



County of Orange
Health Care Agency Behavioral Health Services
Mental Health Services Act

**Prevention
and
Early Intervention
Plan**

January 27, 2009

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Executive Summary

Background

The County previously requested and was approved for \$2,029,700 to be used for Community Program Planning for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). The County now requests a total of \$31,146,234. This amount will be used to provide PEI programs and services for the last quarter of FY 2008/09 and all four quarters of FY 2009/10.

The Planning Process

The Mental Health Services Act (MHSA) Prevention and Early Intervention planning process was conducted in three stages.

The first stage began in March 2007 with presentations and information sharing in over 35 meetings with various stakeholders and community representatives in an effort to increase awareness of the MHSA and the PEI component.

The second stage commenced in December 2007 and involved an extensive community planning process, including numerous stakeholder meetings, 75 community focus groups and two surveys (one for providers and another for the community). Of the 75 focus groups, 21 were multicultural in focus. Focus groups were held in a variety of languages: Spanish, Vietnamese, Farsi, Arabic, Korean, American Sign Language (ASL), and English.

Participants in the planning process reflected the diversity of the County's demographics and included stakeholders from a wide variety of organizations and community groups. Moreover, consumers and family members took an active role in all aspects of the planning process.

The third stage of the MHSA Prevention and Early Intervention planning process commenced in July 2008, when the results of the stakeholder meetings, community focus groups and survey data were compiled and presented to the local MHSA Steering Committee for review. This effort led the Steering Committee to establish a PEI Subcommittee to assist in the process of analyzing and translating the community input into the core design of the PEI Plan.

The PEI Subcommittee identified eight PEI project categories, which resulted in the formation of eight corresponding workgroups to further develop and prioritize ideas for the strategies to be included in the PEI Plan. The workgroups were asked to review the community input and make program recommendations that reflected that input. These eight PEI Project categories and corresponding workgroups are listed below.

Prevention	Training
Early Intervention	School-Based Services
Screening and Assessment	Parent Education and Support
Crisis and Referral	Outreach and Engagement

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Each workgroup met twice, and a total of 613 stakeholders attended these meetings. Spanish, Vietnamese and ASL translators were used to ensure participation of diverse ethnic/cultural groups.

The workgroups developed specific program recommendations to address the identified needs. These recommendations were then considered and approved by the PEI Subcommittee and then the MHSA Steering Committee. Work group facilitators and Health Care Agency staff developed written descriptions of these programs, which were then incorporated into the PEI Plan.

The Plan was made available for a 30-day public comment period (December 22, 2008 – January 21, 2009). A Mental Health Board Public Hearing was held on January 22, 2009. Upon Mental Health Board approval, a request to apply for grant funds will be sent to the Board of Supervisors.

Projects and Programs

Selection of each of the eight projects listed above was based on an inclusive, transparent community planning process. Each contains two or more specific programs, for a total of 33 programs included in the PEI Plan. On the following page is a chart summarizing the projects and the proposed programs within each project. Each project must meet the standards described by the State Department of Mental Health, the Oversight and Accountability Commission and the MHSA legislation and regulations with regards to being culturally and linguistically competent. Each project and program is described in the PEI Plan, and information is provided on the types of target populations/age groups addressed, the number of individuals to be served, expected outcomes, linkages to other MHSA components and providers of other needed services, and collaboration.

Together, these projects/programs provide a comprehensive approach to meeting the Prevention and Early Intervention needs of Orange County residents. Each of the Department of Mental Health (DMH) specified target populations is addressed, and a wide variety of strategies will be used to meet the needs of each. The expectation is that these projects will make a meaningful difference in the incidence and severity of mental illness in Orange County.

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PEI Projects and Programs							
Early Intervention (EI)	School-based Services	Outreach and Engagement	Parent Education & Support	Prevention Services	Screening and Assessment	Crisis and Referral	Training Services
EI Services for Stressed Families	School-based MH services	Information and Referral	Positive Parenting Program	Mental Health Consultants	Providing Assessment Tools and Training	Crisis Prevention Hotline/Warm Lines	Training and Technical Assistance
First Onset Services and Supports	Positive Behavioral Interventions & Supports	Outreach and Engagement	Parent Empowerment Program	Children of Parents with S/U or Mental Illness	Integration of Professional Assessor into Established Programs	Crisis Intervention Network	Child Development Training
Socialization Program for Isolated Adults and Older Adults	School-based Violence Prevention Education		Training Program	PEI Services for Parents & Siblings of TAY in Juv. Justice Syst.	Mobile Assessment Team	Law Enforcement Partnership	Training in Physical Fitness and Nutrition
Peer Mentors for Youth	School Readiness Program Expansion	Parent	Program	Youth Development and Resiliency		Support Services	Stress Management for Caregivers
Peer-led Support Groups		Promotora	Family to Family Program	Transition Services	Survivor		Community-based Stigma Reduction Training

Conclusion

Consistent with California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.270, the PEI community program planning process followed in Orange County was designed to include meaningful involvement and engagement of diverse communities and potential individual participants, their families, and other community stakeholders. To the greatest extent possible, the proposed PEI projects and programs identified in this plan have been designed to build capacity for providing prevention and early intervention services related to mental health at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations).

Once approval has been obtained, the implementation stage will commence. Individuals, families and other community stakeholders involved in the preliminary planning process will be reengaged and provided with an overview of the approved PEI Plan, information specific to the County procurement process, and assistance with capacity building. Outreach will also be conducted to identify and engage other constituency groups and stakeholders who may have not been involved in previous planning efforts to familiarize them with the local PEI effort and to invite them into the implementation process and expand the number of potential implementation partners.

**MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2008-09 and 2009-2010**

County Name: Orange	Date: January 27, 2009
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
Name: Mark Refowitz	Name: Jenny Qian
Telephone Number: (714) 834-6032	Telephone Number: (714) 834-2426
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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 Mark Refowitz
County Mental Health Director

1/26/2009
Date

Instructions: Please provide a narrative response and any necessary attachments to address the following questions. (Suggested page limit including attachments, 6-10 pages)

County: Orange

Date: January 27, 2009

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

a. The overall Community Program Planning Process

Mark Refowitz, Deputy Agency Director, Behavioral Health
Mary Hale, Chief of Operations, Behavioral Health
Alan Albright, PEI Coordinator
Kate Pavich, Mental Health Services Act Coordinator

b. Coordination and management of the Community Program Planning Process

Mark Refowitz, Deputy Agency Director, Behavioral Health
Mary Hale, Chief of Operations, Behavioral Health
Alan Albright, PEI Coordinator
Kate Pavich, Mental Health Services Act Coordinator

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

Veronica Kelley, Ethnic Services Manager
Alan Albright, PEI Coordinator, Focus Group Facilitator, and Workgroup Facilitator
Kimari Phillips, Research Analyst, Survey Data Analysis
Tony Delgado, PEI Workgroup Group Facilitator
Karen Jakernapack, PEI Workgroup Group Facilitator
Cort Curtis, PEI Workgroup Group Facilitator
Greg Masters, PEI Workgroup Group Facilitator
Ken Grebel, PEI Workgroup Group Facilitator
Theri Todd, PEI Workgroup Group Facilitator
Casey Dorman, PEI Workgroup Facilitator

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

The MHSA Prevention and Early Intervention planning process was conducted in three stages.

Stage 1:

The first stage began in March 2007 with presentations and information sharing in over 35 meetings with various stakeholders and community representatives in an effort to increase awareness of the Mental Health Services Act and the PEI component. Information from the MHSOAC County and State Level Policy Direction (Adopted by MHSOAC, Jan. 26, 2007) was used as a tool in these early meetings to facilitate initial discussions regarding the PEI planning process. These early meetings also served as opportunities to create and renew collaborative relationships that would assist with future community PEI planning efforts. Please see **Attachment 1** for a PowerPoint presentation used to train stakeholders about the PEI Component of the MHSA.

These preliminary PEI presentations involved the following community groups and organizations:

Table 1: Preliminary Presentations and Discussions

Date	Organization	Stakeholders
03/13/07	Mental Health Board Children's Committee	Children and youth advocates
03/16/07	Orange County Dept. of Education (OCDE)	Educators
03/23/07	SSA and Probation	Juvenile Justice
04/06/07	Orange County Department of Education	School Nurses
04/09/07	NAMI Orange County	Mental Health advocates
05/23/07	Early Childhood Social Emotional Health System Development	Children and Families Commission
06/04/07	CalOptima	Health Care
07/19/07	Children's Services Coordination Committee	Juvenile Justice
08/16/07	Children's Services Coordination Committee	Juvenile Justice

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08/17/07	Orange County Criminal Justice Coordinating Council	Criminal Justice
10/12/07	MHSA Steering Committee	MHSA
10/16/07	MHSA Community Action Advisory Committee	Consumer representatives
10/22/07	Orange County TAY Conference 2007	TAY Advocates
10/23/07	OCDE Mental Health Collaboration Meeting (SELPA)	Special education
11/07/07	OC Safe From The Start Advisory Council	Child development
11/08/07	Mental Health Board Study Meeting	Mental Health Advisory Board
11/09/07	Developmental Pathways Leadership Committee	Early childhood development
11/14/07	MHSA Steering Committee PEI Subcommittee	MHSA PEI
11/14/07	San Clemente Human Affairs Committee Forum	Underserved ethnic groups
11/16/07	Alcohol & Drug Abuse Advisory Board	Substance abuse
11/27/07	211 OC	Information and referral services
12/03/07	Children and Youth Services All Contract Providers Meeting	Children/TAY service providers
12/03/07	Orange County Congregation Community Organization	Faith-based providers
12/05/07	Anaheim Family Justice Center	Domestic violence
01/14/08	Anaheim Union High School District School Counselors	Educators
01/23/08	Child Care & Development Planning Council	Child care providers
01/23/08	Typical or Troubled Training	Educators
01/25/08	School District Homeless Liaison Network Meeting	Homeless families
01/28/08	Post Partum Depression Work Group (St. Joseph Hospital)	Health care
02/11/08	Older Adult Services Provider Meeting	Older adult service providers
02/12/08	Orange County Special Education Administrators and Program Specialists Meeting	Special Education
02/12/08	School District Prevention Coordinators Meeting	Educators
02/15/08	OC Assistant Superintendents of Schools	Educators

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02/21/08	Irvine Prevention Coalition	Delinquency prevention
02/22/08	Northwood High School	Educators
02/27/08	KidWorks	Family/Community Services
03/04/08	Families Forward	Domestic violence

Stage 2:

The second stage commenced in December 2007 and involved an extensive community planning process including numerous stakeholder meetings, community focus groups, and survey data. Listed below are examples of specific community program planning activities.

Community Outreach:

- Specific outreach to underserved linguistic, ethnic, and cultural communities.
- Specific outreach to community-based organizations and programs that serve or have contact with underserved linguistic, ethnic, and cultural members, including Native Americans and migrant workers.
- Outreach to potential individual participants, their families, and other community stakeholders and cultural members, including Native Americans and migrant workers.

Preparation for Community Program Planning:

- Collection and analysis of data from various service sectors in order to assess current community capacity, resources, and needs.
- Staff development and training for County staff and stakeholders addressing PEI guidelines specific to planning and work plan development.
- County resources and/or consultants utilized to assist in evaluating, summarizing and disseminating information on PEI strategies and resource material.

Focus Groups and Stakeholder Meetings:

- Meetings, dissemination of information and announcements through electronic and print media (including languages other than English), focus groups, community groups, interpreter services, document translations, interviews, survey tools, and other methods to present PEI information to stakeholders and gather input concerning service gaps and needs (see Table 2).
- Support to individual participants, their families, and other community stakeholders, including covering expenses (e.g., transportation, child care, etc.) to ensure their participation in focus groups and community meetings.

Table 2: PEI Stakeholder Meetings and Community Focus Groups**Underserved Populations**

01/26/08	Therapeutic Arts Center of Santa Ana (Spanish Speaking)
02/01/08	Mariposa Women's Center (Spanish Speaking)
03/04/08	Mariposa Parenting Class at Paul Revere School (Spanish Speaking)
03/08/08	Access California Services (Arabic, Farsi Speaking)
03/14/08	Viet Mental Health Awareness & Support Group (Vietnamese Speaking)
03/31/08	CREER (To Believe In) (Spanish- Speaking)
04/04/08	Garden Grove Vietnamese Community (Vietnamese Speaking)
04/06/08	Bát Nhã Buddhist Temple (Santa Ana) (Vietnamese Speaking)
05/07/08	Latino Health Access (Spanish Speaking)
05/08/08	Latino Health Access (Spanish Speaking)
05/19/08	St. Anselm's Refugee Resettlement Center (Vietnamese, Farsi and Arabic Speaking)
05/31/08	Các Sư Cô (Nuns) – Bát Nhã Temple (Vietnamese Speaking)
06/04/08	Multi-Ethnic Task Force
06/05/08	Refugee Provider Forum
06/11/08	Magnolia Resource Center (Spanish Speaking)
06/17/08	Costa Mesa (Spanish Speaking)
06/20/08	Stanton Community Services No. 1 (Vietnamese/Eng Speaking)
06/20/08	Stanton Community Services No. 2 (Vietnamese Speaking)
06/25/08	Grace Education Center (Spanish Speaking)
06/26/08	Korean Community Services (Korean Speaking)

Older Adults

01/16/2008	Ombudsman Regional Coordinators
01/28/2008	Council on Aging
01/29/2008	Adult Protective Services (Social Services Agency)
01/30/2008	South County Seniors
01/31/2008	Mission Hospital Senior Advisory Committee
02/08/2008	Senior Citizen's Advisory Council
02/14/2008	Lakeview Senior Center (Irvine)
02/20/2008	Senior Citizens Advisory Council
02/20/2008	Linkages Program at Council on Aging
02/21/2008	Human Options
02/26/2008	Senior Health Outreach & Prevention Program (SHOPP)
02/27/2008	Laguna Woods Social Services
02/28/2008	No. Orange Co. Senior Services Collaborative
04/25/2008	Office On Aging Contracted Providers
06/06/2008	interlockCARE

Community/Consumers

01/15/08	Community Action Advisory Committee
02/26/08	Coalition of Orange County Community Clinics
03/12/08	Community Services Program Victim Assistance Programs
05/22/08	The Faith and Institutions Together for Health Coalition
03/20/08	Human Options
03/31/08	KidWorks
05/27/08	Multidimensional Treatment Foster Care Foster Parents
05/28/08	National Alliance for the Mentally Ill-Orange County
04/16/08	North County Family Resource Centers
04/23/08	OC DEAF (ASL Speaking)
04/16/08	South County Family Resource Centers
06/14/08	Community Meeting (Santa Ana)
06/17/08	AIDS Services Foundation
06/19/08	Family Assessment, Counseling and Education Services
06/22/08	Community Meeting (Anaheim)
06/22/08	Community Meeting (Laguna Hills)

Children and Youth

12/19/07	Juvenile Justice Commission
01/08/08	Coordinating Nurses
01/17/08	Children's Services Coordination Committee
01/08/08	Children and Families Commission Grantees
02/11/08	California Youth Connection Foster Youth
03/07/08	Child Welfare and Attendance/Student Attendance Review Board Meeting
03/10/08	The Inclusion Collaborative (Orange County Child Care Development and Planning Council)
04/04/08	Help Me Grow
04/14/08	Anaheim City School District
04/24/08	OC School District Representatives (Bowers)
04/28/08	OC Home Visiting Providers
05/21/08	School-Based Health Clinics
06/19/08	Behavioral Health Network

Health Care

02/06/08	CalOptima Provider and Member Advisory Committee Reps.
04/02/08	Institute for Healthcare Advancement (La Habra)
04/03/08	Hospital Association of So. California

Substance Abuse

01/15/08	Alcohol & Drug Abuse Services Contract Providers
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01/31/08	Alcohol and Drug Education and Prevention
05/15/08	Public-Phoenix House

Law Enforcement

11/19/07	Juvenile Bench Officers Meeting
01/31/08	Anaheim Family Justice Center Collaborative
04/08/08	Legal Aid Society of Orange County
05/13/08	Law Enforcement (south)
05/29/08	Law Enforcement (north)

Orange County used a number of culturally/linguistically appropriate mechanisms to inform and include members of unserved and/or underserved populations in our PEI planning process. Visits were made to key members of the target communities, informing them of the details of PEI and asking for their assistance in better understanding the needs of Orange County's diverse communities. Examples of this included meetings at various temples with Buddhist leaders in Orange County, meetings with local community centers, cultural health care providers, Vietnamese and Korean community leaders, refugee community leaders, leaders in the deaf and hard of hearing community, etc. These consultations generated ideas on how to access community populations and resulted in offers to host community meetings/groups to interact with members of the community and obtain their input concerning their prevention and early intervention needs.

Additionally, phone calls were made to community partners to spread the word about PEI. Announcements were made at cultural events such as the Juaneño Band of Mission Indians Health Fair and the Multi Ethnic Behavioral Health Services Task Force meetings. Members of the County's Behavioral Health Cultural Competency & Multi Ethnic Services Department, who have served as cultural brokers with our diverse communities in the past, utilized their positive standing in the various communities to generate participation in the PEI stakeholder process. Partnerships between the Cultural Competency Department and multicultural stakeholder leaders were drawn upon to encourage additional community meetings and to ensure that community members attended and contributed their views. Of the 75 focus groups held, 21 were multicultural in focus. A total of 509 community members attended these groups and provided feedback.

- A total of 11 Spanish language community groups were held. A total of 252 Spanish-speaking Latinos attended. The groups were held in various parts of the County, focusing on those cities that have high populations of Latinos. These meetings were held at times convenient for the community members so they could attend after work or on lunch hours. Child care, as well as transportation, was made available. The entire community meeting was held in Spanish, with Spanish handouts on the MHSA and PEI.

- Five Vietnamese language community groups were held. A total of 163 Vietnamese speakers attended. These meetings were held at times convenient for the community members so they could attend before or after work or on the weekend during temple hours. Child care, as well as transportation, was made available. The entire community meeting was held in Vietnamese, with Vietnamese handouts on the MHSA and PEI.
- Additionally, five community groups were conducted in Farsi, Arabic, American Sign Language (ASL) and Korean. These meetings were held at times convenient for the community members so they could attend before or after work or religious/mosque activities. Child care, as well as transportation, was made available. These community meetings utilized professional interpreters known to the community.

