled, etc kid who are totally stressed out and neglecting their needs
- Autism - Teenagers with high-functioning autism
- Autism - The children on the autism spectrum which includes ADD, ADHD, Aspergers, have multiplied by many fold across the country including our county--there are really no services for this group and their impact will have a huge impact on mental health services if we do not begin the job of early intervention to assist mainstreaming and preparation of job training via education, programs, etc
- Autism – Those children diagnosed with Autism Spectrum Disorders
- Autism and mental health; Children without parental means to access mental health
- Being a spousal caregiver I know that services are underused. How do I get time off for appointments for psych care, meds add to the cost of everything. And I can't get out of the house, we are a hidden part of the community that goes unheard.

- Both low achievers and high achievers Students that have a history of drug abuse in their family
- Cal Poly students who need help but are not "emergency" cases nor people who can wait a month for an appointment.
- CalWORKs families
- Chaotic families
- Children and Teens not yet in severe trouble, but at-risk due to diminished parental involvement or family mental illness.
- children between the ages of two and six who don't qualify for services through tri counties regional center. resources are limited for these children and their families.
- Children born with neurological disorders that need early support. Neurological (autism, epilepsy, ADD) can spark behavior problems if mis-understood.
- children in homes where adults have illness
- Children in large school systems (i.e. public school) whose issues are overlooked, mis-identified as behavior problems, and addressed as behavior problems.
- Children labeled as 'disabled' therefore the MH turns away from treating their Mental Health issues.
- Children of broken homes
- Children of divorce
- children of migrant families who move often to avoid INS
- children of parents who are absent emotionally and identifying the families so we can educate and counsel the families who cycle the emotional demons in our society.
- Children of the uneducated
- Children showing signs of being at risk, but still within the system--i.e. in a school setting--address signs before they become a full crisis stage.
- children suffering from compulsive overeating who use food for comfort due to family or origin dysfunction
- children that are in broken families.
- Children that are served by CWS but due to "the system" are required to stay in their homes amidst unsafe circumstances.
- Children that are unidentified as at-risk and failure to provide appropriate treatment or services as preventative care as opposed to rehabilitative.
- Children unsupervised.
- Children who are in the care of abusive and/or neglectful guardians.
- Children who are not successful in school both academically and socially
- Children who don't have any way to be kids…are very likely to develop mental health problems due to isolation and family dysfunction. Children who get involved in juvenile justice system are usually unable to get self esteem met in socially acceptable ways, becoming social psychopaths, prone to drug abuse etc. People who are isolated for whatever reason don't know enough about available services. Mental illness isolates and creates more isolation, our culture is not kind to those who don't fit in, financially and many other ways. The stigma of mental illness makes people unwilling to seek treatment. This is a complex problem that reaches throughout our culture and demands a multi-pronged approach.
- children who encounter bitter, confrontational divorces
- children who have been molested
- children who have been physically, sexually, and emotionally abused while growing up in a family with drug addiction/alcoholism
- children who have had death occur in the nuclear family
- children who have had head injuries (whether it's from abuse or accident) and they are essentially "walking wounded". They do just well enough to squeak by, but I foresee them having difficulty with the skills needed to be a functional adult.
- Children who lack adult role models to provide positive examples for them. If children had a mentor, they would have a positive role model, when their parents are unable to be a positive influence.
- Children who show signs of mental illness but are unable to access help.
- Children with early signs of behavioral and emotional problems that do not get identified and whose symptoms are interpreted as willful defiance. Children

2-8 years old with these symptoms are often not addressed.
- Children with invisible disabilities
- Children with learning disabilities, ADD,ADHD, ASD, PDD Dual diagnosis clients
- Children with learning disorders that are not diagnosed and then they start acting out and turn to violence and drugs
- Children with untreated learning disorders of all SES groups.
- children with weight issues
- children/youth at risk of suicide.
- College students who are stressed and emotionally fragile, but seem not to be at suicidal level. Perhaps mentioned suicide, but stating that they are not now and are not interested in seeking help.
- College students/young adults who have a mental illness but to the outside world "look fine" and can't get help because they don't have insurance, and no one will listen to them
- continuation high school students (some).
- Could be anyone. I had a fulltime job, was having mental problems. Went to MH on Johnson and was told that since I had a job, go back to it and there was nothing wrong with me. I was having horrible panic and stress attacks. I wasn't sleeping right. Or eating right.
- Currently a sad and vicious cycle. We need healthier parents to have healthier children, which in turn evolve into healthier parents. I feel we need to let children/students know THERE ARE adults who WILL help them in a healthy and supportive way (even when 'the grants' run out)
  dependent adults are high risk groups due to not being able to adequately protect themselves from being mistreated by family and friends, and they may be prevented by caretakers from accessing services that could benefit them.
- Early onset teens who start to self medicate.
- elderly males
- elderly who are financially unstable and need medication.
- Elementary students who have one or both parents that are involved with crime, who have low intelligence and who have difficulty parenting.
- emotionally fragile people
- families broken by divorce
- Families that don't know where to turn when they are stressed or have a child who is in need of quality services.
- families unaware of services.
- Families where the parents seem uninvolved and the teachers, etc. don't seem to notice or care. The kids eventually quit trying. They need someone to encourage them.
- Female Teens
- first time mothers
- Former foster children
- Foster care families
- Get them help before it is a big problem like long term drug/alcoholic abuse. Help before they fall threw the cracks(kids) and become mentally ill/abusers them self from domestic violence. Help before the abused mom gets killed, starts abusing herself, ends up on drugs to cope, etc. Solve at risk any mental health issue that will, are becoming a issue that impact the public in some way(like homeless, drug addiction)
- GLBTQ high school kids who are at higher risk of suicide and depressive issues.
- Having a husband and a daughter with mental illness and working with At-Risk Youth, I feel that there are too many people at all levels who aren't receiving necessary treatment because services are too hard to access and treatment is inconsistent.
- High School youth in stressed families due to long history of drug use;
- Hispanic youth (x2)
- Homeless Vets
- Homeless without children.