Another method used to solicit feedback regarding the needs of the ethnic communities, was a survey tool that was developed and translated into Spanish and Vietnamese. This survey asked specific questions about the current PEI resources available, ease of accessing these resources, opinions about the community needs for PEI, goals for PEI, settings for PEI, and best strategies for addressing PEI. Two different surveys were constructed: one for providers of services and one for the community at large. A total of 390 organizational surveys and 1,564 community surveys were completed.

These surveys were distributed through numerous methods, including hand delivery to community agencies, such as Nhan Hoa Clinic, community centers such as Stanton Community Center, and faith-based centers such as Mission San Juan Capistrano Church. Surveys were mailed to anyone who requested them (with postage paid return envelopes), and supplied to our community partner agencies and consumer groups, etc. A total of 3,000 surveys were mailed to Orange County organizations and community members and 5,000 were handed out.

The survey was also available for completion on line via the Orange County PEI website in English, Spanish, and Vietnamese. Advertisements were placed in local newspapers alerting the community about the survey tool and instructing them how to access it. Each advertisement ran twice in each paper. There were ads placed in three Spanish newspapers, three Vietnamese newspapers, and 27 English newspapers. (See Table 3 below.)

Table 3: Newspapers Publicizing the Community Survey

La Opinion	Spanish
Hoy	Spanish
Excelsior	Spanish

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Nguoi Viet	Vietnamese
Viet Bao	Vietnamese
Vien Dong	Vietnamese
OC Register includes 26 community papers	English

The advertisement was also placed in the Orange County Cultural Connection, a quarterly publication by the Cultural Competency & Multi Ethnic Services Department. This newsletter is available online and has a circulation of approximately 2,000 recipients. In addition, a podcast was made of the advertisement for the survey in Spanish, Vietnamese and English, available through the Cultural Competency website and distributed via numerous email listings.

Four large community meetings were also held to solicit stakeholder participation. These groups were held on weekend dates (Saturday and Sunday) in each of the four regions of Orange County. These cities included Stanton, Santa Ana, Laguna Hills and Anaheim. Notices were also placed in the Orange County Register announcing the meetings. In addition, interpretation in Spanish, Vietnamese and ASL was advertised and provided at these meetings.

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

As stated above, the County of Orange provided significant opportunities for diverse participation in the PEI stakeholder process. The County has identified the following areas of diversity:

- **Geographic Diversity-** Orange County is an urban area, although there are parts of the County that have insufficient public transportation and are not easily accessible without a car. To address this, focus/community groups were held in these areas, which included San Juan Capistrano and Laguna Hills.
- **Ethnic/Racial Diversity-** Orange County is very diverse. The County is made up of approximately 48% Caucasian, 32% Latino, 16% Asian Pacific Islander (API), 1.9% African American, .5% Native Indigenous and 1% other (CA Dept of Finance 1/8/08). The largest API population is Vietnamese, a group which makes up 33% of the API population. Invitations were personally made to local ethnic communities which included Latinos, Vietnamese, Iranians, Koreans, and all MHSA target populations. Efforts were made to hold focus groups for the Native American population, but the demographics of Orange County's Indian population prevented a specific group. That is, there are no reservations, rancheros, etc, and no federally recognized tribes in Orange County. Local

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Native Americans tend to be urban Indians. Outreach efforts were made to our only State recognized tribe, the Juaneño via education about PEI at their first annual Health Fair. Outreach to the underserved population of migrant workers was achieved through our community-based partners who assisted us in including a large number of migrant workers in our Spanish language PEI focus groups.

Additionally, community groups were held respecting cultural norms; for example, one group was held in Vietnamese at a local restaurant in the evening. Food is very cultural and a meal was shared while the group was conducted. Prior to the group starting and afterwards as well, there was a karaoke presentation, which drew a large group, who also provided important feedback on PEI for their community.

- **Language Diversity-** In Orange County, English, Spanish, and Vietnamese are threshold languages, and Korean and Farsi are emerging languages. Focus/community groups were conducted in these languages. Written materials were created, not translated, in Spanish and Vietnamese to ensure comprehension of concept for monolingual community members. A focus/community group was also conducted in American Sign Language to include an often overlooked (and much underserved) community.
- **Socioeconomic Diversity:** Opportunities were made to include both high and low Social Economic Status (SES) participants in the community feedback via groups and surveys. Focus groups were held both within tight communities such as local Family Resource Centers, as well as at established Community Centers which may have a more mainstream attendance.
- **Educational Diversity:** Participants in our community/focus groups were from all walks of life, including educational levels. The groups were run in such way as to ensure MHSA education and information on PEI was clear to all who attended. Multiple media was used to ensure the same (such as PowerPoint presentations, written materials, verbal exchanges, dialogue, etc.)
- **Age Characteristics:** The age characteristics of participants in the community/focus groups varied greatly and (with the exception of young children) generally represented the demographics of the County. Transitional Age Youth, adults, and older adults all participated. Similarly, the age range of respondents to the community survey was 15-91, with the mean age being 43.5 years.
- **Gender Characteristics:** Women were over-represented among community/focus group participants. Culturally, this makes sense since duties associated with family, child rearing, and the caring of older adults falls on the

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females in the household in many cultures (Latinas), although the actual decisions may rely solely on the discretion of the male heads of household (Vietnamese). The Latino groups tended to be heavily female, with occasional male participation. The Vietnamese groups tended to be the opposite, heavily male with occasional female participation. The survey respondents were 66.8% female and 33.1% male.

- **Sexual Orientation-** While no community/focus groups were held specifically for the LGBT/Q population, members of these communities were also present at many of the community/focus groups. Due to cultural norms, asking for self-identification for data purposes was not done.

We used the following mechanisms to assure that our planning process successfully reached diverse audiences:

- Worked directly with the County's Ethnic Services Manager and the Cultural Competency & Multi Ethnic Services Department to ensure participation of the County's diverse communities.
- Held focus/community groups organized by the Cultural Competency Department, drawing on strong relationships in the various cultural communities, utilizing Cultural Competency staff as cultural brokers.
- Provided transportation to those in need; community/focus groups were located within communities to make transportation easier. These groups were also held at hours conducive to the community, such as in the evenings to ensure Latino presence, and allowing individuals who work during the day to attend. Child care was provided so that parents with children could attend. Small meals were also provided to allow for participation of families after work hours.
- Whenever possible, focus/community groups were conducted in the language of the participants. All of the Spanish and Vietnamese groups were conducted in those languages. Interpreters were used in other instances for the Deaf and Hard of Hearing Community, Arabic, Farsi, and Korean speaking groups.

Stage 3:

The third stage of the MHSA Prevention and Early Intervention planning process commenced in July 2008, when the results of the stakeholder meetings, community focus groups, and survey data were compiled and presented to the local MHSA Steering Committee for review. This effort led the Steering Committee to establish a PEI Subcommittee to assist in the process of analyzing and translating the community input into the core design of the PEI Plan in greater detail. This also enhanced the oversight

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of the planning process by creating an additional level of transparency to ensure that the input of the community was being appropriately used to drive the PEI planning effort.

On July 21, 2008, the PEI subcommittee met for the first time. In addition to the participation of members of the Steering Committee, there were also many others in attendance who represented various underserved community groups along with provider organizations serving all PEI priority populations. This meeting led to the identification of eight PEI project categories and the formation of eight corresponding workgroups to further develop and prioritize ideas for the strategies to be included in the PEI Plan. The workgroups were asked to review the community input and make program recommendations that reflected that input. These eight PEI Project categories and corresponding workgroups consisted of:

Prevention	Training
Early Intervention	School-Based Services
Screening and Assessment	Parent Education and Support
Crisis and Referral	Outreach and Engagement

Each of the eight workgroups met twice and were attended by MHSA Steering Committee members (or their alternates) and PEI Subcommittee members, community members, consumers and family members, community-based organizations, educators, and representatives from Social Services, Probation, and the Courts. These workgroup meetings involved a total of 613 attendees and were conducted with the assistance of Spanish, Vietnamese, and ASL translators.

Table 4: PEI Subcommittee and Workgroup Meetings

07/21/08	PEI Sub-Committee
07/30/08	PEI Sub-Committee
08/07/08	<ul style="list-style-type: none"> • Parent Education and Support Workgroup
08/08/08	<ul style="list-style-type: none"> • Training Workgroup
08/11/08	<ul style="list-style-type: none"> • Screening and Assessment Workgroup
08/14/08	<ul style="list-style-type: none"> • School Based Services Workgroup
08/14/08	<ul style="list-style-type: none"> • Outreach and Engagement Workgroup
08/15/08	<ul style="list-style-type: none"> • Prevention Workgroup
08/18/08	<ul style="list-style-type: none"> • Early Intervention Workgroup
08/18/08	<ul style="list-style-type: none"> • Screening and Assessment Workgroup, 2nd meeting
08/20/08	<ul style="list-style-type: none"> • Crisis and Referral Workgroup
08/21/08	<ul style="list-style-type: none"> • Parent Education and Support Workgroup, 2nd meeting
08/22/08	<ul style="list-style-type: none"> • Training Workgroup - 2nd meeting
08/25/08	<ul style="list-style-type: none"> • School Based Services - 2nd meeting

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08/29/08	<ul style="list-style-type: none">• Outreach and Engagement Workgroup - 2nd meeting
08/29/08	<ul style="list-style-type: none">• Crisis and Referral Workgroup - 2nd meeting
09/02/08	<ul style="list-style-type: none">• Prevention Workgroup - 2nd meeting
09/05/08	<ul style="list-style-type: none">• Early Intervention Workgroup - 2nd meeting
09/30/08	PEI Sub-Committee

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

Orange County values greatly the consumer/family member perspective on the services and programs to be provided with MHSA funding. Therefore, consumer participation in the planning process was seen as a high priority. Orange County used a wide variety of strategies to outreach to consumers and family members and to facilitate and encourage their participation in the PEI planning process. A special effort was made to outreach to consumers and family members in unserved/underserved ethnic and cultural minority populations.

Focus groups and surveys were two of the methods used to gather community input. Consumers and family members were well-represented among participants in both of these activities. Two of the focus groups held were for members of the MHSA Community Action Advisory Committee (1/15/07 and 6/17/08). This is a 35-member consumer and family member committee that provides input on MHSA-funded services to Orange County Behavioral Health Services. There were also four focus groups held for the general community. To ensure consumer participation, announcements about these focus groups were distributed at the Adult Mental Health Services clinics and were printed in several newspapers and languages.

In addition, focus groups targeting specific linguistic/cultural communities were conducted. These were held in the languages appropriate for those communities, including Spanish, Vietnamese, Farsi, Arabic, Korean, and American Sign Language. Many clients and family members attended these groups.

To ensure that Health Care Agency clients participated in the PEI Community Survey, staff at the Adult Mental Health clinics were asked to review the survey documents with their clients and to encourage them to complete the survey forms. In addition, HCA clients and staff went out to several mental health clinic sites to distribute surveys to clients and provide any needed assistance in filling out the forms. On six different days (June - 18, 19, 20, 23, 24, and 27), surveys were taken to clinic sites, and a total of 398 survey responses from consumers were obtained as a result of this strategy.

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Hard copies of surveys and an electronic link to the on-line survey were also sent to numerous service providers and faith-based organizations. These organizations were asked to provide the information to their clients/members.

In addition, ads were placed in several local newspapers announcing the link to the PEI Survey tool. The ads were used to reach out to the public at large, including consumers and family members outside the county system. Ads were placed in the following community newspapers: La Opinión (5/19/08), Hoy (5/19/08), Excelsior (5/23/08), Nguoi Viet (5/18/08), Viet Bao (5/22 and 5/24/08), Vien Dong (5/17/08) and the Orange County Register (5/23/08). Please see **Attachment 2** for copies of ads used to publicize the opportunity to participate in the community survey.

The National Alliance for Mental Illness (NAMI) provided assistance in outreaching to family members. NAMI sent its members a web email announcing the surveys and provided a link to the electronic survey.

Consumers and family members were also involved in PEI planning through several other mechanisms. These include: participating in the MHSA Steering Committee, the PEI Subcommittee of the Steering Committee, and eight subject area workgroups that were charged with the responsibility for generating and prioritizing specific program ideas for their respective subject areas (based on the community input that had been collected.)

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**

Individuals from each of the above-mentioned stakeholder groups participated in the Community Planning Process. Please see Tables 1 and 2 for a detailed list of the organizations, communities, and types of professional groups that participated. Orange County conducted a thorough, comprehensive planning process that included

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35 presentations and information sharing meetings, 75 focus group meetings, 16 workgroup meetings (eight groups each met twice), and input from both a community and an organizational survey. In addition, a PEI subcommittee guided the planning process, and all recommendations were approved by the County's 60-member MHSA Steering Committee. The Steering Committee also includes representatives from each of the required categories of participants.

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

To ensure that adequate **training** was provided, information on the PEI component of the Mental Health Services Act was presented at the beginning of each focus group. In addition, the PEI Coordinator made several presentations to the MHSA Community Action Advisory Group and the MHSA Steering Committee. Each of these presentations included an educational component regarding Prevention and Early Intervention.

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 County's community planning process for Community Services and Supports (CSS) was open, participatory and inclusive of a wide variety of diverse stakeholders, including groups not often heard from such as homeless individuals and their families. Meaningful consumer/family member participation in the planning process was encouraged and supported through several different mechanisms, including grocery vouchers, transportation, childcare, and meals at meetings. Orange County conducted community outreach to inform the public about the MHSA and the planning process. Special attention was given to reaching unserved/underserved ethnic minorities and marginalized populations by word of mouth with various community leaders and by advertisements in various languages. Planning process participants were provided broad-based training on a variety of topics.

Workgroups were established for each of the DMH-required age groups, and a 60-member Steering Committee composed of consumers, family members, community leaders, service providers and other interested parties provided leadership in the decision-making process. Input was provided by 15 focus groups and 25 stakeholder group meetings. In addition, MHSA outreach staff went to homeless shelters, clubhouses, and street locations to interview individuals and families. From these interviews, staff created a short documentary on the needs of the homeless mentally ill in Orange County. A total of approximately 4,000 attendees participated in Orange

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County MHSA planning activities, demonstrating strong public involvement and support for the planning process. Orange County's CSS planning process received high praise from both the local community and DMH.

The major lessons learned from the CSS planning process included:

- **It is important to be as inclusive as possible.**
- **Before meaningful participation in the process can occur, training is needed.**
- **A variety of strategies should be used to gather input.**

To ensure **inclusiveness** in the PEI planning process, important stakeholder groups were identified and included in at least one of the 75 focus groups held. Groups were held for community partners as well as potential target populations. Four of the focus groups were conducted for the general public. Although most focus groups were held in English, several were held in other languages (Spanish, Vietnamese, American Sign Language, Arabic, Farsi, and Korean). Over 850 individuals participated in the focus groups.

In addition to the focus groups, individuals were given the opportunity to express their views through surveys and participation in subject specific workgroups. Thus, the planning process was inclusive, and individuals were able to participate through one or more of the strategies available.

To ensure that adequate **training** was provided, information on the PEI component of the Mental Health Services Act was presented at the beginning of each focus group. In addition, the PEI Coordinator made several presentations to the MHSA Community Action Advisory Group and the MHSA Steering Committee. Each of these presentations included an educational component regarding Prevention and Early Intervention.

Several strategies were used to collect input. In addition to the 75 focus groups, two surveys were conducted to gather input from the general community and from various provider organizations. The surveys were widely disseminated and a substantial number were completed. Surveys were available both in hard copy and electronic forms. The community surveys were available in English, Spanish, and Vietnamese. HCA clients and staff went to several of the County-operated mental health clinic sites to encourage clients to complete the surveys and, when needed, to assist them in filling out the forms.

Below is more detailed information about survey distribution and the number of responses.

- **Mailed** over 3,000 surveys to OC organizations and community members
- **Handed out** over 5,000 surveys throughout OC at meetings, clinics, community based organizations, etc.
- **E-mailed** announcements regarding the online surveys (including a hyperlink for easy access)
- **390 Organizational Surveys Received**
- **1,564 Community Surveys Received**
- **Language of Community Surveys Received**
 - 84.7% English (n = 1,325)
 - 11.7% Spanish (n = 183)
 - 3.6% Vietnamese (n = 56)

Steering Committee members, consumers/family members, and other interested stakeholders also participated in **workgroups** charged with recommending specific strategies for addressing eight different areas identified by the focus groups and surveys.

Based on the information provided above, it is clear that the PEI planning process successfully incorporated the major lessons learned from the CSS planning process.

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.

Measures of success include:

- Engagement of diverse community partners and affected communities in the stakeholder meetings, focus groups, and workgroups
- Wide geographic distribution of stakeholder and focus group meetings
- The large number of surveys completed by community and organizational respondents
- The assistance that was provided at clinic sites to enable participation of mental health services clients, including TAY

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

a. The date of the public hearing: January 22, 2009

The Public Hearing date was January 22, 2009.

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

The PEI Plan was available for comment during a 30-day period between December 22, 2008 and January 21, 2009. A copy of the Plan was posted on both the County's MHSA website and the Orange County Network of Care site. Also posted were an Executive Summary of the Plan and directions on how to obtain a hard copy. The Executive Summary was translated into Spanish and Vietnamese, and these translations are also available on the website.

Advertisements were placed in local media, including ethnic specific media announcing the availability of the Plan for review and the date of the Public Hearing. Hard copies were available at the MHSA Office and were sent to anyone requesting a copy. Copies of the Plan were also distributed to Orange County libraries, members of the MHSA Steering Committee, the OC Mental Health Board, the Community Action Advisory Council, and provider agencies.

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

Two Public Comments were received during the 30-day period. The first expressed the need for a better support system to assist parents with children who are mentally ill. That comment was referred to the appropriate staff providing Community Services and Supports (CSS). A response was sent explaining that this issue is better addressed through CSS rather than PEI.

The second comment received expressed interest in adding a public awareness campaign regarding suicide prevention. An answer was sent explaining that Orange County would address this issue through participation in the Statewide Suicide Prevention Project.

For a copy of these comments and the response provided, please see **Attachment 4**. There were no substantive changes in the Plan made as a result of these comments.

d. The estimated number of participants: Approximately 71 people attended the Public Hearing. Please see **Attachment 5** for the Public Hearing Minutes. The Mental Health Board unanimously approved the Plan.

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County: Orange

PEI Project Name: Early Intervention

Date: 11/08

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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

The strategies and priority populations recommended to be included in the **Early Intervention Services Project** were selected on the basis of the following stakeholder input and data analysis.