- Homeless Women
- I am a teacher in Lucia Mar but I do not know where the real needs are for mental health services. I do feel uncomfortable answering these questions without real knowledge of the situation. I think people who work in the field and people with real knowledge should be making these suggestions.
- I am most familiar with community college students (all ages) who are not able to handle the additional stress of college. These students are often referred to the college by local agencies who see the college as an element of "rehab" - but this is often not realistic and causes additional emotional harm to the individuals.
- I believe all the groups would benefit from early prevention and/or detection. Knowledge is the key.
- I believe I am seeing more students with behavioral/emotional issues related to drug and alcohol abuse during pregnancy. There seems to be an increase in attention and impulsivity issues within the elementary school population- which often goes untreated due to dysfunctional parents.
- I believe it is best to make care available to the entire population. Service provided in segments becomes too expensive, and it makes those in the middle "have-nots." In general, homemakers could be a key population to serve because their mental health affects so many others.
- I believe persons showing early signs or behaviors of brain illnesses are in the greatest need of early intervention services.
- I don't think money should be spent only on the nonwhite. It has been the nonwhite that has been killing their children. The so called normal and affluent are the most overlooked of all populations, in my opinion.
- I don't think that there is a specific group, it can affect anyone.
- I feel that all people/groups are equal in their needs for help.
- I feel that the children of special need adults often get overlooked.
- I see a great need among families who need help due to drug and socio/economic problems. Their children are in desperate need of help.
- illiterate
- illiterates who may not have understanding of mental conditions and so are unaware of need for assistance.
- In each of the groups: unidentified sensory-motor/developmental issues that impede social interaction skills and judgment or problem-solving skills. Failures become the expected routine of life -- with no sense of alternatives.
- Individuals who have no health insurance coverage or who have Medi-Cal and there are no providers who accept Medi-Cal.
- individuals who may not be considered low income
- Individuals with undereducated guardians or deficits themselves.
- Infants exposed to drugs and alcohol prenatally
- Intervention in families who are risk of having children removed from the home or who are asking for their children to be removed.
- It can be anyone. A traumatic life event can happen in your family even when you seem like the most unlikely candidate. The event can have impact you never imagined. it can be nearly impossible to recover from without help and there might not be anyone to help you.
- Juvenile repeat offenders
- Juveniles with problem behaviors that get noted as behavior/conduct problems, when they are really mental health problems.
- Kids who are suicidal, depressed, needing to be out of their homes, etc
- Latina population especially non English speakers
- lesbians/gays,40-70 yr
- Low functioning adults
- low income undocumented individuals
- Low SES children of all ethnicities
- lower IQ (not MR) functioning children with juvenile justice involvement;
- MANY youth need these services today. They don't always 'look' like the stereotypic 'at-risk' student, so many youth, in many different peer environments are in need of theses services! It's all of them!
- Mental health workers. Those who think it is their duty to save the world with a misguided perception of their own importance
- methamphetamine users

- Mother's in high risk families with borderline neglect, current or hx of substance abuse, domestic violence and isolation.
- Much of the problems appear to be related to alcoholism or drug addiction with one or more family members
- Narrow (the) focus to provide care to those who have the least access to service. Preventing suicide, substance abuse, homelessness, etc is the priority and some of the above groups are already getting some intervention at some level.
- Our adolescent "at risk" population who may have possibly been overlooked for years (perhaps they are quiet and stay out of the "light"), (Columbine or suicide). These children most likely needed intervention in elementary school. I often wonder what will happen to a specific child later in his/her life. Recently we had one arrested for murder...sad, but sadder yet, we weren't shocked.
- Parents who are uneducated, unskilled-effect this has on children. Children with no father support.
- Pay attention to people with developmental disabilities with significant recent changes in acting out behavior. Mental illness in this population under diagnosed.
- People 18-25 on the streets self-medicating, couch surfing, and getting in trouble with the law.
  People abandoned from support after serving in the military services. And people that haven't experience a "live" encounter with Jesus Christ: John 3:16
- People that are placed in custody due to misdiagnoses by law enforcement
  people that don't have any local family
- people who "act out", and children who are not succeeding because no one knows how to help them.
- people who are at risk of losing a significant period of time with their children.
- People who are newly homeless are socially isolated, this creates mental health problems.
- people who are older such as 40-60 years who have never received help with therapy to work through problems.
- People who are repeatedly in contact with police, who go through the system, but never get the problems sufficiently addressed and hopefully resolved.
- People who are struggling to be self-sufficient in school, work or home. Those not able to cope in the "mainstream".
- People who develop Alzheimer's or other serious mental heath problems.
- People who do not have immediate family in the area that are willing to help.
- People who don't realize or refuse to recognize they have a problem
- People who exhibit symptoms but refuse treatment on their own
- people who self -medicate
- People whose behavior and thinking is deteriorating
- People with limited or no job skills.
- poor white families
- post PHF discharges that don't follow through.
- pregnant addicts
- pregnant/parenting young families
- Prevention should be a priority in all groups regardless of the population. This provides a basis for making transition into intervention easier and with better outcomes.
- Selecting a group is a bad approach.
- self medicating for mental illness not treated by physician.
- single men
- single mom/dad with multiple children
- Single mothers
- single mothers and their children
- single parents trying to juggle too many jobs and responsibilities on an income that's too low
- Single working parents with low incomes. They are stuck in the middle because they make too much to qualify for welfare or they don't make enough to feed their family.

- Sorry...don't know enough to provide a useful answer. I'm just an average, unaware citizen. This survey is good in that it points out to me how unaware I am...not good!
- Spanish Speakers --Spanish speaking families sometimes have children who will manifest problems (mental, physical emotional etc.,) because something is happening at home. The parents sometimes have bigger problems than their children.
- Specifically individuals who are not sure of what resources are available or who are afraid of asking for help due to stigma or the fear of hospitalization or the removal of children.
- Substance exposed Infants (0-5) where interventions can have the greatest impact due to their cognitive development stage.
- suicidal teenagers (x2)
- Teenagers and adolescents with learning disabilities
- Teenagers while still in high school. Our schools in SLO tend to downplay and stigmatize mental illness. Early intervention for those who have mental health issues and don't know where to turn, seek help.
- Teens who view themselves as having mental issues
- Teens with depression
- Teens, young adults, and young parents who are mentally ill, substance abusing, or victims whose parents and caretakers were also mentally ill, substance abusing or victims, so they had no appropriate role models.
- the disenfranchised that need to have outreach
- The elderly who are dealing with being caregivers of those with Alzheimer's Disease or who may be at risk for suicide due to undiagnosed depression.
- the family as a unit
- the uneducated
- The working homeless families that are in need.
- They ALL do.... All of these are BIG needs.
- This issue is not limited to socio, economic, racial or other "group" in any way.
- those misdiagnosed with other conditions who's actual problem is mental illness.
- those resisting care
- Those that are employed with no insurance and not eligible for financial assistance
- those that are uneducated and believe that therapy is a bad based on stigma
- Those who are depressed due to any given circumstance. Many of which are afraid/embarrassed to ask for help or who do not know how to ask for help.
- Those who are in the middle and upper incomes that can be on the edge of losing everything if they were to lose their job or separate from their spouse (forced to leave home due to curt order, domestic violence).
- Those with Medi-Cal or no insurance (excluding illegal residents). The M/C population has increasing difficulty accessing care because there are so few Mental Health Providers in SLO County willing to accept M/C (or patients with no insurance).
- undereducated,
- Unemployed and/or children growing up in a dysfunctional family.
- unemployed mothers
- unemployed young adults
- Unevaluated latch key children
- War vets, especially Iraq conflict
- We are jailing far too many people in this country. We need to identify and help adolescents and young adults with mental and anger problems before they become part of the criminal justice system. (I don't know why we use the word "justice" in the above phrase.) Our system is becoming less and less just.
- wheelchair bound people
- white middle class has no idea how to access services in a crisis situation (or just following) and/or may be worried that they can't afford services

- Women (x2)
- Women who are single parents who have difficulty finding employment. These women feel forced to be in domestically violent relationships which place their children at risk for trauma and neglect.
- young adults coping with LGBTQ related issues
- Young adults do not know how to access help for mental problem that could lead to suicide. If they do look for help is there long term, affordable counseling or access to affordable medication?
- young adults from 18-22 that are too old for youth programs and too young for adult programs
- Young adults who are away from home
- Young adults who are ready to give up.
- Young adults who are undergoing their first experience with mental illness
- Young parents with substance abuse problems and poor life skills need particular attention. With training and education, they can hopefully be rehabbed and trained to that they can make responsible decisions and care for their families to break the cycle of poverty and abuse.
- Young women who might commit suicide.
- Young, unemployed inexperienced parents, with issues such as substance abuse
- youngsters who have no relationship with a stable adult youngsters who are alienated, isolated or abused those who have a teacher, coworker, boss or neighbor noting signs of mental illness
- Youth in need of jobs
- Youth that have been continually passed from grade to grade that can not make the "grade" because of behavioral issues and not able to obtain the medication the need to become productive in our society. Because of the way our schools are set up they are setting up the most vulnerable kids to be lost in the system.
- Youth who are left alone often
- youth who have attempted suicide
- Youth with families with mental illness, criminal backgrounds, and unemployment.
- Youthful offenders whose parents are in denial about the circumstances that are really happening.