Focus Group Feedback:

Early intervention services were identified as a priority need in 87% of the focus groups conducted. These focus groups included older adults, members of underserved cultural populations, consumers and their family members, health care and mental health providers, substance abuse treatment providers, law enforcement, and the general public.

Participants identified a need for culturally/linguistically competent, community/home-based early intervention resources to address ALL priority populations and age groups as a means to assist those individuals who may be experiencing early signs of emotional, behavioral or mental health conditions. Many community stakeholders and representatives of organizational providers from a variety of service sectors (other than mental health) reported having routine contact with many individuals and families who could benefit from PEI services in addition to the other forms of assistance they were seeking if only on-site PEI resources were available. Suggestions for the types of on-site PEI resources needed included brief individual and family counseling, support groups, substance abuse, and crisis/trauma resources.

Locations suggested by stakeholders where early mental health intervention could occur included:

- Primary care and hospital-based provider locations
- Schools, preschools, day care
- Juvenile justice facilities
- Foster care facilities
- Law enforcement/courts
- Veteran's service locations
- Faith based organizations
- Family Resource Centers
- Senior Centers

Survey Data Review

Quantitative and qualitative data from the 1,564 Community Surveys and 390 Organizational Surveys received during the local planning process provide clear support for early intervention services in Orange County (OC). Early intervention services are the core of many of the PEI strategies survey respondents advocated. For example, 46% of community respondents selected training on early recognition and response to mental illness as a priority strategy for addressing PEI in OC, and 47% selected providing early and periodic screening, diagnosis, and treatment for mental illness.

To help organizational respondents better serve those in need of PEI services, 41% selected a need for (a) PEI information and training, (b) access/linkage to and/or consultation regarding

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existing PEI services in the community, (c) assistance with capacity building for more PEI services, and (d) resources to better address the PEI needs of underserved groups.

Early intervention was the theme of one-third of the combined written suggestions from community and organizational survey respondents. These suggestions mentioned priority populations that respondents think would especially benefit from early intervention services, including people starting to show signs of serious mental illness, older adults, foster/adopted youth and their families, women at risk for post-partum depression, military veterans and families, homeless individuals, and victims of violence or other trauma.

The wide variety of services and resources to be offered through the Early Intervention Services Project and associated programs will help the County address many of the community mental health issues that survey respondents rated as a priority, such as the number of undetected mental health problems, school failure or dropout rates, arrests and incarcerations, removal of children from their homes/families, problems facing military veterans and their families, and unemployment. In addition, as suggested by survey responses and other community input, certain programs within the Early Intervention Services Project will use trained peers to mentor at-risk youth and lead topic-based support group discussions.

3. PEI Project Description:

Early Intervention Services are those 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. The expected result is to avoid the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

To this end, the “Early Intervention Services Project” was selected based upon two outstanding responses that emerged from the local community planning process: (1) Numerous individuals and community organizations in Orange County indicated that early intervention services to isolated, underserved, and unserved populations are greatly needed; and (2) Those needing these services exist across a vast expanse of the socioeconomic, cultural, and demographic landscape covered by those who live in Orange County, and who continue to have limited access to mental health prevention and early intervention services.

Community work groups overwhelmingly endorsed specific programmatic themes and specific populations in need throughout the local planning process. The result was the emergence of a broad range of proposed programs that would have “ready access” as its cornerstone feature. These include socialization programs, community support groups, services for stressed families, mentoring programs, and the early identification of individuals experiencing the onset of a serious psychiatric illness. These five “themes” of services drove the final selection process of the five varied programs and subprograms to be described below.

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The five programs below are included in the Early Intervention Services Project:

- Early Intervention Services for Stressed Families
- First Onset Services and Supports
 - First Onset of Psychiatric Illness Program
 - Mental Health Consultation to Primary Care
 - Post-Partum Depression Program
- Socialization Program for Isolated Adults and Older Adults
- Peer Mentors for Youth Program
- Peer-led Support Groups

As noted in the brief program descriptions that follow, strategies to promote optimal outcomes include evidence-based and promising practices, collaboration with other systems and organizations to leverage resources already existing in the community, service delivery in natural settings, linkage to resources in the community that may address basic needs, and assurance of services for individuals experiencing at-risk mental states or first onset of a serious psychiatric illness.

Below is a brief description of each of the five Early Intervention Services Project programs:

(a.) Early Intervention Services for Stressed Families

This program will serve families from many different backgrounds. The primary focus of the program is to reach and support those families whose stressors may make the children more vulnerable to mental health problems. For all people involved in this program, outcome measures specific to resiliency and the alleviation of family stress will be collected in addition to other measures of individual mental health status and system effectiveness.

A child/youth's behavioral/emotional health is often reflective of, and influenced by, the family's overall functioning, especially as it relates to coping with stressful and unexpected life events. No matter the source of such events, children and families that have had their resiliency compromised can benefit from brief mental health interventions that may minimize the need for more extensive behavioral health services at a later time.

This program is designed to provide culturally/linguistically appropriate *crisis and brief short-term counseling* to address the early intervention needs of four populations in Orange County identified by stakeholders as underserved, unserved, and/or at risk of compromised resiliency.

These four populations are:

- Families of children who have been reported to Child Protective Services without substantiated abuse or neglect findings, as well as those not taken into protective custody.

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- Youth (approx. age 12 to 18) who come into contact with law enforcement agencies and who lack necessary family guidance, supervision, and support to prevent further juvenile justice involvement.
- Children living with family members who have developmental or physical illnesses/disabilities.
- Children living in families that are impacted by divorce, domestic violence, trauma, unemployment, homelessness, etc. Also included are the families of active duty military/returning veterans.

To leverage community resources, this program will provide master level clinical staff to existing culturally/linguistically competent community agencies that indicate they are in a position to provide or expand early intervention services to one of the populations noted above. For example, regarding families of children who have not been taken into protective custody, the Families and Communities Together (FaCT) program could be utilized to provide mental health prevention and early intervention services such as family support and education through the community-based Family Resource Centers (FRC). FaCT is a partnership between the County of Orange Social Services Agency and Orangewood Children's Foundation and supports the FRCs by providing program development and administration, funding, and training.

(b.) First Onset Services and Supports

This program is designed to identify and serve those individuals experiencing their first onset of serious psychiatric illness. Transitional age youth and young adults will be the focus of one sub program; mothers experiencing post partum depression another; and the third sub program (which provides mental health consultation to primary care) will be focused on older adults who may be experiencing the first episode of disorders seen primarily in later life. For all people involved in this program, outcome measures specific to recovery will be collected in addition to other measures of individual mental health status and system effectiveness.

There are three components to this program, which are described in brief below:

First Onset of Psychiatric Illness Program: This program will serve diverse persons age 14-25 experiencing the first onset of psychotic illness, with a Duration of Untreated Psychosis (DUP) of less than one year. Targeted populations are prioritized, but to the extent resources are available, clients may be seen regardless of insurance status. Clients will generally be those seeking services, but efforts will include improved access and engagement, improved public awareness, and primary practitioner training. Services will be provided in naturalistic settings and in-home.

Program development will be significantly informed by the Early Psychosis Prevention and Intervention Program (EPPIC) in Australia, the Early Diagnosis and Preventative Treatment of Psychotic Illness Clinic (EDAPT) at University of California at Davis, and best practice guidelines and model programs from around the United States, including the Family Psycho-education model developed by William McFarlane. Shared decision-making will be emphasized. Family engagement and support will be crucial, and families will be partners in recovery. In addition to medication assessment and monitoring, services will include

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psycho-education, cognitive-behavioral services, groups, multi-family groups, peer mentoring, development of long-term economic and social support, opportunities for physical fitness activity, and services to address substance misuse and wellness recovery action plans.

The goals of the First Onset of Psychiatric Illness Program are:

- Early identification of first onset of psychosis
- Early comprehensive treatment of first onset of psychosis

Mental Health Consultation to Primary Care: This program will provide clinical consultation to primary health care providers to increase their capacity to screen for and identify first onset of depression in older adults, and make referrals in order to improve older adults' access to early mental health interventions. PEI funding will provide a licensed clinical practitioner to conduct outreach and training to approximately 300 Orange County physicians per year.

The Goals of the Mental Health Consultation to Primary Care Program are:

- Early identification of depression in diverse older adults
- Improvement of access to mental health prevention and early intervention services such as early detection and education for adults

Post-Partum Depression Program: This program will address the need for short-term treatment for the 10-13% of women who experience post partum depression. It will provide mental health treatment services for new mothers who are experiencing symptoms of post-partum depression. In October 2007, the Maternal Depression Task Force was formed as an informal partnership devoted to addressing the unmet needs of new mothers experiencing depression in Orange County. One of the community needs identified by this task force was increased mental health treatment services for mothers' newly diagnosed with post-partum depression. This program will partner with Orange County hospitals that currently provide screening for post partum depression, but which lack resources to provide treatment. PEI funding will provide clinical staff to deliver brief culturally/linguistically competent psychotherapeutic services for those mothers who have been identified as suffering from post-partum depression. Clinical staff will also ensure that linkage occurs to other needed services in the community to support the positive functioning of the mother.

The Goals of the Post-Partum Depression Program are:

- Early intervention and treatment of depression in new mothers
- Prevention of serious emotional or behavioral disorders for both mother and child

(c.) Socialization Program for Isolated Adults and Older Adults

This program will serve adults and older adults who may be isolated and/or homebound but are experiencing the onset of serious psychiatric illness, particularly of those appearing later in life. For all people involved in this program, outcome measures specific to recovery will be collected in addition to other measures of individual mental health status and system effectiveness.

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The Socialization Program for Isolated Adults and Older Adults will bring trained, friendly culturally/linguistically competent visitors to the homes of isolated adults and older adults with the task of decreasing the sense of isolation those individuals may feel and increasing opportunities for them to socialize with others. Upon building a one-on-one relationship with an individual, the friendly visitor will facilitate linkage between the individual and a local community-based socialization center or to any other community resource that is needed. Community-based socialization centers in Orange County include senior and community centers as well as local hospitals that offer socialization activities such as supportive and group counseling, local ethnic communities, and faith-based organizations. Once linkage with community resources has been established and supports are in place, visits from the friendly visitor will decrease until a mutually agreeable termination point occurs that is in line with PEI guidelines of being of “short duration.”

This program will initially partner with a number of senior citizen centers across Orange County, which can act as operational bases for the friendly visitors. PEI funds will be used to fund the friendly visitors and as well as a program overseer.

The goals of the Socialization Program for Isolated Adults and Older Adults are to:

- Provide social support to isolated adults and older adults
- Improve personal functioning and decrease symptoms of depression

(d.) Peer Mentors for Youth Program

This program will serve a broad range of youth from different backgrounds. The common factor is that these youth have life experiences that may make them vulnerable to mental health problems. Of particular concern are children and youth at risk of or experiencing juvenile justice involvement. This population will receive priority access and assignment of mentors. For all youth involved in this program, outcome measures specific to involvement in the juvenile justice system will be collected, in addition to other measures of individual mental health status and system effectiveness.

The Peer Mentors for Youth Program matches older youths as mentors to younger youth at-risk for significant emotional problems, school failure, and juvenile justice involvement, as well as youth in stressed families. The mentors provide guidance, advice, and the support that at-risk youth may need in order to meet the challenges of adolescent life. The older youths not only serve as mentors, but as role models to the younger ones. Older youth, having been through the same life stage and (most likely) similar problems, predicaments, and challenges in their homes, schools, and communities, are in the position to provide culturally/linguistically competent and friendly advice, positive influence, attention, and moral support.

The California Association of Peer Programs (CAPP) published a study in 2001 that showed that peer mentoring programs had a positive impact on the mentors, as well as the mentees in the areas of personal development, communication, decision making and problem solving, and conflict resolution/violence prevention. Orange County’s desired outcome of the proposed Peer Mentoring for Youth Program mirrors the outcome of the 2001 study.

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Mentoring has already been welcomed into our local community; however, PEI focus groups and workgroups consistently identified a need for the expansion of peer mentoring services in Orange County, especially to those youth who did not have a mental health diagnosis. Examples of peer mentoring programs currently achieving success in Orange County include the Orangewood Children's Foundation 4Kids Peer Mentoring Program and the Project Together Program operated by the Mental Health Association of Orange County.

The goals of the Peer Mentors for Youth Program are to:

- Provide mentors to youths at risk of emotional problems, school failure, and juvenile justice involvement
- Improve personal functioning across many life domains

(e.) Peer-Led Support Groups

This program will serve a broad range of people of different backgrounds and ages; these clients will have life experiences that may make them vulnerable to mental health problems. Of particular concern are children and youth at risk of or experiencing juvenile justice involvement. In this program, the group leaders will include youth with experience in the juvenile justice system. For all youth involved in this program, outcome measures specific to involvement in the juvenile justice system will be collected in addition to other measures of individual mental health status and system effectiveness.

The Peer-Led Support Groups will be theme- or topic-based discussions of short duration that are facilitated by a person who is coping with or has coped with the same issues and concerns as other members of the group. The groups will provide empathy and understanding that members of the group may not find in other areas of their life. They will also provide the support and connection to a community that is needed to prevent the emotional isolation and stigma that can lead to problems requiring intensive and long-term mental health interventions. The peer leader will work to facilitate the group process, but also link group members to other needed resources in the community when needed, including cultural/linguistic resources. A few examples of populations that could be served in a peer-led support group include youth at risk of or experiencing juvenile justice involvement, victims of crime and/or trauma, those experiencing loss/bereavement, returning veterans, and persons with disabled family members.

The Peer-Led Support Groups Program will collaborate with existing organizations throughout Orange County that are currently running groups or that are interested in providing groups. Groups could be held in diverse settings, such as Family Resource Centers, senior centers, after school programs, faith-based agencies, community-based non-profit mental health centers, homeless and domestic violence shelters, and Boys and Girls Clubs. Community-based organizations will hire, train, and supervise peer group facilitators; ensure that established standards of training and supervision are met for group facilitators; and provide linkage for group members to other needed resources.

The goals of the Peer-Led Support Groups are to:

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- Provide support needed to those facing difficult circumstances but have nowhere to turn for assistance
- Prevent the emotional isolation and stigma that can lead to problems requiring intensive and long-term mental health interventions

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Early Intervention Services for Stressed Families	Individuals: Families:	Individuals: 270 Families: 120	15
First Onset Services and Supports	Individuals: Families:	Individuals: 400 Families:	15
Socialization Program for Isolated Adults and Older Adults	Individuals: Families:	Individuals: 270 Families:	15
Peer Mentors for Youth Program	Individuals: Families:	Individuals: 60 Families:	15
Peer-Led Support Groups	Individuals: Families:	Individuals: 450 Families:	15
	Individuals: Families:	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals:1,450 Families: 120	

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

A vibrant component of Orange County's MHSAs Community Services and Support Plan is its Outreach and Engagement Programs. These programs have exceeded their expectations in the number and variety of individuals being assisted in some way, whether it is linkage to a Full Service Partnership or assistance provided by community-based organizations to meet an identified need. Presently, not only does the County run adult, transitional age youth, and children's outreach and engagement programs, but it also contracts with several community organizations to provide the same type of services. Examples include: Korean Community Services, Orange County Asian and Pacific Islander Community Alliance, and Nhan Hoa Comprehensive Health Care Clinic, which are all well-situated to provide linkage to needed services.

Additionally, these outreach and engagement programs have developed relationships with multiple community providers and can continue to be available to assist those needing help. Examples include: a teen experiencing initial symptoms of psychosis who needs first-break services that are non-stigmatizing; a family that is displaced due to fires and is in need of food and shelter; or an older adult who has lost a spouse and yearns for human contact. The County's outreach and engagement programs are available to provide the community link for any new PEI programs that identify those in need of mental health prevention and early intervention services.

Another PEI project being proposed is the PEI Outreach and Engagement Services Project, which will include two programs: (1) Information and referral services that will facilitate the speedy referral of individuals seeking mental health care or simply in need of information that can assist them, and (2) PEI Outreach and Engagement Services that will target priority populations identified by community organizations that have contact with individuals needing services. The programs included in the Outreach and Engagement Project are expected to work closely with providers of the Early Intervention Services programs.

Training will also be available for new MHSAs PEI service providers that arise in the County. During the initial rollout of the County's MHSAs programs, the County provided monthly three-day "Immersion Trainings." This training consisted of two tracks, Community and Clinical, and individuals from diverse organizations, such as community and social service providers, law enforcement, school districts, teachers, students, and others were invited. The goals of the curriculum were to train participants on the recovery model, the current Orange County treatment system, specific needs of mental health clients, how to better serve those with co-occurring disorders, and how to apply the knowledge trainees were receiving to their particular job requirements. This training will continue to be available to new service providers under PEI funding, increasing the community's awareness and access to specific programs that meet an identified need.

Ongoing adjustments in providing necessary training will also be made in line with the County's MHSAs Workforce, Education, and Training Plan. The County aims to solidify an overall

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integrated mental health plan that seeks to reach out to all priority populations and provide access to early intervention services.

It should also be noted that during the County's local PEI planning process, 75 focus groups were presented with PEI educational information, which raised awareness of existing programs among community members, as well as potential programs to come under PEI funding. In addition, the eight workgroups (some with 40+ members) were developed for the purpose of identifying needed PEI programs. This allowed a high level of interaction among members of diverse community organizations and the public, also increasing the awareness of MHSA and non-MHSA programs in the County. As the County moves toward an Integrated Plan, this kind of networking will continue to increase knowledge among community members of County and Statewide MHSA programs. Additionally, the County's Network of Care website continues to be upgraded in regard to its depth and breadth of mental health information. As public awareness of this website continues to expand among community members, it will become an important link for the public to access local mental health programs.

6. Collaboration and System Enhancements

The County has not determined the exact mechanism for partnering with community-based organizations (e.g., a formal contractual agreement), but as noted in the program description, it will collaborate and leverage funds with the wide array of service providers that already exist throughout the community. Many of the programs identified in this Early Intervention Services Project require specific skills and competencies that can ideally be provided by those organizations already knowledgeable and aware of the resources needed to ensure successful outcomes. Many of these organizations were identified during the focus groups held throughout the County, the Steering and subcommittee meetings, and through the workgroups used to develop the programs.