Participants

Provider/Subject Matter Expert

Provider Forums, 4 sessions - 24 table groups		152
MHS Cultural Competency Committee		6
MHS Staff		13
DAS staff		10
DSS Staff		9
County Childcare Planning Council		18
FCN Staff		10
TMHA Staff		9
11 sessions / 30 affinities	**subtotal**	**227**

Consumers/Family

Consumers - Srs - TMHA		8
Consumers - Adults - TMHA		23
Consumers - Teens - Vicente (2 grps)		8
Family - FCN parents		8
Family - NAMI		25
Family - TMHA FSG		17
7 sessions / 2 affinities	**subtotal**	**89**

Special Populations

Latino Outreach Council		11
Latino - ELAC, Morro Bay (Spanish)		35
Latino - ELAC, Oceano (Spanish)		10
Latino - Parent Grp, Paso (Spanish)		38
Latino - Parent Grp, Paso (Spanish)		16
Latino - Rural Assistance (Spanish)		9
Latino - Rural Assistance (Spanish)		12
Youth - LifeBound Leadership, Nipomo		11
Youth - JSC minors, 2 sessions		32
Youth - Grizzly Academy		12
11 sessions / 2 affinities	**subtotal**	**186**

TOTAL SESSIONS: 29 **TOTAL** **502**

Total Participants	Persons with Mental Illness	Family Members	Providers	Latino	Teens (13-18)	Gender F	Gender M
502	17% 69	32% 125	47% 192	40% 184	20% 83	63% 291	37% 172

Focus Groups Results

Themes/Desired Guiding Practices for overall PEI effort and service delivery:

- **Early identification**. As early as possible. Don't wait for problems/more problems. Increase number of entities who can identify.
- **Cooperative, coordinated, integrated services**. Agencies, schools, organizations must work better together; communicate better, work with families as partners. Have one point person than can access services from many, instead of people having to deal with so many different entities. Consistency, congruent messages.
- **Access.** Easy to access. Convenient locations, flexible hours, low/no cost, easy referrals, short wait times, well-known, comfortable, welcoming, and safe.
- **Utilize existing relationships/natural connections**. Increase community's involvement in helping to care for each other, identify problems. Outreach to "non-traditional" people that know what's going on – coaches, hair stylist, Meals on Wheels, mail carrier – use as paraprofessionals. Use natural connections.
- **Expand/enhance programs** that already exist and are successful.
- **Parent Involvement.** Treat parents/care givers as partners. Include in decision-making, listen to their input, communicate fully.
- **Parent/Whole Family Intervention, Support, Treatment.** Include parents/whole family in assessments, interventions. The whole family system usually needs support; don't just focus on the child.
- **Culturally aware and appropriate**. Vary services and approaches to different cultural groups.

RESULTS BY RANKING – ALL GROUPS COMBINED – FOCUS GROUPS

Providers: How would you design the best system P/EI system?
Others: What helps prevent emotional problems? What keeps people/kids healthy?
What helps people be happier, healthier, feel better?

Service / Programming	Elements desired	All Focus Groups, 502 participants n = 34
School-based Services, in general. Key is "school based"	Screening Assessments Counseling, therapy Support services Parenting classes	100% 34
Counseling/Support Groups, School-based	Available to children and parents Counselors at all campuses Variety of support groups Counselors available Drop in services	100% 34
Awareness Campaign Community Education / Training	MI facts Signs/symptoms Resources – what to do Stigma reduction	91% 31
Screening, in general	Early Variety of ages Specific groups Universal groups	88% 30
Parent Training/Education: mental health awareness	Signs/symptoms Resources and Referrals Decreasing stigma Encouraging help	88% 30
Parenting Skills	Communication Behavior problems Anger management Child development Relationship building Discipline Risky behaviors Being Involved	85% 29
One Stop Shops Wellness Centers FRCs/CRCs Help Centers	In all communities MH screening, assessment, treatment Walk in/drop in services Support groups Walk in counseling Therapy Array of human services and daily needs Welcoming and safe place to be Bilingual, bicultural services	85% 29
Life Skills / Coping Skills Training – all ages Focus on children, first Include in parenting skills classes	Anger management Assertiveness Communication skills Self esteem Social skills Feelings – knowing them, expressing them Stress management Asset development, resiliency Provided at school, part of curriculum	79% 27

Counseling/Therapy Individual, Couples, Family	Need more of it, more counselors, therapists Easy to access, readily available, low cost/free See “low level” cases Short term, specific-issue help Walk in, “on demand”	74% 25
Alcohol and Drug Abuse Prevention, Intervention, Treatment	Education – youth and adults Connection with MH – self medicating Support groups Prenatal use Parent ed dealing with teens using Integrate MHS and DAS Screening for use	65% 22
Teacher Training/Education: MH issues	Signs/symptoms Resources and referrals Positive approach Helping parents	65% 22
Stigma Reduction	Broad community campaign Parents – so they’ll seek help Integrate into school curriculums	62% 21
Responses below reported by 50% or less of participants		
Assessment	Early School-based and In-home Whole family – not just person with presenting problem Assessment centers – Martha’s Place, all ages	50% 17
Student Training/Education: MH issues	Signs/symptoms Resources and referral How to help a friend Who to talk to Integrate in curriculum – health class Connection with AOD abuse, DV, trauma, stress	50% 17
Screening, school based		44% 15
Family Advocates	For all/any Navigate system Provide daily support	41% 14
Domestic Violence Child Abuse Sexual Abuse	Prevention Identification and early intervention Support groups for children exposed MH assessment for those involved	38% 13
In Home Services In Home Visits	Expand Counseling Assessments/screenings Parenting education Earliest identification and intervention Especially for pregnant women, new moms/parents	38% 13
Physician, Health care provider Training/Education: MH awareness, issues	Signs/symptoms Resources and Referrals	38% 13
Senior Services	Screening In home services Mentor youth Meals on Wheels involvement	35% 12
Family Focus / Whole Family Services	Screening/assessment for whole families Support services for everyone involved	35% 12
Stress Management School and community	Training, classes All ages	32% 11

Providers and Law Enforcement Training/Education	Signs/symptoms Interventions Resources and referrals Positive Approaches	29% 10
Hotline / "Warmline" Helpline	Staffed with mental health professionals Can "triage" – crisis, not crisis – will handle all Provide guidance, advice Resources and Referral An enhanced 211	29% 10
Activities for Youth School or community-based	Things to do, positive alternatives Sports, Boxing clubs Dance, music, art Rec centers, clubs, Organizations Outings	29% 10
Homeless Services Housing	HOP Provide housing Target homeless for MH care Support Groups	26% 9
Trauma Intervention	Services right away Assess and intervention Target populations with trauma PTSD, Grief, Loss, Violence	26% 9
Integrated Services Teams	Team of providers review a case Expand SAFE or MDT, or SAFE/MDT-like – for all ages, don't have to be intense	24% 8
Academic Support	Tutoring "Stay in school" message Easier to be at school School success linked to self esteem, linked to MH	23% 8
Basic Needs	Meet them to decrease risk factors Food Housing Clothing	18% 6
Outreach / Education to Community Networks	Involve "non-traditionals" Train those who come in contact with a lot of people – mail carriers, clergy, Meals on Wheels, hair stylist	18% 6
Suicide	Prevention Intervention	18% 6
Faith Community Involvement	Training/education to clergy Signs/symptoms Resources and referral Outreach to congregations Partner with MH professional to church leader	15% 5
Father Involvement	Increasing, securing POPS – like programs	15% 5
Pregnancy Prevention Sex Education		8% 3
Transportation	Available to get to services Available nights/weekends Free/low cost	8% 3
Mentors for Youth		6% 2
Jobs	Vocational training Volunteer opps	6% 2
Gang Prevention / Intervention		3% 1

COMPARATIVE RESULTS – FOCUS GROUPS AND INPUT FORUMS

Top 10 responses by affinity (includes ties)

Providers	Consumers / Family Members	Latino, Limited/no English	High Risk Youth	Vs. Survey Responses (top 5)
School-based Services, in general. Counseling/Support Groups, School-based Awareness Campaign Community Education / Training Parenting Skills Screening, in general Parent Training/Education: mental health awareness One Stop Shops Family Resource Centers Help Centers Life Skills / Coping Skills Training – all ages Focus on children, first Add to parenting skills classes Stigma Reduction Alcohol and Drug Abuse Prevention, Intervention, Treatment Teacher Training/Education: MH issues	Assessment / Screening At school sites At community sites Awareness Campaign Community Education / Training Counseling/Support Groups, School-based Parent Training/Education: mental health awareness Student Training/Education: MH issues Life Skills / Coping Skills Training – all ages Focus on children, first Add to parenting skills classes One Stop Shops Family Resource Centers Help Centers Physician, Health care provider Training/Education: MH awareness, issues Provider and Law Enforcement Training/Ed Counseling, Therapy Peer Programs Buddy System Peer Support Groups Teacher Training/Education: MH issues	Activities for Youth Parenting Skills Academic Support Alcohol and Drug Abuse Prevention, Intervention, Treatment Counseling/Support Groups, School-based Parent Training/Education: mental health awareness Student Training/Education: MH issues One Stop Shops Family Resource Centers Help Centers Counseling, Therapy Gang Prevention / Intervention Rec Centers – create Sex Education Pregnancy Prevention	Activities for Youth Counseling/Support Groups, School-based Rec Centers – create Parenting Skills Student Training/ Education: MH issues One Stop Shops Family Resource Centers Help Centers Jobs Vocational training Volunteer opps	Early screening, diagnosis and help Support, resources, skills for youth and families for identifying and dealing with MH issues “One stop” help centers, FRCs, wellness centers Education and support for parents, grandparents, caregivers Training to teachers, law enforcement, et al – signs and response to mental illness