A number of potential community-based partners were referred to in the program description section above. These include: FRCs, senior and community centers, mentoring programs, homeless and domestic violence shelters, after school programs, faith-based agencies, community-based non-profit mental health centers, Boys and Girls Clubs, hospitals, primary care providers, Social Services Agency, and law enforcement agencies. These are a few examples of the types of organizations the County desires to partner with to share the MSHA vision of expanding the network of care to the mentally ill and others, and reducing the incidence and severity of mental illness. Consequently, whether it is a Request for Proposals, a Solicitation of Interest, or some other means to collaborate with community organizations, the County will work closely with those interested in assisting individuals in need of early intervention services.

7. Intended Outcomes

Early Intervention Services to Stressed Families

Individual level outcomes:

- Improved personal functioning
- Increased strength of overall family functioning for those experiencing stressful situations

Program/system outcomes:

- Reduced number of persons experiencing mental health symptoms

First Onset Services and Supports

First Onset of Psychotic Illness

Individual level outcomes:

- Reduced burden of psychotic illness

Program/system outcomes:

- Reduced prevalence of psychotic disorders

Mental Health Consultation to Primary Care

Individual level outcomes

- Improved personal functioning

Program/system outcomes:

- Increased access to treatment for depression in culturally diverse older adults
- Reduced prevalence of severe depression in older adults

Post-Partum Depression Program

Individual level outcomes

- Reduced stigma through the strength-based approach of home visitation
- Increased strength of overall family functioning for mothers, babies, and siblings

Program/system outcomes

- Reduction in disparities in access to mental health services
- Reduction in number of mothers who experience increased symptoms of depression

Socialization Program for Adults and Older Adults

Individual level outcomes:

- Increased social support among isolated adults and older adults
- Improved personal functioning
- Reduced stigma

Program/system outcomes:

- Reduced number of persons experiencing mental health symptoms

Peer Mentors for Youth

Individual level outcomes:

- Improved personal development, communication, decision making and problem solving, and conflict resolution/violence prevention among mentees
- Reduced stigma

Program/system outcomes:

- Reduced number of persons experiencing mental health symptoms

Peer-Led Support Groups

Individual level outcomes:

- Increased support needed to those facing difficult circumstances
- Improved personal functioning
- Reduced emotional isolation and stigma

Program/system outcomes:

- Reduction in number of persons experiencing mental health symptoms

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

Given the breadth of the early intervention services being proposed, well-designed coordination will rely on a three-prong approach to ensure ready access to appropriate services. First, education about the developing Early Intervention Services Project programs and the existing MHSA and non-MHSA programs in Orange County will need to be made available to as many programs and individuals as possible. The County's MHSA Behavioral Health Training Unit, funded by Workforce Education Training (WET) dollars, will continue its Immersion Training to train community and social service providers, law enforcement, school districts, teachers, students, and others on: the recovery model; the current Orange County treatment system; specific needs of mental health clients; how to better serve those with co-occurring disorders; and how to apply the knowledge trainees receive to their particular job requirements. This training will allow new service providers to gain an understanding of the referral process to the Early Intervention Project programs and other programs existing within the County's system of care.

Secondly, new early intervention services will require educated staff to fill the proposed staffing requirements. OC's WET plan also includes scholarships, stipends, and a "20/20 program." These are designed to address the identified mental health occupational shortages. These programs also offer financial assistance to individuals desiring postsecondary education in behavioral health in exchange for a commitment to provide services in a qualified facility in Orange County. The County program that oversees these WET-funded services will work closely with potential providers in identifying those who might utilize these training dollars to meet the growing need for diverse trained mental health staff.

Even with a well-educated staff and informed community partners, challenges will continue to exist in regard to actually navigating the expanding array of MHSA-funded mental health programs. However, the MHSA website and the OC Network of Care website will make more readily available information on the MHSA programs.

Finally, The County will continue to maintain coordination meetings among CSS providers, such as the monthly Transitional Age Youth (TAY) meetings that include County staff (from different programs within Orange County's Behavioral Health Divisions) and contract agencies. Thus, a forum exists to identify challenges that prevent TAY and others from ready access to needed services.

9. Additional Comments (optional)

None

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County: Orange PEI Project Name: School-Based Services

Date: 11/08

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
B. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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

During the local community program planning process, input was gathered from many individuals and partnering organizations with respect to the needs and service gaps for school children. In fact, school-based prevention and early intervention services were identified by over half of the 75 community focus groups and stakeholder meetings conducted as a priority need. Furthermore, these groups identified other needs, such as PEI training/consultation for staff; School Attendance Review Board (SARB) resources; home-based outreach and engagement; work, employment and independent living assistance for TAY; peer mentoring/support programs; resiliency building resources; universal periodic developmental/social/emotional screening; day care/preschool consultation and PEI resources; after school PEI resources; anti-bullying interventions; enhanced school curriculums with a focus on mental health, character building, social skills; and exercise, nutrition and recreational resources.

However, merely identifying the need for these kinds of services by itself does not guarantee that all school districts will participate or be willing to collaborate to build a county-wide system of care for all students. To address this point, two dedicated stakeholder meetings provided exclusively for key representatives from each of the 28 partnering school districts in Orange County were held in April 2008. These meetings provided a means to bring all the participants together to build consensus and assure full participation in school-based projects and programs.

As a result of these meetings, consensus was reached among the 28 district representatives to support the School-Based PEI Project and associated programs. This consensus virtually assures that every child in Orange County will have access to a common array of prevention and early intervention resources no matter in what city they reside or school district they attend.

For example, key representatives from each of the 28 partnering school districts in Orange County identified a need for opportunities to expand Positive Behavioral Interventions and Supports/Response to Intervention programs; school-based mental health resources, family resource/support services, staff/student/family mental health education, violence prevention and education resources; and expanded information and referral resources.

Survey Data Review

During the local planning process, a total of 1,564 Community Surveys and 390 Organizational Surveys were received. The completed surveys provided quantitative and qualitative data that demonstrate the need for county-wide school-based PEI services. Nearly 50% of community respondents selected schools as one of the three most effective settings for (a) identifying OC residents needing PEI services and (b) providing early and periodic screening, diagnosis, and treatment for mental illness.

Many of the PEI strategies that survey respondents advocated aim to train and educate a broad range of school personnel and students from early education through college. For example, 46% of community respondents selected training for educators and others on early recognition

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and response to mental illness as a priority strategy for addressing PEI. In addition, the majority (58%) of organizational respondents selected working with local community leaders, teachers, pastors, doctors, and advocates as a strategy that would have the most local impact with underserved groups. Providing resource and referral information in multiple languages at school/college, pre-school, child care, and other medical and workplace settings was also selected (by 42% of organizational and 40% of community respondents) as a high-impact strategy for delivering PEI services that respond to the needs of underserved groups.

Nearly one-quarter of the combined written suggestions from community and organizational survey respondents mentioned the need for school-based services (preschool through college), and school settings were specified more than any other potential settings for PEI services. These school-based suggestions also indicated priority populations that respondents think would especially benefit from such PEI services, including all levels of school personnel, young children (age 0-5) and their parents, elementary through college students, foster/adoptive children, children in stressed families, and children with disabilities (cognitive, emotional, and/or physical).

By providing a broad range of services and resources through the School-Based PEI Project and associated programs, The County will be able to address many of the community mental health issues that survey respondents rated as a priority, such as suicide, homelessness, community and domestic violence, school failure or dropout rates, undetected mental health problems, arrests and incarcerations, stigma/discrimination related to mental illness, and unemployment. The School-Based PEI Project has been shaped in response to valuable community input regarding the need for on-site, comprehensive, collaborative PEI programs that educate and serve students of all ages, parents, and school faculty/staff within various school settings.

Review of Additional Data

Additional data and information from the following sources were also reviewed and utilized during the planning process:

- U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
- New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.
- The Orange County 13th Annual Report on the Conditions of Children Call to Action
- The Orange County 14th Annual Report on the Conditions of Children

3. PEI Project Description:

School-based PEI projects/programs provide outreach and education to children, youth, families, and school staff to increase awareness of mental health issues and reduce stigma and discrimination; build resiliency and increase protective factors in children and youth; foster a positive school climate; prevent suicide; expand early mental health intervention services;; provide professional development/training on mental health for those working with children and youth in schools; and support policies and practices that demonstrate that students' social/emotional health and competencies. Such programs are a primary part of the school's mission.

In Orange County, there are over 500,000 school-age children attending 300 public schools (K-12) operated by 28 elementary, high schools and unified school districts. Partnering with local schools presents numerous opportunities for educators, parents, and mental health professionals in Orange County to collaborate in supporting the resiliency and emotional well-being of all students. It also expands opportunities to intervene early in the lives of children experiencing academic, social and/or family problems that put them at risk of future problems involving mental illness and school failure.

During the local community program planning process, input was gathered from many individuals and partnering organizations with respect to the needs and service gaps for school children. In fact, school-based mental health prevention and early intervention services were identified as a priority need by over half of the 75 community focus groups and stakeholder meetings conducted. However, merely identifying the need by itself does not guarantee that all school districts will participate or be willing to collaborate to build a county-wide system of care for all students. To address this point, two dedicated stakeholder meetings provided exclusively for key representatives from each of the 28 partnering school districts in Orange County were held in April 2008. These meetings served as a means to bring all the participants together in order to build consensus and assure full participation in school-based projects and programs.

As a result of these meetings, consensus was reached among the 28 district representatives to support the School-Based PEI Project and associated programs. This consensus virtually assures that every child in Orange County will have access to a common array of prevention and early intervention resources no matter in what city they reside or school district they attend.

The School-Based Services Project includes four types of Programs:

- School-Based Mental Health Prevention and Early Intervention Services
- Positive Behavioral Interventions and Supports (PBIS)
- School-Based Violence Prevention Education
- School Readiness Program Expansion

All four of these School Based Services Projects will serve a broad range of students of different backgrounds and ages with life experiences that may make them vulnerable to mental health problems. Of particular concern are those children and youth at risk of school failure. In these programs, these students will receive priority access to mental health

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prevention and early intervention services. For all students involved in these programs, outcome measures specific to school success will be collected in addition to other measures of individual mental health status and system effectiveness.

Below is a brief description of each of these programs.

(a.) School-Based Mental Health Prevention and Early Intervention Services

The School-Based Mental Health Prevention and Early Intervention Services Project will include a combination of prevention and intervention strategies that will work to, empower families, reduce risk factors, build resiliency, and strengthen culturally appropriate coping skills. Conditions associated with mental illness and poor school performance will be prevented and treated successfully through a number of effective, research-based and school-based practices. School-based collaboratives will be enhanced to provide parent education, individual/group counseling, crisis intervention, case management, community linkages, referrals, educational groups, screening and early intervention, School based-services will also embrace a youth development framework that promotes resiliency through supportive relationships, and engaging and meaningful opportunities that foster a sense of physical and emotional safety. Peer-to-peer helping programs play a major role in reducing the alienation and disconnectedness many youth feel from their schools, families, and society.

School-based services will also play a critical role in increasing the effectiveness of the Student Attendance Review Board, Student Consultation/Support Teams, and Student Assistance Programs. The PEI Survey identified schools as one of the most desirable/comfortable locations to seek help and access services. The trust and sense of safety developed between children, families and school based services fosters an approach that supports and treats all priority populations. Stigma and discrimination related to mental health issues will be reduced as school-based services will be integrated into day to day school-wide operations.

(b.) Positive Behavioral Interventions and Supports (PBIS)

Positive Behavioral Interventions and Supports (PBIS) is a *systems* approach to increasing the success capacity of support staff, parent, and community efforts. This program includes, *practices* that support students and families, and uses *data* to guide decision making. PBIS teaches, models, reinforces, and monitors the development of pro-social behaviors for all students and their families.

PBIS is a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing mental illness, problem behavior and emotional distress. It *increases* school's ability to educate **all** students, especially students with challenging social behaviors by establishing: (a) clearly defined *outcomes* that relate to the reduction of the incidence of mental illness, academic success and social-emotional

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resiliency, and (b) *systems* competency of schools, families, and communities, allowing for the early identification and intervention for those students and families most at-risk. *Preventing* the development, future occurrences, and worsening of emotional and behavioral problems is given top priority in all interventions. Interventions and practices will be *research-based* and a full continuum of effective, efficient, and relevant interventions will be utilized to support all students and their families. PBIS provides support along a continuum of need and intensity based on a *three-tiered system: universal, targeted and individual*.

PBIS provides the framework to unify and integrate education, public health, child and family welfare, juvenile justice, and mental health in its efforts to create a comprehensive system of care through:

- *Primary prevention of mental illness* (universal), is provided to the entire school and focuses on teaching every student, faculty, and staff member behavioral expectations for every school setting, and the positive and negative consequences for appropriate and inappropriate behaviors. Research shows that about 80 % of behavior problems can be avoided with well-implemented primary prevention.
- *Secondary prevention* of mental illness (targeted), introduces more intensive instructional strategies and supports to a smaller number of students (about 15–20 percent) who are at risk and do not respond to the primary prevention strategies alone. Secondary strategies may include the use of study halls and academic tutoring for students who are struggling academically and small group instruction for those with behavioral challenges (e.g., anger management, social problem solving, and social skills instruction).
- *Tertiary prevention* of mental illness (individual), is reserved for the 3–5% of students who have serious and persistent behavioral and academic challenges. These interventions are highly individualized to meet the students' needs and usually require the use of interagency collaboration (e.g., child welfare, mental health, juvenile justice)

(c.) School-Based Violence Prevention Education

Effective School-Based Violence Prevention Education is research-based and scientifically grounded. These effective practices are based on positive youth development and resiliency practice. They enrich student's socio-emotional development and link students to mentors while building upon meaningful relationships with adults.

Exemplary Violence Prevention Education will be integrated into the curriculum to mitigate a student's risk of development of mental illness and school failure. The expansion of effective programs is critical to the development of pro-social skills as well as the emotional and social development of children. Expanding prevention education sites to alternative school settings, after school programs, and the broader community, will ensure a comprehensive approach to prevention of mental health problems.

Examples of School-Based Violence Prevention Education programs include: gang prevention education, safe and healthy lifestyles, media literacy, conflict resolution,

character building education., Reducing children's exposure to violence reduces their risk of exposure to trauma and subsequent mental illness.

(d.) School Readiness Program Expansion

Services to families with children under the age of six are proposed using several different delivery models that have been proven effective based on the successful implementation of programs in Orange County. These programs use the National Education Goals Panel definition of School Readiness. This type of School Readiness Program (SR) comprehensively addresses the diverse needs of young children and includes the delivery of quality early care and education, health and social services, as well as family and community support. In addition, these programs improve schools' readiness for children through family-friendly environments in school-based or school-linked settings. Through a structured system that is already in place for families with children under the age of six, enhancements to improve, coordinate, and sustain mental health programs and interventions can be provided in the following ways:

- **Provide on-site comprehensive developmental/behavioral screening:** Community developmental screening and mental health prevention and early intervention services such as referral, linkage and parental education for young children will be provided by specialized experts at various Orange County sites. The goal is to identify children with symptoms of developmental, behavioral, cognitive or speech delays, and/or lack of healthcare coverage and refer them for further evaluation, intervention, and linkage to care. Follow-up will be provided to ensure linkage and access to needed services. Culturally/linguistically appropriate in-home visitation will be provided to families of children at risk for severe emotional challenges (this includes homeless families, pregnant teens, and foster children) in order to orient families to the mental health system and encourage them to access needed services.
- **Expand the School-Based Nurse Program:** The school-based school nurse initiative provides for general health and development screenings and referrals to services for young children so that conditions are identified and early intervention provided before children start school. This program will be expanded to enhance the behavioral health capabilities of School Readiness Nurses and early care and education providers. Such expansion will enhance their ability to address behavioral health concerns through consultations and linkage to behavioral health services.
- **Ensure that mental health professional services are available and expand existing services using non-traditional settings, such as family child care homes and private child care programs:** Programming will assist in identifying, treating, and managing preschool children exhibiting high-risk behavior. The primary emphasis will be parent engagement, early intervention, and prevention utilizing an innovative approach (service before diagnosis). Programs will offer outreach and education on improving parenting skills, removing barriers to service, and increasing provider behavioral management skills in preschool, daycare, and related settings.

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- **Integrate mental health professional services into current pediatric and obstetrical clinical support:** Currently, pediatric clinical advice and telephone triage support is available to assist school readiness nurses in coordinating care with primary care physicians, providing case reviews, and offering pediatric clinical education for school readiness nurses and pediatricians throughout the County. Integrating mental health professional services into primary care services with school readiness nurses and private pediatric and obstetric practices is recommended. Mental Health Professional positions are needed to provide consultation services to district staff and early care and education providers to ensure responsive referrals, continuity of care, and access to indicated services.
- **Expand support for early care and education and integrate mental health professionals into current pediatric clinical advice and telephone triage:** Professional support services will be provided to several groups of people, including parents, early childhood providers, administrators, teachers, directors and community partners serving the early care and education population. A culturally competent training module is included to help professionals identify signs and symptoms of mental illness across the life span; strategies to manage behavior; and skills to develop a resource plan informed by a continuum of care.
- **Expand home-visitation model/services:** Consultation services will be provided to existing county home visitation staff through access to Mental Health/Social Service experts who can provide education and technical assistance related to mental health. This will enhance the multi-disciplinary team approach in serving at-risk families, particularly homeless/motel families, teen parents, and children in foster care. Consultants may participate in case reviews to ensure responsive referrals, continuity of care and access to indicated services. Mental health-related education, Technical Assistance (TA), and brief early intervention services will be provided.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
School-Based Mental Health Prevention and Early Intervention Services	Individuals: Families:	Individuals: 5,880 Families: 3,750	15
Positive Behavioral Interventions and Supports (PBIS)	Individuals: 610,257* Families:	Individuals:18,873 Families: 4,718	15
School-Based Violence Prevention Education	Individuals:503,304* Families:	Individuals: Families:	15
School Readiness Program Expansion	Individuals: 10,995 Families:	Individuals: 1,500 Families: 1,000	15
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals:610,257 Families:	Individuals:26,253 Families: 718	

*Countywide prevention programs implemented at all Orange County schools and benefiting all students.

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

The programs contained in the School-Based Services Project were selected as a result of an inclusive planning process that not only encouraged participation from the general community, but also involved numerous stakeholders from the education community. For example, two dedicated stakeholder meetings were conducted exclusively for key representatives from each of the 28 partnering school districts in Orange County. These served as a means to bring all the participants together in order to build consensus and assure full participation in school-based projects and programs. As a result of these meetings, consensus was reached among the 28 district representatives to support the School-Based PEI Project and associated programs. This consensus virtually assures that every student in Orange County will have access to a common array of prevention and early intervention resources no matter in what city they reside or school district they attend.

The consensus among school district representatives will also help ensure continuity across service providers in terms of how services are provided and resources are accessed and managed. Linkages to County Behavioral Health and providers of other needed community services will be an essential element of these programs. Specific policies and procedures will be required that clearly outline the process that all school district providers will follow to access assessment and treatment services from any regionally located County Behavioral Health program. These policies and procedures will be routinely monitored to ensure that they are working as intended, and that any identified service gaps and/or barriers are addressed in a timely manner.

Providers of school-based services will be required to assess identified individual students and families for other service needs, and to establish procedures for accessing community-based resources available to assist with such things as health care, child care, housing, employment, etc.

6. Collaboration and System Enhancements

This project will consist of several program components that will require extensive collaboration among multiple public and community-based provider agencies and organizations that play an integral role in the health, safety, and welfare of children and TAY in Orange County. These agencies and organizations include:

- 13 Elementary School Districts
- 3 High School Districts
- 12 Unified School Districts
- Orange County Health Care Agency, Department of Behavioral Health Services
- 21 Law Enforcement Agencies
- Public and private early care and education providers
- County home visitation staff

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- Orange County Head Start
- American Academy of Pediatrics
- CalOptima (OC Medi-Cal managed care administrator)
- Children and Families Commission of Orange County
- Coalition of Orange County Community Clinics
- Homeless Families / Shelter Projects serving children
- Orange County School Nurses Association
- Orangewood Children's Foundation
- Orange County District Attorney
- Orange County Probation Department
- Orange County Social Services Agency
- Community College and University degree granting and training programs
- Special Education Local Planning Area / Special Education
- National Alliance for the Mentally Ill - Orange County
- Parent Teacher Association / Parent Teacher Organization

The Orange County Health Care Agency, Behavioral Health Services, currently enjoys productive working relationships with each of these organizations and can use these existing relationships as a basis upon which to build and expand the programs contained in this project. Interagency agreements will need to be expanded or created and new contractual agreements will need to be developed through multiple Requests for Proposals and through Master Agreements, where appropriate. Local providers will be encouraged to leverage resources available to them as a means to expand and sustain project resources in combination with ongoing PEI funding and other potential grant funding (when available). This could include the Student Mental Health Initiative and other Statewide Projects.

7. Intended Outcomes

School-Based Mental Health Prevention and Early Intervention Services

Individual (At-risk students):

- Improved mental health status
- Improved school performance
- Improved resilience and protective factors
- Increased knowledge/awareness of mental health issues and community resources

System/Program (School Districts):

- Increased number of school districts reporting on-site mental health resources
- Increased ability to identify and assist/refer students in need of early intervention services

Positive Behavioral Interventions and Supports (PBIS)

Individual (Students / At-risk students):

- Improved resilience and protective factors
- Improved school performance
- Improved social behaviors

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- Improved mental health status

System/Program (School Districts):

- Increased number reporting on-site PBIS resources
- Increased ability to identify and assist/refer students in need of early intervention services
- Increased student attendance and retention rates

School-Based Violence Prevention Education

Individual (Students):

- Improved resilience and protective factors
- Increased appropriate help-seeking

System/Program (School Districts):

- .
- Increased ability to respond to critical incidents and acts of violence.

School Readiness Program Expansion

Individual (Students / At-risk students):

- Improved resilience and protective factors
- Improved school readiness and performance
- Improved mental health status

System/Program:

- Increased number of professional support services provided to parents, early childhood providers, administrators, teachers, directors, and non-traditional community partners serving the early care and education population
- Increased ability of providers of early care and education to identify and assist/refer students in need of early intervention services and school readiness resources.

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized

8. Coordination with Other MHSA Components

On a routine basis, training and technical assistance (TA) will be provided by County MHSA staff to partnering district providers of these school-based services. The training/TA will provide information about other existing MHSA components and programs that may be of assistance to the students and families being served, including both CSS and PEI component programs.

The coordinators and staffs of these programs will also be invited to meet quarterly with Orange County Behavioral Health and other MHSA contract provider staff to share program information updates and provide networking opportunities. This routine meeting has been utilized successfully during Orange County's CSS program implementation, especially with regard to building collaborative relationships among providers of children's, TAY, and adult services.

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School district providers will also be required to establish specific policies and procedures that clearly outline the process that they will follow to access other MHSA programs and services that may be of assistance with addressing the needs of at-risk students or their families. Examples of such programs include the Full Service/Wraparound, Crisis Residential, and Mentoring programs for children and TAY. These policies and procedures will be routinely monitored to ensure that they are working as intended, and that any identified service gaps and/or barriers are addressed in a timely manner.

9. Additional Comments (optional)

None

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County: Orange PEI Project Name: Outreach and Engagement Services Date: 11/08

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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

Focus Group Feedback

During the local community planning process, Orange County stakeholders identified a need for culturally competent, community and home-based outreach and engagement resources to address all PEI priority populations and age groups. Outreach and engagement efforts were identified as a primary means to assist those individuals who may be experiencing early signs of emotional, behavioral or mental health conditions to access early care and needed resources. In fact, outreach and engagement as a primary strategy to assist at-risk individuals and families was identified as a priority in 72 of the 75 focus groups that were facilitated during the local planning process. These groups included older adults, members of underserved cultural populations, consumers and their family members, health care providers, substance abuse treatment providers, and law enforcement.

Stakeholders also recommended that the settings in which outreach efforts are focused include the following:

- Primary care and hospital-based provider locations
- Schools, preschools, and day care
- Juvenile justice facilities
- Foster care facilities
- Veteran's service locations
- Faith-based organizations
- Family Resource Centers
- Senior Centers
- Law enforcement agencies/courts

Survey Data Review

A total of 1,564 Community Surveys and 390 Organizational Surveys were received during the local planning process. The quantitative and qualitative data clearly suggest a need for outreach and engagement PEI services in Orange County (OC). The proposed outreach and engagement services would assist community organizations in reaching a wide spectrum of priority populations who require assistance in accessing PEI services.

When asked what strategies would have the most impact at the local level, especially in efforts to reach underserved groups, organizational respondents showed strong support for (a) offering services where cultural, ethnic, and other underserved groups normally meet (61%) (b) working with local community leaders, pastors, doctors, teachers, and advocates (58%) and (c) providing resource and referral information in multiple languages at various medical, workplace, and school settings (42%). A similar percentage of community respondents (40%) also saw the importance of providing resource and referral information at a wide range of community settings.

When asked to select the most effective settings for identifying OC residents needing PEI services, community respondents selected schools (49%), doctor offices/clinics (44%), social services (37%), hospitals and skilled nursing facilities (34%), community based organizations (31%), and law enforcement agencies and courts (26%). In addition, the majority (61%) of the "other" priority settings specified by community respondents were neighborhood settings including streets, parks, shelters, and places where homeless individuals congregate.

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When the written suggestions from community and organizational survey respondents were combined, one-quarter were found to be related to outreach and engagement services. Respondents identified priority populations that would especially benefit from such PEI services. Suggested priority populations included children/youth, older adults, people who have attempted or might attempt suicide, individuals with a dual diagnosis, homeless populations, military veterans and families, victims of violence or other trauma, women at risk for post-partum depression, and individuals/families experiencing early signs of mental illness first onset.

Through the proposed Outreach and Engagement PEI Project and associated programs, wide-reaching services and resources will enable the County to reduce many of the community mental health problems prioritized by survey respondents, including suicide, prolonged suffering/trauma, homelessness, community/domestic violence, and problems facing military veterans and their families. The services the County has planned for outreach and engagement, including information and referral services, will be an important step toward improving access to PEI services requested by the community.

3. PEI Project Description:

Outreach and Engagement Services are those that proactively identify members of the PEI priority populations who are at risk of emotional, behavioral or mental health conditions and provide easy and immediate access, information, and referral assistance to culturally competent early intervention services as needed.

The Outreach and Engagement Services Project consists of two programs:

- Information and Referral Services
- Outreach and Engagement Services

Each Program is briefly described below.

(a.) Information and Referral Services

This program will serve a wide range of residents from different backgrounds and different ages who are seeking mental health-related information or who have had life experiences that may make them vulnerable to mental health problems. Within this population, linguistically and cultural isolated populations are of particular concern because of their low rates of use of mental health services. The staffing pattern and protocols used in the program will be designed to improve access to services for these groups. For all people involved in this program, outcome measures identifying their cultural and linguistic characteristics will be collected in addition to other measures of system effectiveness.

Information and Referral Services (IRS) will provide specialized assistance to telephone callers who may be at risk of emotional, behavioral, or mental health conditions by providing easy and immediate access, information, and referral assistance to culturally competent, linguistically appropriate prevention and early intervention services as needed. In the initial phase of the development of the program, local referral and assistance networks, including but not limited to 211, will be contacted to establish referral protocols. Program staff will

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contact all of the other PEI programs, BHS and other treatment facilities and related programs in the social services, health, legal and education systems to identify contact personnel, intake criteria, services offered, etc. These contacts will also publicize the IRS and other new PEI programs. The Information and Referral Services, with PEI administration, will be responsible for maintaining an up to date directory of these services. In doing this, the program will be building on and organizing the extensive amount of information already developed by CSS components and other behavioral health services but currently not available in a single database. They will also coordinate this information with the Network of Care. The database will be available to all PEI and BHS treatment programs.

Services in this program will include strengths/needs assessment, education, case management, and linkage. Callers to the Information and Referral Services who are looking for assistance/information regarding mental health/co-occurring disorders will speak with trained Mental Health Staff Specialists who will assist the callers in identifying their service needs and available resources. The mental health staff at the IRS will be both culturally and linguistically diverse to ensure that all callers will have access to needed services. The Mental Health Staff Specialist will maintain extended contact with callers and provide ongoing support services over time until callers have been successfully engaged in needed services. Callers may contact and request assistance from the same staff specialist for linkage to other needed PEI or behavioral health services. Because of the initial program work on identifying and organizing information about resources, the Mental Health Staff Specialist working in this capacity will be well-informed of all services for prevention and early intervention available in diverse communities as well as support/educational groups for families and individuals

With the PEI Crisis and Referral programs, the CSS Crisis Assessment Team and the CSS Outreach and Engagement units, the Outreach Services will constitute the frontline services for many people seeking assistance. Joint training, planning and resource development will be part of the initial plan for the new services. On an ongoing basis, the IRS staff will be supervised by clinical staff and provided ongoing training on cultural and linguistic competence, mental health disorders, and prevention and early intervention.

Because this first contact is so critical in establishing a positive view about mental health services, cultural competence will be a first priority with this program. Every effort will be made to include not only staff who speak threshold languages but also speakers of emerging languages, such as Korean and Farsi. For other languages, access to other program staff and/or translation services will be arranged. This unit will also have specialized training in differing cultural perceptions of mental illness and on effective interventions to reduce the barriers to services. Stigma reduction will be a significant goal of the education both to the individual and the community during the helping process.

(b.) Outreach and Engagement Services

This program is designed for those people who have had life experiences that may make them vulnerable to mental health problems, but who are hard to reach in traditional ways because of cultural or linguistic barriers. For all people involved in this program, outcome

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measures identifying their cultural and linguistic characteristics will be collected, in addition to other measures of system effectiveness.

Current CSS Outreach and Engagement programs and other similar programs have already identified underserved groups within Orange County. These include: the Middle Eastern population, elderly men, military personnel, recent immigrants of all ethnicities, people on probation, and others who are unlikely to initiate contact on their own with a mental health service, even a prevention service. The PEI Outreach and Engagement Services (OES) program will focus on these hard to reach groups. Identification with potential target groups or individuals will be accomplished through already established relationships with community organizations, (e.g., non-profits, schools, community agencies, health care providers, first responders, judicial system, correctional system, etc.) that have developed trust with the community and have contact with the individuals, families or groups who require assistance in accessing prevention and/or early intervention services.

Staff will ask respected members of the community organization to introduce them to those needing information and assistance and will maintain the contact with that individual or family until no further assistance is needed. Unlike the CSS Outreach program, which focuses on individuals already clearly in need of behavioral health treatment and need to be linked to services, the PEI Outreach program will often be in contact with people at the early stages of problems for whom referral to another PEI program or a self-help group may be sufficient. To ensure that appropriate support and referrals can be made when needed, OES staff will receive extensive initial training and ongoing clinical supervision to assist them to recognize the signs of serious mental illness. Staff will also receive training on resources available and will work closely with the Information and Referral Services, as well as other “first contact” programs.

Stigma reduction will be a significant goal of the education both to the individual and the community during the outreach process. As with the IRS program, staff will be representative of the target populations with regard to language and will include those who are bilingual in Spanish, Vietnamese, Korean, Farsi, and American Sign Language. This unit will also have specialized training in differing cultural perceptions of mental illness and on effective interventions to reduce the barriers to services. Additionally, training on the special perceptions and beliefs about mental illness and barriers to treatment within groups such as elderly men, deaf and hard of hearing, military personnel etc. will be provided. Staff will be selected on the basis of life experiences, as well as their language capacities.

As part of the PEI Outreach Program, Orange County also proposes to establish a website targeting Transitional Age Youth based on a model being used in Australia called: “Reach Out!”

This website would provide a mechanism for teens to:

- Communicate with other teens,
- Obtain information on many topics related to mental health,
- Access community forums,

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- [Access a warm line/hotline,](#)
- [Keep a record of their thoughts,](#)
- [Find resources for help with mental illness, substance abuse, eating disorders, managing independence, etc.](#)

The website would be user-friendly and linked to other websites that might provide additional help and support. Currently, a similar idea is being piloted by the Orange County TAY FSP for their members and appears to be having a positive response.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Information and Referral Services	Individuals: Families:	Individuals: 7,500 Families: 2,500	15
Outreach and Engagement	Individuals: Families:	Individuals: 900 Families: 300	15
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: 8,400 Families: 2,800	

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

The Outreach and Engagement Service providers will incorporate and maintain an updated and shared data base both within the Health Care Agency and in the community in order to link individuals and families to the most appropriate services as possible.

Outreach and Engagement Service providers will utilize a comprehensive case management approach which will incorporate a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's mental health needs through access to appropriate and available resources.

A media campaign informing the community and service providers of the services offered by this project will also be conducted. What type of media campaign? Communication with primary care, private or public mental health, and other service providers will be a critical function of this project in order to establish collaborative relationships and facilitate referrals and client access to needed PEI services. How will this communication take place?

6. Collaboration and System Enhancements

Outreach and Engagement Service will enhance the present system by increasing access to services by the PEI priority populations and improving collaboration among providers as referrals sources and service providers. This will be accomplished by providing a thorough assessment of needs, symptoms, and behaviors, and ensuring clients' linkage to services by directly making all initial calls for appointments and providing follow-up contact with the agency accepting referral and the client being referred.

The participants in the community focus groups were vocal in expressing their frustration at not knowing how or where to call for help with children and adults in need of PEI services. Many community agencies are already working with or come in contact with members of the PEI priority populations and will be able to improve the level of assistance provided to these individuals by utilizing the resources associated with this project. The Outreach and Engagement Services project will enhance the existing community provider network by filling this need and reducing the number of individuals who experience early signs and symptoms but have difficulty accessing needed mental health supports and services.

7. Intended Outcomes

The following outcomes apply to all programs within the Outreach and Engagement Project:

Individual Outcomes

- Increased appropriate help-seeking
- Increased successful follow-through on linkages/referrals
- Increased satisfaction with outreach, linkage, and referral services

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Systems/Programs

- Increased number of organizations with capacity to ensure effective linkage to services
- Increased number and quality of linkage relationships to MH and other critical service organizations (e.g., substance abuse, domestic violence, veteran's. older adult programs, etc.)
- Earlier access to MH treatment and services, as appropriate
- Decreased duration of untreated mental illness

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

Individuals and families identified by outreach and engagement or who contact the information and referral service, and who meet criteria, and can be appropriately served by the Full Service Partnerships or other MHSA/CSS or PEI programs will be referred and assisted through the linkage process. Those who do not meet criteria or need for the Full Service Partnership Programs, which would be those experiencing symptoms but have not yet suffered impairments in functioning as a result, and/or children experiencing behavioral, psychological impairments but do not meet criteria for a Metal Health (DSM-IV-TR) diagnosis may also be referred to MHSA programs as well as contracted programs which can provide culture and linguistic specific services.

All community-based service providers, both private and public will be explored in assisting the caller or outreach participant in linking with the most appropriate services. Ongoing communication with other MHSA components will be of crucial importance as a means to enhance the network of existing and new service providers that are available to provide prevention and early mental health intervention to at-risk populations.

9. Additional Comments (optional)

None

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County: Orange PEI Project Name: Parent Education and Support Services Date: 11/08

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

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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The strategies and populations recommended for the **Parent Education and Supports Program** were selected on the basis of the following stakeholder input and data analysis.

Focus Group Feedback:

Parent education and support services were identified as a priority need in 60% of the focus groups that were conducted. These focus groups included members of underserved cultural populations, consumers and their family members, health care and mental health providers, substance abuse treatment providers, law enforcement, and the general public.

In general, participants identified a need for culturally competent, community/home-based parenting resources to address the priority populations inclusive of at-risk youth as a means to assist parents of children who may be experiencing early signs of emotional, behavioral or mental health conditions.

Focus group participants identified parents as a vital resource for children who needed to be strengthened and supported. Specific prevention and early intervention resources include accessible and culturally competent parenting education and information, support groups and skill building opportunities, and parent mentoring and peer/parent support groups.

Parents living in particularly stressful situations impacted by stressors such as homelessness, substance abuse, and domestic violence were identified as a priority, in addition to the following:

- Single parents
- Teen parents
- Parents with mental health and/or substance use problems
- Foster parents
- Parents of disabled children
- Immigrant parents

Survey Results

Quantitative and qualitative data from the 1,564 Community Surveys and 390 Organizational Surveys received during our local planning process confirm a strong interest in PEI parent education and support services in Orange County (OC). For example, 38% of community respondents selected education and support services for parents, grandparents, and caregivers at community centers, churches, and other community settings as a priority strategy for addressing PEI in OC.

Providing resource and referral information in multiple languages at various workplace, school and medical settings also was selected (by 42% of organizational and 40% of community respondents) as a high-impact strategy for delivering PEI services that respond to the needs of underserved groups in OC. In addition, the majority of organizational respondents thought that the most impact at the local level would come from (a) offering services where cultural, ethnic, and other underserved groups normally meet (61%) and (b) working with local community leaders, pastors, doctors, teachers, and advocates (58%).