RESULTS BY AFFINITY

Service / Programming	Elements desired	Providers, 227 n = 30	Consumers/ Family Members, 89 n = 7	Latino, limited English, 131 n = 7	Youth – high risk, 55 n = 5
Academic Support	Tutoring "Stay in school" message Easier to be at school School success linked to self esteem, linked to MH issues	20%		57%	20%
Activities for Youth School or community-based	Things to do Sports, Boxing clubs Dance, music, art Rec centers Outings	20%	29%	100%	100%
Alcohol and Drug Abuse Prevention, Intervention, Treatment	Education – youth and adults Connection with MH – self medicating Support groups Prenatal use Parent ed dealing with teens using Integrate MHS and DAS Screening for use	60%	14%	86%	20%
Assessment	Early School-based, In home, community Whole family – not just person with presenting problem Assessment centers – Martha's Place, all ages	47%	100%		40%
Awareness Campaign Community Education / Training	MI facts Signs/symptoms Resources – what to do Stigma reduction	90%	100%	14%	40%
Basic Needs	Food Housing Clothing	20%			
Counseling/Support Groups, School-based	Available to children and parents Counselors at all campuses Variety of support groups Counselors available Drop in services	100%	100%	43% (support groups)	80%
Counseling/Therapy Individual, Couples, Family	Need more of it, more counselors, therapists Easy to access, readily available See "low level" cases Provide short term, specific-issue help Walk in, "on demand" No/low coast	70%	71%	43%	20%
Domestic Violence Child Abuse Sexual Abuse	Prevention Identification and early intervention Support groups for children exposed MH assessment for those involved	33%	14%		40%

Faith Community Involvement	Training/education to clergy Signs/symptoms Resources and referral Outreach to congregations Partner with MH professional to care for congregation	13%		100%	
Family Advocates	For all/anybody Personal advocate Navigate system Provide daily support Help with daily living needs	40%	29%		
Family Focus / Whole Family Services	Screening/assessment for whole families Support services for everyone involved	28%			
Father Involvement	Increasing, securing POPS – like programs	13%			20%
Gang Prevention / Intervention				43%	
Homeless Services Housing	Provide Housing HOP Provide housing Target homeless for MH care Support Groups	23%	57%		
Hotline / "Warmline" Helpline	Staffed with mental health professionals Can "triage" – crisis, not crisis – will handle all Provide guidance, advice Resources and Referral An enhanced 211	23%	43%		40%
In Home Services In Home Visits	Expand Counseling Assessments/screenings Parenting education Earliest identification and intervention Especially for pregnant women, new moms/parents	28%	29%		
Integrated Services Teams	Team of providers review a case Expand SAFE or MDT, or SAFE/MDT-like – for all ages, don't have to be intense	23%	14%		
Jobs Vocational training Volunteer opps				14%	40%
Life Skills / Coping Skills Training – all ages Focus on children, first Add to parenting skills classes	Anger management Assertiveness Communication skills Self esteem Social skills Feelings – knowing them, expressing them Stress management Asset development, resiliency Provided at school, part of curriculum	80%	86%		40%

Mentors for Youth				29%	40%
One Stop Shops Family Resource Centers Community Resource Centers Help Centers	In all communities MH screening, assessment, treatment Walk in/drop in services Support groups Walk in counseling Therapy Array of human services and daily needs Welcoming and safe place to be Bilingual, bicultural services	83%	86%	43%	60%
Outreach / Education to Community Networks	Involve “non-traditionals” Train those who come in contact with a lot of people – mail carriers, clergy, Meals on Wheels, hair stylist	20%			
Parent Training/Education: mental health awareness	Signs/symptoms Resources and Referrals Decreasing stigma Encouraging help	87%	100%	43%	40%
Parenting Skills	Communication Behavior problems Anger management Child development Relationship building Discipline Risky behaviors Being Involved	90%		86%	60%
Peer Programs Buddy System Peer Support Groups			71%		40%
Physician, Health care provider Training/Education: MH awareness, issues	Signs/symptoms Resources and Referrals	28%	86%		
Providers and Law Enforcement Training/Education	Signs/symptoms Interventions Resources and referrals Positive Approaches	27%	86%		
Rec Centers - Create				43%	100%
School-based Services, in general. Key is “school based”	Screening Assessments Counseling, therapy Support services Parenting classes	100%	43%	29%	40%
Pregnancy Prevention Sex Education		6%		43%	
Screening, in general	Early Variety of ages Specific groups Universal groups	90%	57%		40%
Screening, school based		40%	14%		