Nearly one-quarter of the combined written suggestions from community and organizational survey respondents referred to parent education and support services and mentioned priority

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populations that they think would especially benefit from such PEI services. Suggested priority populations included parents and caregivers of young children (age 0-5), parents of children with disabilities (cognitive, emotional, and/or physical), foster/adoptive parents, single parents, individuals and families with a history of substance abuse or dual diagnosis, homeless families, military veterans and families, and victims of domestic/school violence or other trauma.

Providing an array of services and resources through the Parent Education and Support PEI Project and associated programs is just one way that OC aims to address many of the community mental health issues that survey respondents prioritized, including community/domestic violence and problems facing military veterans and their families. In addition, these programs aim to reduce the number of (a) school failures or dropouts, (b) undetected mental health problems, (c) arrests and incarcerations, and (d) children removed from their homes/families. The programs proposed in the Parent Education and Support PEI Project will implement evidence-based training programs and approaches to reach diverse parents and families with the PEI education, guidance, and resources they need to assist at-risk children and adolescents in their respective communities.

3. PEI Project Description:

Parent Education and Support Projects/Programs specifically target mothers and fathers, as well as grandparents and others who have responsibility for caring for at-risk children and youth. These projects/programs foster effective parenting skills and family communication, healthy identities and extended family values, child growth and development, and self-esteem. Parenting support, education, and skills training for parents or other adults who suffer from a mental illness and who are raising children would also be considered. Services may also include assisting parents in reducing the incidence of child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances.

All five Parent Education and Support Project Programs are designed to serve families from many different backgrounds. The primary focus of each of these programs is to reach and support those families whose stressors may make the children more vulnerable to mental health problems. For all people involved in these programs, outcome measures specific to resiliency and the alleviation of family stress will be collected in addition to other measures of individual mental health status and system effectiveness.

The Parent Education and Support project consists of five programs. Below is a brief description of each program.

(a.) Triple P-Continuum of Care Services:

The Positive Parenting Program (Triple P) is a system of care approach to early intervention for conduct and other behavioral disorders for children and their families. Triple P is a best practice parent education curriculum and parenting model that offers varying interventions. Developed by Matt Sanders at the University of Queensland in Australia, it promotes a multi-level strategy recognizing that parents have diverse needs,

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from primary prevention to intervention. The goal of a triple P program is to increase early childhood social competence and decrease disruptive behavior disorders. Triple P is both a model itself, as well as a philosophical way to approach to looking at promoting well being in early childhood.

Primary Prevention - Triple P Level 1: This level will include a social marketing campaign which will promote optimal child/parent relationships and the positive management of childhood behavior. This level aims to increase community awareness of parenting resources, to encourage parents to participate in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns.

Early Intervention Strategy – Levels 2 and 3: These levels will provide a short term intervention for families experiencing difficulties with childhood behavior management. **Level 2** is a brief, one or two-session primary health care intervention providing anticipatory developmental guidance to parents of children with minimal behavior difficulties, with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies. **Level 3** is a four-session primary care intervention that targets children with mild to moderate behavior difficulties and includes active skills training for parents. These services are provided by trained primary care providers as a part of their regular operations, with mental health staff serving as trainers and consultants as needed.

Early Intervention Strategy Levels 4 and 5: For families with children who have mild behavior problems identified by primary care providers, **Level 4** is an intensive eight to ten-sessions individual, group or self-help parenting program. For parents of children with more severe behavior difficulties, **Level 5** is an enhanced behavioral family intervention program. This level is used for families where parenting difficulties are complicated by other sources of family distress (e.g. relationship conflict, parental depression or high levels of stress). These services are provided by mental health staff but in primary care settings.

This program will be new to Orange County. The Triple P program will be implemented along with the statewide coordinating efforts of the California Institute of Mental Health in order to maximize the use of funding for training, proprietary materials, social marketing efforts, etc. The social marketing efforts will be initiated in the third year of the PEI programs. It is anticipated that Medi-Cal revenue will be generated for some of the Level 4 and 5 early intervention services delivered, per the information given at the recent California Institute of Mental Health (CIMH) conference on Triple P.

(b.) Parent Empowerment Program.

The Parent Empowerment Program (PEP) is a structured coaching and training program designed to help parents, including those with the most difficult and challenging children, quickly regain and maintain control. Within a week of starting the program, most parents learn how to stop arguments, minimize lying, and reestablish their power and authority. With PEP training, parents become empowered to discipline and supervise their children

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at the level each child needs, with special emphasis on rebuilding parental authority, building school success, ending drug and alcohol involvement, and reclaiming their children from gangs. Services for parents are delivered in a weekly group format and follow a structured curriculum, as well as providing in-group problem solving. Services will be delivered in the primary language of the parents.

PEP also trains educators, Probation Department staff, and others to meet the behavioral and academic needs of minors referred by the Juvenile Justice system. In addition, the program keeps the court and probation officers informed on the weekly progress of the parents and children participating in the program. Although open to parents of younger children, this program is targeted on parents of youth 11-18 who are actually or potentially involved in the Juvenile Justice system and other youth displaying similar characteristics.

A pilot program using Parent Empowerment principles and methods has been operating in Orange County for four years. It has demonstrated an excellent track record of acceptance by parents and professionals and demonstrated effectiveness in improving school attendance for both English and Spanish-speaking youth. This program is somewhat unique in that Parent Empowerment is a widely used approach in educational circles but not well known in the juvenile justice arena. However, both local experience and controlled studies demonstrate the usefulness of the program. The program will extend the current services available in the County.

(c.) Training Programs for Parents (COPE model):

The Community Parent Education (COPE) program will increase the number of strong families in Orange County by providing parenting education aimed at improving child rearing skills and healthy choices for families. The service delivery model places a primary emphasis on parent education, early intervention and prevention, and outcomes monitoring. This program will address the needs of the family unit, especially high-risk families with children ages 0-12 under extreme stressors such as risk of academic failure, mental health concerns, and/or socioeconomic concerns. COPE can also provide behavior intervention training to educators and childcare providers working with preschool age children.

The COPE model is delivered in large groups of parents (15-25 families) in a 10-week parenting strategy class in the primary language of the parents. As an early intervention service, the program is a first line treatment to elicit healthy change in problematic behavior patterns. Lessons are administered through discussion-based sessions facilitated by a trained group leader. Discussions are generated through pre-filmed video clips that are designed to focus on specific behavior change principles. A new principle is introduced, discussed and practiced each week. Strategies covered throughout the ten weeks include: Praise and Positive Attention, When/Then Strategy, Effective Use of Transitions etc. Families that realize notable success with the intervention often find that they are able to avoid unnecessary clinical referrals, diagnoses, and medication-based treatments for the child.

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For families that require additional services beyond COPE, the strategies and skills acquired through the class provide a foundation of behavioral techniques that will supplement and support more intensive treatments. The ability to offer a concurrent social skills intervention program for the children is necessary to facilitate attendance and promote gains by exposing children to the concepts being taught in the COPE program.

In addition to direct intervention targeting fundamental social skills, these child groups also provide high-quality child care, which is a necessary component for limiting critical barriers to parent participation. Approximately 80% of families participating in COPE take advantage of the childcare/social skills program. This model is cost-effective and reduces access barriers as the classes are provided in community settings that already exist (schools, Family Resource Centers, etc.). The COPE classes are currently being offered in English and Spanish to the Orange County community; the PEI project would extend these efforts.

(d.) Promotora Model-Community Health Educators:

The Promotora (or Health Promoter in English) Model uses a community health educator approach to educate and provide parenting resources to communities. The Promotora model of community outreach is based on a Latin-American program type that reaches underserved populations through peer education. This means Promotoras are members of the communities with which they liaise.

They take the community health worker model one step further because they speak the same language, come from the same neighborhood, and (commonly) share some life experiences with the community members they serve. In this forum, Promotoras provide parents/caregivers (including other family members such as grandparents) with parenting education and resources to assist at-risk children and adolescents. This model uses trusted community members, who are already entrenched in specific communities (Latino, API, Older Adult, etc).

Promotoras use a variety of methods to make contact with the community. From intimate group gatherings in individuals' homes to large community meetings, they make direct contact with target audiences, conveying crucial information to provide community support. This can be done in small groups at community centers, family resource centers or recreation rooms of apartment complexes, churches/mosques/temples, or individually to families in their homes, motels, or other preferred locations in the language/s of their community, respecting and drawing upon the strengths of the culture of the parent and family.

The Promotora model ensures that the many social and cultural characteristics of unserved, underserved people can be drawn upon to improve the appropriate utilization of preventative services. These social and cultural characteristics can be defined as strong family support through the many interdependent ties of the extended family, as is the case with Latinos and the network of comadres and compadres (co-mothers and co-fathers), which are part of the family unit. The same can be said for Asian Pacific Islanders, who

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draw on an extensive familial and informal family system to assist in the parenting of their children.

The strength of these family ties may help or hinder efforts to improve behaviors because the information shared by the family is believed over that shared by a health care professional. For example, one study reported that Latinos rarely turn to health care professionals for child development-related information, but instead seek out peers or authority figures within their own social networks. Therefore, if misinformation is held by a figure of respect within the family network, it is likely to be passed onto others and reinforces the misinformation. This can result in negative consequences on the current and future health status of the family.

New staff needed for this program will include eight community mental health educators. Services would be delivered primarily in groups of parents both large and small but with the option for individual meetings also. Meetings would vary depending on community need – they could be one time, several times, or be ongoing and open ended where parents could join at any point. Each staff member could conduct at least four meetings a week and would spend additional time in individual consultation. Further implementation details are given below in the section entitled “Parent Services Organization Implementation.”

(e.) Family to Family Support

Family to Family Support offers advocacy, technical assistance, and ongoing support to families by building a network of contacts and mutual support modeled on the successful Regional Center program. Family to Family Support can be offered through existing agencies in Orange County. The goal of this program will be to establish a unified family support system for families and caretakers of those who have mental health problems and other stressed families in the targeted populations noted in the survey results. The goal of the program is to prevent the development of mental health problems in other members of the family.

In the Family to Family Support model, staff members recruit volunteers from diverse families or caretakers of those who are entering the mental health system and match them with new families who have requested contact with other families in a similar situation. The volunteers contact the requesting family, provide support and share the knowledge they have gained through their experience navigating the system. Staff will connect families with extant family support units such as the National Association for the Mentally Ill (NAMI)'s Family to Family ten week group program if interested. Staff will also provide resource materials to requesting families and train new volunteers.

Parent Services Organization Implementation:

To implement the Parent Education and Training component for all of the programs above, a Parent Services Organization (PSO) will be established. All of the programs described above

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(except the Triple P program) will be available to all organizations in Orange County that are regularly in contact with parents of children and transitional age youth in targeted populations.

Such organizations/agencies include: schools, primary health clinics, health care providers, probation offices, family resource centers, social services offices, foster family agencies, etc. Depending on their individual needs and resources the organizations can apply to either:

1. Have their own staff trained in one or more of the methods used by the PSO,
2. Have a trained staff from the PSO visit their site on a regular basis to provide the program(s) selected by the requesting agency, or
3. Can apply for funding from the PSO to hire and train staff members to deliver these services (preferred method).

The PSO will have the responsibility for implementing all of the activities described below. The PSO will supply trained staff, technical assistance, outcome evaluation, administration, and coordination of all of these services. Support provided to both the PSO field staff and those staff hired in local organizations through a PSO subcontract will be considered as in-kind resources for the Parent Education and Training Project.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Positive Parenting Program (Triple P)	Individuals: Families:	Individuals: 800 Families: 600	15
Parent Empowerment Program	Individuals:750 Families: 625	Individuals: Families:	15
Parent Training Program	Individuals: 1,000 Families: 500	Individuals: Families:	15
Promotora Program	Individuals: 500 Families: 375	Individuals: Families:	15
Family to Family Program	Individuals: 500 Families: 250	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 2,750 Families: 1,750	Individuals: 800 Families: 600	

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

Both the Triple P Program and the PSO will be required to establish formal linkage and referral mechanisms to treatment and assessment resources to serve participants that need more extensive treatment. These referral mechanisms will include access to private and public health and mental health providers. Programs will be required to also establish formal linkage mechanisms with those organizations that can provide assistance to families, including but not limited to, other PEI and MHSA components, other Health Care Agency programs (including Drug Alcohol Services), the Children and Family Services Division of Social Services, Probation and Juvenile Court, Family Court (Domestic Violence section), One Stop Job Training Centers, Family Resource Centers, Regional Center, and Children and Family Commission programs. Linkages have already been established between these organizations and the Health Care agency, which will provide a basis for the parenting organizations efforts.

6. Collaboration and System Enhancements

The development of the Parent Education and Training Project (PET) includes involvement from the juvenile justice system, Children and Family Commission (Prop 10), Social Services Agency, Dept. of Education, County Drug and Alcohol Services, Regional Center, private non-profit parenting, mental health and health organizations, and others. The programs described above resulted from a collaborative planning process of representatives from the many organizations who will provide both participants and resources for participants in the PET programs.

We believe that the model of implementation selected for the programs – i.e. the Parent Services Organization with multiple ways for community organization involvement - will enhance and encourage linkage, collaboration, and mutual discovery of additional resources for parents. Rather than isolated programs providing similar services to different populations, the PSO can serve as central point for not only these PEI funded programs but also other extant parent education and support programs. Over time, the PSO can spearhead a Parenting and Caretaker Services Network. This collaboration will be built on existing local collaboratives, including the Children's local Services Coordinating Council, a subcommittee of the Board of Supervisors, the Early Childhood System of Care, and the Truancy Response Project.

7. Intended Outcomes

Individual Outcomes:

For all of the five listed programs, the following outcomes will be examined:

- Increased knowledge of social, emotional, and behavioral issues for children and teens as measured by standardized questionnaires appropriate to the age group served
- Increased knowledge of risk and resilience/protective factors as measured by standardized questionnaires appropriate to the age group served
- Increased successful follow-through on linkage/referrals
- Satisfaction with linkage/referral process

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Program and System Outcomes

The programmatic and system outcomes to be measured will be:

- Enhanced capacity of organizations to provide prevention programs and early intervention services
- Increased number of prevention programs and activities
- Increased number of individuals and families who receive prevention and early intervention services

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

Coordination with Community Services and Support (CSS) Programs:

The parenting programs will have established referral protocols with the Children and Youth Services (CYS) Division of the Orange County Health Care Agency (OCHCA) Behavioral Health Services (BHS), including the MHSA CSS programs. Examples of such programs include the four Full Service Partnerships (FSPs), the two crisis residential programs, and the crisis in-home stabilization program. The referrals will be “two-way” – parenting programs may refer families to an FSP; however, the FSP or other CYS programs may also refer parents to an activity provided by the Parent Education Project. In the case of the Family to Family program, the program is designed to work in conjunction with extant CYS programs. This two-way coordination will take place also with the other divisions of OCHCA BHS (Adult Mental Health Services and Alcohol and Drug Abuse Services). In addition, BHS staff will be surveyed to identify organizations serving parents and families that might benefit from involvement with the parenting programs.

Coordination with the Workforce Education and Training (WET) programs:

The WET plan includes stipends for staff training, a consumer training program, and funding for supervision that will be available to the PEI projects and staff.

9. Additional Comments (optional)

None

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County: Orange PEI Project Name Prevention Services Date: 11/08

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
D. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

2B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The strategies and priority populations recommended to be included in the **Prevention Services Project** were selected on the basis of the following stakeholder input and data analysis.

Focus Group Feedback:

Prevention services were identified as a need by ALL focus groups as a means to reduce risk factors or stressors, build protective factors and skills, and increase resiliency and problem solving skills across all age groups and priority populations.

Groups frequently identified a need for culturally competent, community/home-based prevention resources to address the following risk factors:

- Domestic/dating violence
- Bullying
- Teen pregnancy
- Substance abuse
- School failure
- Homelessness
- Suicide
- Delinquent behavior

Survey Results

Quantitative and qualitative data from the 1,564 Community Surveys and 390 Organizational Surveys received during our local planning process confirm the need for prevention services in Orange County (OC). Prevention services are an important precursor and counterpart to many of the PEI strategies supported by survey respondents. For example, 46% of community respondents indicated that training educators, law enforcement, emergency responders, doctors, nurses, and nursing home staff on early recognition and response to mental illness as a priority strategy for addressing PEI in OC. Also, 38% selected as a priority: education and support services for parents, grandparents, and caregivers at community centers, churches, and other community settings.

To help organizational respondents better serve those in need of PEI services, 41% selected a need for (a) PEI information and training, (b) access/linkage to and/or consultation regarding existing PEI services in the community, (c) assistance with capacity building for more PEI services, and (d) resources to better address the PEI needs of underserved groups.

In order to better reach underserved groups, organizational respondents showed strong support for high-impact, local-level strategies such as (a) offering services where cultural, ethnic, and other underserved groups normally meet (61%), (b) working with local community leaders, pastors, doctors, teachers, and advocates (58%), and (c) providing work-based programs through employee assistance programs (28%).

Approximately 42% of the combined written suggestions from community and organizational survey respondents were related to prevention services and mentioned priority populations that respondents think would especially benefit from such services. Suggested priority populations included transitional age youth, families of youth involved in the juvenile justice system,

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homeless populations, those with a family history of mental illness and/or substance abuse, and victims of violence or other trauma.

The Prevention Services Project and associated programs will enable OC to provide universal, selective, and indicated prevention services and resources to reduce many of the community mental health problems that survey respondents prioritized. These include prolonged suffering/trauma, homelessness, community/domestic violence, school failure or dropout rates, and the number of children removed from their homes/families. The Prevention Services Project will provide valuable technical assistance and linkage to resources that can help professionals on the frontlines (e.g., educators, health care providers, emergency responders) to expand their behavioral health expertise and promote resiliency in various at-risk populations.

3. PEI Project Description:

Prevention is a process designed to reduce the likelihood that an event or condition may occur. Research shows that prevention strategies share a common approach for many conditions. Simply stated, effective prevention focuses on those factors that can be changed.

Prevention interventions may be classified according to their target groups:

Universal: target the general public or a whole population group that has not been identified on the basis of individual risk. (Examples: education for school-aged children and youth on mental illnesses; gatekeeper training on warning signs for suicide and how to intervene)

Selective: target members of a subgroup whose risk of developing mental illness is significantly higher than average. (Examples: mental health consultation to support groups for older adults who have lost a spouse; screening women for post partum depression and targeting children of parents with depression for intervention; mental health consultation to facilitators of group sessions for youth engaged in substance use/abuse and children of substance-abusing parents; and mental health consultation to child care centers and family child care homes)

Indicated: target individuals who are displaying early danger signs of mental health problems such as substance use, failing grades, delinquency, school dropout, involvement in the criminal justice system and violence. (Examples: Programs designed to build resiliency and protective factors and reduce risk factors in stressed families; programs to address behavioral problems such as substance abuse and delinquency)

The Prevention Project consists of five programs.

- PEI Mental Health Consultants
- Children of Substance Abusers or Mentally Ill Parents
- PEI Services for Parents and Siblings of Youth in the Juvenile Justice System
- Youth Development and Resiliency
- Transition Services

A brief description of each program is provided below.

(a.) PEI Mental Health Consultant

This program will serve a variety of people from different backgrounds and ages with life experiences that may make them vulnerable to mental health problems. Of particular concern are those who are experiencing the onset of serious mental illness. The trainings, workshops, and other activities will assist the audience in identifying the early signs of mental illness and steps to take to secure treatment. For all people involved in this program, outcome measures specific to the identification of serious mental illness will be collected in addition to other measures of individual mental health status and system effectiveness.

PEI Mental Health Consultants (MHC) will provide staff trainings and in-services; facilitate support groups and wellness workshops, provide technical assistance and staff consults, and encourage programming that supports culturally/linguistically competent mental health promotion. MHC's will also develop and distribute materials to further this goal. This intervention will target staff at community agencies throughout Orange County. Providing greater knowledge and support to key service providers will decrease the incidence and impact of mental health problems and increase early identification of potential problems in individuals. It will also decrease the stigma that mental health issues create in a community and result in more appropriate and successful linkages to services.

The demand for services from Orange County-based MHCs will result in some of the highest need communities being the first to benefit from this service. Community-based organizations serve all ages of underserved racial, ethnic, linguistic, and cultural populations. This is particularly true of populations who may be reluctant to approach traditional mental health providers due to fear of stigma and discrimination.

(b.) Children of Substance Abusers or Mentally Ill Parents

This program will serve a wide range of families from different backgrounds that have in common a parental history of serious substance abuse or mental disorder. Children in these families have a high rate of exposure to trauma. In this program, children with exposure to trauma will receive priority access and interventions specific to their concerns. For all people involved in this program, outcome measures specific to the amelioration of the impact of traumatic experiences will be collected in addition to other measures of individual mental health status and system effectiveness.

Programs that treat individuals for mental health or substance abuse disorders rarely provide services to their at-risk family members. Children in families where a family member is being treated for these disorders are themselves at risk. These children often experience trauma, neglect, stigma, failure in school, and other more severe problems. These stressors can trigger the onset of mental health problems.

Research shows that short-term cognitive behavioral interventions provided through individual and group sessions and constructed to build protective factors, increase resiliency in this population. Utilizing trained staff, this approach can effectively prevent the progression or onset of mental health problems or co-occurring disorders.

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Clients in treatment will be encouraged to enroll their children in a short-term program that utilizes the Brief Strategic Family Therapy (BSFT) model. This nationally tested intervention demonstrates that the numbers of children who go on to experience severe behavioral problems are reduced. BSFT is a short-term intervention used to address problem behaviors that accompany school failure, depression, and family stress. The core components of this intervention will focus on validating the child's experience, addressing a sense of guilt and shame, strengthening communication skills, and helping to develop their own support system. The program is tailored to meet the diverse needs of each participant. Therefore, enrollment is open-ended so that participants can enter the program at any point and still receive the benefit of stand-alone modules. Services will be provided on site where the parents are already enrolled for treatment. This assures that access will be maximized and a family systems approach can be utilized.

(c.) PEI Services for Parents and Siblings of Youth in the Juvenile Justice System

This program will serve a broad range of people from different backgrounds whose family member's actual or potential involvement in the juvenile justice system may make them vulnerable to mental health problems. Assistance to these family members is expected to impact their well being as well as that of the justice involved youth. For all youth involved in this program, outcome measures specific to involvement in the juvenile justice system of all family members will be collected in addition to other measures of individual mental health status and system effectiveness.

A variety of services for minors are available in the Juvenile Justice System. However, there are few, if any services, for their parents and their siblings. Parents of these children are often in need of basic parenting skills development. In addition, siblings of youth who are already in the juvenile justice system are at a higher risk of delinquency and becoming involved in criminal behavior. This program will focus on reducing risk factors for children and youth and increasing protective factors through culturally and linguistically appropriate parent training and family strengthening programs.

The intervention will be a multi-level, family-centered intervention that will target the siblings of juveniles in the justice system and their parents. Studies indicate that supportive parent-child relationships, positive discipline methods, and active parental involvement may reduce the risk for depression, isolation and behavioral problems such as substance abuse and delinquency. All of these may be indicators of or signal the onset of mental health problems.

This program will enhance protective factors such as parental supervision, attachment to parents, and consistency of discipline. It will also address risk factors such as family conflict and isolation. A culturally competent social learning approach to behavior change will build resiliency and strengthen positive social behaviors by helping the participants focus on setting realistic goals, improving anger management skills, and improving academic performance while seeking to reduce risk factors for substance use, gang involvement and peer pressure. Services will be provided at a community-based organization. Prospective participants will be recruited through the juvenile court system directly. Consumers will also

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be reached indirectly, through outreach via probation, facilities that are housing juveniles in the justice system, and referrals from partner agencies such as Alcohol Drug Abuse Services and Social Services.

A short-term 10-week prevention program will include an initial interview to assess the risk of mental illness. The individuals displaying behaviors indicative of mental health issues will be linked to appropriate services. Individuals who are simply at risk will be provided individual and group sessions, academic, and youth development activities and adult mentoring.

Topics for parents will concentrate on effective family management skills, positive reinforcement, disciplinary techniques, prevention and recognition of warning signs for substance abuse behavior and mental illness, family conflict resolution, and active listening. Topics for siblings will include anger management, peer pressure, academic performance, gang involvement, and substance use. Utilizing culturally/linguistically appropriate mentors for both parents and youth will also be incorporated into the program.

(d.) Youth Development and Resiliency

This program will serve youth from different backgrounds with life experiences that may make them vulnerable to mental health problems. Of particular concern are those at risk of or experiencing juvenile justice involvement. These youth will have priority access to this program. For all youth involved in this program, outcome measures specific to involvement in the juvenile justice system will be collected in addition to other measures of individual mental health status and system effectiveness.

The Youth Development and Resiliency (YD&R) program will promote healthy development of youth by providing support and meaningful opportunities to help them meet their developmental needs. The program will adopt the philosophy that builds on inherent talents, skills, strengths, and expertise. The program will also provide the opportunity to act on passions, use skills, and generate change through relevant and sustained action while creating an individual sense of worth.

The Orange County Department of Education has two key Youth Development programs – the Orange County Friday Night Live Partnership (FNL) and Peer Assistance Leadership (PAL®) – both use a positive youth development framework to develop skills and competencies. These programs will be enhanced by integrating the approach adopted by Community IMPACT USA (CIUSA) and core principles for engaging young people in community change. YD&R activities will help build the capacity of existing organizations in ways that ensure that participants engage in bringing about meaningful change and experience personal success. This will empower them to effect change in the community and their own lives.

Research shows that key experiences necessary for healthy youth development include supportive relationships with adults and peers; challenging and engaging learning experiences; meaningful opportunities for involvement and membership; and physical and emotional safety. These ideas are currently being implemented by PAL® and FNL in

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Orange County. The training and outreach provided through this program enhancement will provide additional opportunities for children to succeed, thrive, and rebound in the face of adversity.

Evidence-based programs indicate that when short-term actions are embedded in the long-term agenda of an organization, there is effective youth engagement. This enhancement will include strategies to engage disenfranchised youth who are experiencing behavioral problems and are facing failure in school. These program activities are steeped in youth development principles, which serve to increase school connectedness, build social skills and increase resiliency. Absence of these factors is related to high rates of disruptive behavior, substance and tobacco use, emotional distress, failure in school, and family dysfunction.

Qualified staff will provide training and guidance to the youth leaders of PAL and FNL and the staff at schools who facilitate club operations. Staff will provide capacity building training and support to youth and adults at the clubs and other school organizations. The goal is to develop meaningful and relevant projects to enhance personal skills, leadership skills, and team skills. Personal skills (such as promoting self-efficacy), leadership skills (such as public speaking, writing, problem identification, goal setting and project planning) and team skills (such as communication, facilitation, and the ability to work with diverse peers and partner with adults in various settings) will be emphasized in training.

(e.) Transition Services

This program will serve a broad range of youth from different backgrounds and with life experiences that may make them vulnerable to mental health problems. Of particular concern are those at risk of or experiencing juvenile justice involvement. This program is based on a model shown to be effective in preventing juvenile delinquency. Youth with actual or potential involvement in the juvenile justice system will have priority access to this program. For all youth involved in this program, outcome measures specific to involvement in the juvenile justice system will be collected in addition to other measures of individual mental health and system effectiveness.

The Transition Program (TP) includes a wide array of services designed to assist students experiencing some type of transition in their lives. Individuals experiencing transition, especially youth, are by definition experiencing multiple stressors related to change. Transition includes, but is not limited to, going from high school to college, juvenile detention to traditional or alternative school, foster care to independent living, school to employment or back to school. The program will be a partnership between primary and secondary schools, community-based organizations (CBO's), mentoring programs, and the private business sector.

The program will also direct services to youth who display commitment and motivation but are challenged by low grades, absence of family support and/or a history of behavioral problems. Services will primarily be offered to individuals who are economically and culturally disadvantaged and would otherwise be unlikely to pursue college or better career options. Many of these individuals have experienced trauma; are living in stressed families;

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are at risk of school failure or juvenile justice system involvement; or are experiencing some form of behavioral problems. Many of these individuals, because of their histories and the difficulties that transitional experiences bring, are at risk for mental problems.

The program design adopts key components of Career Beginnings, an evidence-based program of the Office of Juvenile Justice Delinquency Prevention. The intervention is designed to provide assistance as these students navigate through the college-admissions process or the process of finding full-time employment. Services offered will include tutoring, help with college financial aid applications and enrollment forms, application for scholarships, job information, and career fairs.

A second component of the program will include mentoring to help participants explore college and career options through educational workshops, career specific training, college campus tours, and high-quality summer work experiences. This effort will be coordinated through existing agencies offering mentoring services in Orange County. The intervention will be short-term but participants can reacquire services based on their situational needs. The Program will be located at a neutral, community-based organization that has access to the target populations through outreach and existing collaborative relationships.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Mental Health Consultants	Individuals: 5,250 Families: N/A	Individuals: N/A Families: N/A	15
Children of Substance Users and Mentally Ill Parents	Individuals: 450 Families: 150	Individuals: N/A Families: N/A	15
PEI Services for parents and siblings of youth in the Juvenile Justice System	Individuals: 225 Families: 75	Individuals: N/A Families: N/A	15
Youth Development and Resiliency	Individuals*: 225 Families: N/A	Individuals: N/A Families: N/A	15
Transition services	Individuals: 450 Families: N/A	Individuals: N/A Families: N/A	15
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 6,600 Families: 225	Individuals: N/A Families: N/A	15

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

These prevention programs are designed to identify risk factors and promptly link participants who may need treatment for mental health services or other related problems to services. Such services may include: county-funded mental health services, alcohol drug treatment services or primary health care, housing, vocational, and life-skills support through direct referrals to these agencies. As an element of this process, follow-up will be made to ensure that clients successfully make the connection to services and are receiving treatment or further assessment. All proposed programs under the prevention services section of the PEI plan are designed to meet the demand for services by individuals in some of the highest need communities. Most of the populations targeted by these programs are populated by an overrepresentation of youth and underserved racial, ethnic, and cultural populations.

6. Collaboration and System Enhancements

All five strategies will include partnerships with Youth Guidance Centers (YGC) and Probation Camps, the juvenile court system, mental health and alcohol drug abuse services, social service agencies, Probation, and community-based organizations offering prevention and treatment services in mental health and alcohol drug use. Orange County Department of Education, District Continuation Schools, individual Orange County School Districts, community colleges, and Community Health Clinics are also identified as key partners. These formal and informal relationships will serve to strengthen and expand prevention services to provide a seamless linkage to treatment and care. Each program will require ongoing training and staff development to sustain programs viability, account for changing program dynamics, and maximize the outcomes.

7. Intended Outcomes

Intended Outcomes at the Individual Level Applicable for all Prevention Priorities:

- Increased high school attendance
- Improved coping skills
- Increased early identification of potential mental health problems

Intended Outcomes at the Individual Level for Mental Health Consultant Priority

- Increased cultural competency and knowledge base of school staff and primary care providers regarding mental illness

Intended Outcomes at Program/System Level Applicable for all Prevention Priorities

- Increased number of school organizations engaged in prevention activities
- Increased number of youth receiving prevention programs

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- Increased access to wellness, resiliency and mental health services for unserved, underserved and stigmatized populations

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

Workforce, Education and Training (WET): Coordination efforts with the WET component will be very proactive. WET may be able to provide valuable resources and technical assistance to support all above mentioned prevention efforts. Specifically, help with training curriculum, other materials, and equipment will be solicited from WET staff.

Community Services and Support: As noted above, all prevention efforts also lend themselves to identify at-risk participants. Prevention services are designed to link these individuals to county-funded mental health services, county-funded alcohol and drug treatment services, and/or primary health care providers through direct referrals to these agencies. In addition follow-up will be provided to ensure that they receive treatment or further assessment.

Capital Facilities and Information Technology: This component will support prevention efforts through enhanced capabilities such as infrastructure for outcomes data collection, on-line resources for improved linkages, and access to the existing network of services.

Prevention and Early Intervention (PEI): Prevention Project efforts will collaborate with all other PEI Projects including elements of Early Intervention Services, Parent Education and Support Services, School-Based Services, Outreach and Engagement, Screening and Assessment and Training Services.

9. Additional Comments (optional)

None

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County: **Orange** PEI Project Name: **Screening and Assessment Services** Date: **11/08**

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
E. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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

The strategies and priority populations recommended to be included in the **Screening and Assessment Project** were selected on the basis of the following stakeholder input and analysis.

Focus Group Feedback:

Screening and assessment services were identified as a priority need by over half of the 75 focus groups that were conducted. These focus groups included older adults, members of underserved cultural populations, consumers and their family members, health care and mental health providers, substance abuse treatment providers, law enforcement, and the general public.

These groups frequently identified a need for culturally competent screening and assessment resources to address ALL priority populations and age groups as a means to identify early those individuals who may be experiencing early signs of emotional, behavioral or mental health conditions. In particular, the following populations were identified by the community focus group participants as benefiting the most from access to early identification efforts:

- Children
- Transitional age youth
- Veterans
- Adults
- Older adults

Locations suggested by stakeholders where screening and assessment services could be incorporated included:

- Primary care and hospital-based provider locations
- Schools, preschools, day care
- Juvenile justice facilities
- Foster care facilities
- Veteran's service locations
- Faith based organizations
- Family Resource Centers
- Senior Centers
- Law enforcement/courts

Survey Data Results

During the Orange County planning process, staff received 1,564 Community Surveys and 390 Organizational Surveys. The quantitative and qualitative data from these survey responses show a high level of interest in having more screening and assessment services available in Orange County (OC). For example, 47% of community respondents selected providing early and periodic screening, diagnosis, and treatment for mental illness as a priority strategy for OC, and 46% selected training on early recognition and response to mental illness.

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When asked what could strengthen the County's efforts to deliver PEI services (e.g., screening and assessment) that respond to the needs of underserved groups, organizational respondents showed strong support for (a) offering services where cultural, ethnic, and other underserved groups normally meet (61%); (b) working with local community leaders, pastors, doctors, teachers, and advocates (58%); and (c) providing work-based programs through employee assistance programs (28%). When asked to select the most effective settings for identifying OC residents needing PEI services (e.g., through screening and assessment), community respondents selected schools (49%), doctor offices/clinics (44%), social services (37%), hospitals and skilled nursing facilities (34%), community based organizations (31%), and law enforcement and courts (26%). "Other" priority settings specified by community respondents (e.g., potential screening and assessment sites) included places where people are comfortable and go to on a regular basis, such as civic centers and community events.

Approximately 10% of the combined written suggestions from community and organizational survey respondents mentioned the need for screening and assessment services, and 32% were related to the need for early identification of mental health problems. These suggestions included priority populations that respondents think would especially benefit from such PEI services. These priority populations include transitional age youth and adults involved with the justice system or drug court, children and youth at risk of school failure or dropout, older adults, homeless populations, foster/adoptive families, pregnant women and new mothers, military veterans and families, and victims of violence or other trauma.

The Screening and Assessment Services PEI Project and associated programs propose several user-friendly and mobile assessment services and resources which will help OC health care providers with early identification of the community mental health issues prioritized by survey respondents. These include problems facing military veterans and their families, undetected mental health problems, and factors affecting rates of school failures or dropouts, arrests and incarcerations, and the number of children removed from their homes/families. Therefore, screening and assessment services are an integral part of many of the PEI strategies survey respondents advocated.

3. PEI Project Description:

Screening and assessment provides the means by which one can identify the existence of a mental illness, the stage at which that illness developed, and the links to provide the appropriate level of care. Evidence indicates that a critical point exists in the natural course of mental disorders, after which treatment is less effective. The first step in establishing successful early intervention is to ensure that the potential seriousness of unrecognized and poorly treated mental illness is identified and understood.

Recognizing the stage at which a potential mental illness has developed helps to determine the appropriate level of care. Early screening and assessment promotes the study of novel interventions, consumer choice, and sequential specialization of care. A wide array of effective mental health services and treatments is available to allow children, adults, and older adults to

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be vital contributors to their communities. Yet, many people remain unserved, in part because of the stigma of seeking help.

Screening and assessment is a flexible and collaborative decision-making process in which teams of individuals, families and professionals reach consensus about the nature and extent of the problem being expressed. It helps to assure that every individual or family who expresses a concern is receiving the appropriate help to address that concern and meet their needs.

The Screening and Assessment Project includes three types of Programs:

- Providing Assessment Tools and Training
- Integration of Professional Assessors into Established Programs
- Mobile Assessment Team

Each of these programs will serve members of the community from different backgrounds and different ages with life experiences that may make them vulnerable to mental health problems. Of particular concern in the population are trauma-exposed individuals, who will be receiving priority access and instruments specific to their concerns. For all people involved in these programs, outcome measures specific to the amelioration of the impact of traumatic experiences will be collected in addition to other measures of individual mental health status and system effectiveness.