Senior Services	Screening In home services Mentor youth Meals on Wheels involvement	40%			
Stigma Reduction	Broad community campaign Parents – so they'll seek help Integrate into school curriculums	63%	57%		20%
Stress Management	Training, classes All ages At schools	27%	29%	29%	60%
Student Training/Education: MH issues	Signs/symptoms Resources and referral How to help a friend Who to talk to Integrate in curriculum – health class Connection of MI with AOD abuse, DV, trauma, stress	43%	100%	43%	60%
Suicide	Prevention Intervention	13%	29%		20%
Teacher Training/Education: MH issues	Signs/symptoms Resources and referrals Positive approach Helping parents	60%	71%	14%	40%
Transportation	Available to get to services Available nights/weekends Free/low cost			29%	40%
Trauma Intervention	Services right away Assess and intervention Target populations with trauma PTSD, Grief, Loss, Violence	20%	29%	29%	40%

PEI PROJECTS IDEAS

Recommendations forwarded to Planning Team from age-specific Workgroups

Goals:

Early Identification and Early Care • Increase/Improve Access to Care • Reduce Impact of Trauma•
Reduce Stigma/Discrimination • Increase Prevention Efforts and Develop Resilient Individuals

Suggested Projects – Based on Input from Community, Focus Groups, Workgroups	Age Group	Suggested Target Pops/ Focus	Suggested Strategies / Approaches Design Ideas / Concepts
Awareness campaign - general MH education; stigma reduction	All	Community at large Seniors	Various outreach strategies Have regular, on-going messages Use website, newspaper ads (especially free publications)
Teacher MH education / training – awareness and identification	Children and Youth TAY	All elementaries All middle schools All schools Schools that have had the least training GB elementary Cal Poly profs (if preschool: target high poverty/high gang rate areas)	Include all faculty/staff, not just teachers Include student teachers/add to curriculum at teaching schools Create a team of MH educators – they rotate through the schools, on regular/set basis – could reach all schools in county Training includes signs, symptoms, risk factors contributing to MI and co-occurring disorders, and who to contact.
Parenting Classes – broad audience	0-5 YO K-12 parents + relative caregivers	All parents Parents of 0-3 Dads of 0-3 Parents of young children Parents of abused kids Spanish speaking parents	Create Parent Education Coordinator – map current classes/offering, refer, find gaps, track – may not need to add more, just coordinate better Encourage early and continued education – decrease stigma of getting help Regional, offered at least quarterly, bilingual Expand "Strengthening Families" Curriculum should include??
Parenting Classes / Parent Coaching - "in crisis" parents, "on demand"	K-12 parents (or relative caregivers)	Parents "in crisis" Parents of kids at high risk (TBD) What behavior problems to target?	"On demand" classes, coaching, support. Create service to decrease wait time for care Include support groups Include family mentoring models (family to family) Curriculum includes??
Student Prevention / "Wellness" Ed/ Youth Development –	K-12	K-middle school Preschool TBD	Include classes on choices, values, maturity, navigating the world, building emotional IQ, social skills, helping a peer

Broad Audience Coping skills, protective factors,/ resiliency, communication skills, stress reduction, etc			that's struggling, who to refer to/who to go to for help School based – during and after school Build on existing programs Include peer classes/activities/peer support groups Include parent components

Suggested Projects – Based on Input from Community, Focus Groups, Workgroups	Age Group	Suggested Target Pops/ Focus	Suggested Strategies / Approaches Design Ideas / Concepts
Screening – Children/Youth (could include DV and AOD)	Children and Youth	0-2 YO Teacher or Parent requests All entering Pre-K, K All entering Mid school, HS Pre-SARB/SARB Childhood trauma parent with MI/sub abuse Isolated Declining HS grades Drop Outs	Use ASQ, SDQ Screening locations? Who screens?
Family advocates / Resource Specialists / Promotoras / Partners / "Linkers" – connect to resources, help with daily needs On campuses, in the community	All	Use with all target groups Place in underserved areas – schools and communities	Use in conjunction with other projects Place on campus with therapists Place on campus to assist struggling Children and Youth and families Community based teams – assist those ID'd through other projects Connect with those ID'd through screenings
Therapists / counselors on campus:	Children and Youth	Middle School K-6 Transitional grades – 6th, 8th (0-5, Martha's also requested)	easy access, self referral individual, groups serve parents/whole family too Fund therapist for each selected site – as many regular, consistent hours as possible
Counseling / therapy – target groups and general public	All	Children and Youth ID'd via screening Young Adults from "brief intervention" Srs ID'd via screening and outreach	increased # of therapist will be needed to assist those ID'd for care from any screening/assessment/outreach work Short term Low intensity community based easy access, self referral not enough bilingual therapists – meet underserved pop needs
Support Groups – Targeted groups Priority Populations	All ages	- Children and Youth whose parents have MI - Children and Youth who have siblings with MI -Veterans – returning from current conflicts -Veterans -PTSD -Seniors with depression -Adopted Children -Children involved with CWS	Create groups for those target groups ID'd/receiving services in other PEI programs Create for high risk groups prioritized by community Fund facilitators Offer throughout county, various hours On campus and community based Provide transportation (via Fam Advocates?)
Coping Skills / Support Services	Children and Youth	Targeted groups with specific risk factors, such as: Adopted kids	Support Groups Counseling Anger Management skills/classes

		Children with DV in family Children w/ parents with MI/sub abuse	Include recreational activities

Suggested Projects – Based on Input from Community, Focus Groups, Workgroups	Age Group	Suggested Target Pops/ Focus	Suggested Strategies / Approaches Design Ideas / Concepts
Screening, Referral and Support – targeted Adults "Brief Intervention/Red Flag" Program	TAY Young Adults	-16-25 YO who are caregivers (parents, care for siblings, care for own parents) -18-25 YO that have first contact with law enforcement for AOD, violence, or DAS contact	Target population is identified, referred to "case manager" who makes contact, assesses situation, offers support, connects to resources (daily needs, MH/AOD screening/assessment, support groups, counseling, etc)
"Successful Launch Program" – to assist targeted transitional groups	TAY	-Exiting Foster Care System, especially those not in ILP -Graduating Continuation School -Drop Outs	Mentor-type person connects with individual 1 yr before exit, follows at least 1 yr after transition – focus on life skills, employment, independent living, really involvement – more than referrals
Screening and Support Program -targeted Seniors	Older Adults	-Isolated – mobile home parks; Sr communities -At Sr Centers -At health screenings Won't seek assessment/care due to stigma	Screening: via general practitioners, senior centers, health care screenings (EOC, CHC), mobile home parks Link to regular physical exams Use self administered instrument at dr's office – can fill it out while waiting for dr's appt If a "positive" screening: "Linker" contacts OA, offers assistance, ensures connection to resources Create Outreach/Screening Position to do screenings, connect with GPs Create team of "Linkers" / Advocates
"Friendly Visitor" programs / create "Caring Neighbors" – Seniors – expand	Older Adults	Isolated Mobile Home Park residents	Expand existing visiting programs Increase use of neighbors – run neighbor involvement campaign Utilize students – create inter-generational program Utilize churches – provide referrals, recruitment - Fund Coordinator/Outreach position
Peer counseling – Seniors	Older Adults		Expand existing peer counseling programs
Integrated Services Teams – expanded locations and ages	Children and Youth Adults OA		Include physicians and clergy/faith community Community based For Seniors – create Coordinator position, especially focused on bringing Sr services together, maximizing church community involvement
Community Resource Centers - enhance existing gathering places to include MH information, Resource and Referral	All	TBD	Fund "CRC Developer" to "create" MH info areas at existing "natural" settings in many communities (churches, schools, markets, libraries, post offices, etc). Include MH awareness info and resource

			and referral. Staff part time with Family Advocates, community volunteers – rotate through region -Outreach to schools as to services/help available -211 should refer to centers
Community Resource Centers / Wellness Centers / Help Centers – create new ones	All	Priority regions/areas TBD	Hubs in informing, connecting, and delivering services Outreach to schools as to services/help available 211 should refer to centers

Suggested Projects – Based on Input from Community, Focus Groups, Workgroups	Age Group	Suggested Target Pops/ Focus	Suggested Strategies / Approaches Design Ideas / Concepts
Student MH awareness			put MH into curriculum Use peer leaders to lead message/campaign Utilize school papers
Parent education – MH awareness			
Others:			

NOTICE OF AVAILABILITY FOR PUBLIC REVIEW & COMMENT
And
NOTICE OF PUBLIC HEARING

San Luis Obispo County
Mental Health Services Act

NOTICE OF AVAILABILITY FOR PUBLIC REVIEW

WHO: San Luis Obispo County Behavioral Health Department

WHAT: The MHSA Prevention and Early Intervention Component proposed plan for San Luis Obispo County, outlining the recommendations for use of PEI funds, is available for a 30-day public review and comment from November 18 through December 17, 2008.

HOW: To review the proposed plan or submit comments,

Visit: http://www.slocounty.ca.gov/health/mentalhealthservices.htm

Call: (805) 788-2055

Email: fwarren@co.slo.ca.us

Comments must be received no later than December 17, 2008.

NOTICE OF PUBLIC HEARING

WHO: San Luis Obispo County Mental Health Advisory Board

WHAT: A public hearing to receive comment regarding the Mental Health Services Act Prevention and Early Intervention Component proposed plan.

WHEN: Wednesday December 17, 2008, 3:00 p.m. – 4:00 p.m.

WHERE: Behavioral Health Campus, Annex Conference Room,
2180 Johnson Ave, SLO.

FOR FURTHER INFORMATION:
Please contact Frank Warren, (805) 788 - 2055 or fwarren@co.slo.ca.us