Below is a description of each of these programs.

(a) Providing Assessment Tools and Training to Established Community-Based Organizations, Programs, and Services

The Tools and Training program will provide testing instruments and training for established community-based organizations, programs and services so that staff members can provide their own screening and assessment to their clients/consumers. The objective of this program is to provide simple tools that a lay person might be able to administer to determine whether an individual's behavior might warrant a referral for mental health services or for further assessment. The type of tool that will be utilized might be a standardized instrument, simple paper and pencil instrument, or structured interview protocol. The types of settings in which these assessments might be used are such places as rape crisis services, veterans' services, immigrant support centers, pediatric services, older adult service centers, family resource centers, and others.

Examples of the types of tools and training that will be available to care providers and family members would be: How to conduct simple structured interviews, Mental Health Screening Tool (MHST 0-5), Family Psychosocial Screening, Edinburgh Postnatal Depression Scale, Staying Healthy Assessment Tool, Parent Practices Interview. These

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are a few among the many assessment tools available to the lay person and also to a professional trained to interpret testing results.

(b) Integration of Professional Assessor into Established Programs and Services

Integration of a professional assessor into established programs and services will consist of providing a full or part-time employee to be on-site to provide screening and assessment for program clients/consumers and their family members. This individual will be a psychologist or other mental health care provider trained to administer a variety of testing instruments to help determine whether mental health services are wanted or needed. The number of screeners or assessors employed will be directly related to the nature of the program or service and the number of individuals to be served in each individual program.

The types of settings where an assessor can be employed will include programs for trauma-exposed individuals, the juvenile justice system, Public Defender's Office, community-based organizations, pediatric services, drug and alcohol treatment settings, social services, community centers, refugee centers, faith-based organizations, schools, senior centers, safety net providers, and domestic violence centers.

(c) On-Call Mobile Assessment Team Providing Assessment and Screening Services

The Mobile Assessment and Screening Team will be a centralized assessment service that will be available to community groups, organizations, and outreach services to provide mental health screening and assessment for trauma-exposed individuals and others to determine whether further referral for mental health services is wanted or needed. The Mobile Assessment Team will be on-call to answer questions or to provide screening and assessment services upon request. This can involve a field visit or might simply involve providing information.

The Mobile Assessment Team will also be available to groups and organizations to provide educational and screening opportunities to their consumers. Examples of such topics are: "Mental Health Screening Days," "Depression Screening Days," "How to Get Mental Health Help When You Need It," "Signs to Look for to Seek Mental Health Treatment," "Who Provides Mental Health Help", "Types of Places to Seek Mental Health Treatment," "How to Ask for Help When You Need It," etc.

The types of settings where the assessment team might provide these services include: community agencies, home visitation services, or parent organizations. The team will participate in such activities as health screening days or depression screening days, as well as being on call for assessment advice and education. The mobile assessment team will be distinct from Orange County's Centralized Assessment Team (CAT), in that its main function would be to screen, assess and educate individuals and groups on mental health issues and treatment options. The CAT team assesses individuals in emergency situations. The mobile assessment team might also make referrals to mental health

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services and providers and thus, would develop a database of available treatment resources.

The types of tools employed by the Mobile Assessment Team will be varied and tailored to the particular setting and population. Examples of the types of tools that will be used include: various Post Traumatic Stress Disorder tests, Columbia Health Screen (CHS), Columbia Depression Scale (CDS), Diagnostic Predictive Scales (DPS-8), Achenbach System of Empirically Based Assessment, Ages and Stages Questionnaire: Social Emotional (ASQ: SE), Connors Rating Scale (CRS-R), Devereaux Early Childhood Assessment, Eyberg Child Behavior Inventory (ECBI), Sutter-Eyberg Student Behavior Inventory (SESBI-R), Bridges Screening Tool. These tools typically require administration and interpretation by a trained mental health professional.

Implementation Partners

Implementation partners for this project and for each of the programs within it will include existing community programs and services that will employ professional assessors. Many of these programs serve individuals who are either at risk of developing emotional or behavioral problems or they may serve individuals who have been exposed to trauma. Consultation with these programs will help determine the actual staffing needs based on the type of program and the numbers of individuals served.

Other partners will include professionals who are experts in psychological assessments. Through a series of consultations, the appropriate types of screening and assessment instruments will be selected, which include linguistically validated tools. Further consultations will help determine the type and extent of the training required to administer the screening and assessment instruments.

Currently, there are a number of existing mobile health clinics that provide medical services and screenings to various populations and geographic regions within the County of Orange. Consultation with these organizations will help establish a model for operating a mobile mental health screening and assessment service. Consultations will also include the possibility of integrating mental health screening and assessment with these existing medical services.

The Probation Department works in concert with other county government agencies and community-based organizations in providing an array of services at regional Youth and Family Resource Centers. Consultation with the department will help determine how screening and assessment services can be integrated and expanded into their program.

For each of the programs within the Screening and Assessment project the following actions will be performed: outreach and training for providers and staff of various organizations and groups; provision of assessment tools and education on the nature and scope of the project; and consultations with existing programs on how screening and assessment services can be integrated.

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The individual programs will be staffed with psychologists and other mental health professionals (e.g., social workers and Marriage and Family Therapists) who are skilled in administering various screening and assessment instruments. On-going training and research will be provided for staff to continually evaluate the appropriateness and effectiveness of certain instruments for particular age groups and populations.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Providing Assessment Tools and Training	Individuals: Families:	Individuals: 500 Families:	15
Integration of Professional Assessor into Established Programs	Individuals: Families:	Individuals: 900 Families: 200	15
Mobile Assessment Team	Individuals: Families:	Individuals: 550 Families: 150	15
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: 1,950 Families: 150	

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

The target population of the Screening and Assessment Project is any individual who might present themselves with a potential mental health, emotional or behavioral problem. Screening and assessment is only a first step in a process of providing services that will target and treat potential problems. Linkages with follow-up services will be a necessary component of the project as individuals are determined to need or want further help. Without the linkage component, individuals will be left with nowhere to turn to access needed services.

Key community partners and services providers include county alcohol and drug prevention and treatment providers, Youth and Family Resource Centers, Children and Youth Services, and Adult Mental Health Services. The County Behavioral Health Services will provide on-site consultation and technical assistance on best practices to link families to more extensive services as indicated.

6. Collaboration and System Enhancements

New partnerships will be developed with existing mental health services and community organizations and agencies to provide screening and assessment services in settings which are non-threatening/non stigmatizing to participants (individuals and families). As a result of this project, the importance and value of mental health treatment and the means to access it will be enhanced. Formal agreements, either a Memorandum of Understanding or interagency agreements, will be developed and used as a model for future collaborative efforts.

7. Intended Outcomes

Providing Assessment Tools and Training

Individual:

- Increased understanding of their mental health issues and options (individuals and families)
- Increased appropriate help-seeking (individuals and families)
- Increased ability to make decisions and recommendations regarding their clients' mental and emotional status (service providers)

System/Program:

- Increased referrals for mental health services
- Reduced incidence of long-term care for chronic mental health problems

Integration of Professional Assessor

Individual:

- Reduced time gap between assessment for mental health problems and referral for needed services
- Increased access to mental health resources and options (clients)

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System/Program:

- Enhanced capacity of organizations to identify mental health problems in its early stages
- Increased number of community organizations providing identification and early intervention (short-term MH services)

Mobile Assessment Team

Individual:

- Increased awareness and knowledge of mental health problems
- Increased self-empowerment to address mental and emotional problems
- Improved mental and emotional health status

System/Program:

- Increased knowledge of social, emotional, and behavioral issues
- Increased education to the public on the nature of mental illness and the overcoming of mental obstacles

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

Screening and Assessment Services can be viewed as the beginning point for many individuals and families who might never realize the value and availability of treatment for a mental health condition if it was never identified. There will be many opportunities for the Screening and Assessment project to interface and coordinate with virtually all of the other MHSA projects and programs. Most of the other MHSA projects could be seen as referral resources for those individuals who could benefit from treatment identified through screening and assessment. Furthermore, many of these projects could benefit from the services of the Screening and Assessment programs by providing expertise in differential evaluations and assessments to help determine the most appropriate services for their clients.

Early Intervention Services is a project directed toward individuals and families for whom a short-duration intervention is appropriate to improve a mental health problem or concern very early in its manifestation. The Screening and Assessment Project will work closely with the school based PEI project to increase awareness of mental health issues, reduce stigma and discrimination and expand early intervention services. The Outreach and Engagement Project will be a valuable resource for individuals and families to locate and access needed and wanted services. The Parent Education and Support Project may be an appropriate referral resource for the families of individuals who are experiencing mental health or family problems.

The Prevention Project and the Crisis and Referral Project may call upon the services of the Screening and Assessment programs to more fully evaluate the extent of a mental health problem identified within their programs.

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There will be many opportunities with the Training Project to coordinate training of staff members and lay population in the use of screening and assessment instruments. Many of the goals of the Training Project overlay the goals of Screening and Assessment. As the goal of the Training Project is to better understand, identify, and address the potential mental health needs of PEI priority populations and help these populations access/utilize local community mental health resources, so does the Screening and Assessment programs.

The Screening and Assessment programs will coordinate with the CSS component programs designed to serve populations in crisis such as the Crisis Assessment Team and the Crisis Stabilization programs to avoid duplication of service and facilitate referrals. Referral protocols will be established between all CSS programs and the Screening and Assessment programs. The resources of the Workforce Education and Training component, such as stipends for staff training and funding for supervision, will be available to the Screening and Assessment programs.

Partnerships and agreements that have been formed as a result of the CSS planning process will be called upon to provide consultation and technical assistance on best practices to engage the unserved, underserved, and inappropriately served populations. The County Mental Health Department will provide on-site consultation to help establish program protocols and policies as needed.

9. Additional Comments (optional):

No additional comments.

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County: Orange PEI Project Name: Crisis and Referral Services

Date: 11/08

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
F. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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

The strategies and priority populations recommended for the **Crisis and Referral Services Program** were selected on the basis of the following stakeholder input and data analysis.

Focus Group Feedback:

Orange County stakeholders were in agreement that crisis services needed to be expanded and enhanced across all age groups and PEI priority populations. In fact, services to individuals in crisis were identified as a priority by focus groups facilitated for older adults, members of underserved cultural populations, consumers and their family members, health care and mental health providers, substance abuse treatment providers, law enforcement, and the general public.

Strategies that were recommended included support for the development of a dedicated Orange County Suicide/Crisis Hotline, warm lines, crisis response teams providing community and home-based services, support to individuals and families who experience the loss of a loved one due to suicide, and expanding the existing Orange County Psychiatric Law Enforcement Partnerships in order to identify and serve individuals who are at risk of developing severe mental health problem before a psychiatric crisis occurs.

Survey Data Review:

Based on the 1,564 Community Surveys and 390 Organizational Surveys received during Orange County's local planning process, quantitative and qualitative data clearly demonstrate support for crisis and referral PEI services. For example, 46% of community respondents selected training for law enforcement, emergency responders, doctors, nurses, nursing home staff, and educators on early recognition and response to mental illness as a priority strategy for addressing PEI in this County.

Providing resource and referral information in multiple languages at various medical, workplace, and school settings also was selected (by 42% of organizational and 40% of community respondents) as a high-impact strategy for delivering PEI services that respond to the needs of underserved groups in OC. In addition, the majority (61%) of the "other" priority settings specified by community respondents for identifying OC residents needing PEI services were neighborhoods and community-based settings, including streets, parks, shelters, and places where homeless congregate.

Fifteen percent of the combined written suggestions from community and organizational survey respondents were related to crisis and referral services and mentioned priority populations that respondents think would especially benefit from such PEI services. Suggested priority populations included: children/youth, those who have attempted or might attempt suicide, homeless individuals, older adults, military veterans and families, emergency first responders, victims of domestic/school violence or other trauma, women at risk for post-partum depression, and people starting to show signs of serious mental illness.

To address many of the community mental health issues that survey respondents ranked as a priority for OC, the Crisis and Referral PEI Project and associated programs will deliver a range

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of crisis prevention and early intervention services. A variety of methods will be used, ranging from peer support, to over-the-phone assistance, to response teams that provide intervention and follow-up/referrals for continued care, and expanded partnerships between mental health and law enforcement agencies. In addition to supporting existing crisis response efforts in the County, the proposed crisis and referral PEI services will: help assess the risk of and prevent certain crises; prevent and reduce suicidal behavior and its impact; and provide a network of professional and peer support available round-the-clock.

3. PEI Project Description:

Crisis response projects/programs encompass a wide range of culturally competent, population-specific strategies aimed at reducing suicidal behavior and its impact on family, friends, and communities.

The Crisis and Referral Services Project consists of four programs:

- Crisis Prevention Hotline/Warm Line Network
- Crisis Intervention Network
- Law Enforcement Partnerships
- Survivor Support Services

A brief description of each program is provided below.

(a.) Crisis Prevention Hotline/Warm Line Network

This program will serve a broad range of people of different backgrounds and different ages who are experiencing mental health related crises. Within this population, linguistically and culturally isolated populations are of particular concern because of the additional barriers they face in accessing mental health services. In developing this program, there will be a special focus on having staff who are linguistically diverse and culturally knowledgeable on the hot/warm lines to make them truly accessible to all. The response protocols will also incorporate the issues about help seeking and mental illness specific to cultural groups. For all people involved in this program, outcome measures identifying their cultural and linguistic characteristics and prior familiarity with mental health concepts will be collected in addition to other measures of individual mental health status and system effectiveness.

The Orange County Crisis Prevention Hotline will be an accredited 24-hour, toll-free suicide prevention service available to anyone in crisis or experiencing suicidal thoughts. Immediate, confidential, and linguistically/culturally competent over-the-phone assistance will be provided to anyone seeking crisis and/or suicide prevention services for themselves or someone they know. The deaf and hard of hearing community will also be able to access via a video relay system and/or TTY. Callers who are not experiencing a crisis will be triaged and offered access to a Warm Line or other appropriate resources.

The Orange County Warm Line Network will consist of non-crisis, peer support telephone services for individuals and family members. The network will operate evenings and weekends, providing confidential, culturally competent emotional support to teens, seniors,

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parents, and other populations with special needs. Staffed by trained volunteers and counselors (e.g., people in recovery, family members of mental health consumers, etc.) who are supervised by mental health professionals, this free service will also provide callers with information about local resources and other community-based support services so that they may better cope with emotional, personal, and family issues. Network providers will have access to a shared database of local resources that is routinely updated.

Text and web-based resources will also be considered, especially for teens, transitional age youth, the deaf and hard of hearing and other individuals who prefer this form of communication.

(b.) Crisis Intervention Network

This program will serve a variety of people of different backgrounds and different ages who are experiencing mental health related crises. Within this population, linguistically and culturally isolated populations are of particular concern because of the additional barriers they face in accessing mental health services. The staffing pattern and protocols used will be developed to help reduce these barriers. For all people involved in this program, outcome measures identifying their cultural and linguistic characteristics and prior familiarity with mental health concepts will be collected in addition to other measures of individual mental health status and system effectiveness.

Crisis Intervention Network will be available to respond to critical incidents in the community that may have psychological/traumatic effects on children, adults, and families. These regionally located resources will consist of professionals who can provide immediate crisis intervention services that include suicide, disaster, either natural or man-made, multiple casualty incidents, and victims or witnesses to violence or crime within the County of Orange. Linkages to County Mental Health services will be made at point of first contact. The effectiveness of these resources will be enhanced by quick access to County Behavioral Health Programs. A standardized referral protocol will consist of establishing liaisons with regionally located Behavioral Health Programs to insure access to services as needed.

(c.) Law Enforcement Partnership

This program will serve an array of people from different backgrounds and ages that are experiencing a crisis that comes to the attention of law enforcement officials. Within this group are many who are experiencing the onset of serious psychiatric illness. Specific protocols for this population will be developed. For all people involved in this program, outcome measures specific to recovery will be collected in addition to other measures of individual mental health status and system effectiveness.

The Orange County Psychiatric Emergency Response Team (PERT) is an MHS/CSS funded partnership with the Garden Grove, Orange, and Westminster Police Departments and South Orange County Sheriff's Department. Teams of mental health and law enforcement staff provide mental health evaluations to adults who are suffering an acute mental illness and who may require psychiatric hospitalization. Often times, law

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enforcement responds to situations where individuals are in mental or emotional distress yet do not require acute services or hospitalization. These individuals may be exposed to domestic violence, abuse or other factors that put them at risk. The target population may include children, transitional youth, adults and older adults.

The expansion of the PERT partnerships to include prevention and early intervention options will enhance the ability of County mental health to partner with law enforcement agencies to identify individuals at risk of developing severe mental health problem. Services are to be community-based and of short duration, allowing the teams to intervene and assist at-risk individuals and/or families by providing needed resources, mental health counseling, referrals and follow-up contacts. Since local police departments are often first responders to community and domestic disturbances involving individuals exhibiting early sign of mental illness, this PERT expansion will be an ideal opportunity to identify and address the needs of individuals who can benefit the most from prevention and early intervention services.

(d.) Survivor Support Services

This program will serve a broad range of people from different backgrounds and different ages whose lives have been impacted by mental illness and in particular, suicide. These experiences often reach the level of trauma. For all people involved in this program, outcome measures specific to the amelioration of the impact of traumatic experiences will be collected in addition to other measures of individual mental health and system effectiveness.

A growing body of research demonstrates that a peer support approach to delivering services, using persons with direct experience of mental illness (especially those impacted by suicide), is a powerful tool to prevent suicide and future suicide attempts. Culturally appropriate follow-up care and support would target those who have attempted suicide and the family members/loved ones of those who have committed suicide. The result would be to reduce suicidal behavior and its impact on family, friends, and communities.

Through a peer-led group support model, Survivor Support Services will:

- Provide education and information regarding the personal and social impact of suicide;
- Address survivors' emotions and needs;
- Improve family functioning/communication;
- Identify and understand the factors that promote a survivor's resilience and strength in survivors;
- Provide bereavement services and support; and
- Address issues of stigma and shame.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Crisis Prevention Hotline/Warm Lines	Individuals: Families:	Individuals: 5,000 Families: 750	15
Crisis Intervention Network	Individuals: Families:	Individuals: 1,875 Families: 1575	15
Law Enforcement Partnership	Individuals: Families:	Individuals: 1,125 Families: 975	15
Survivor Support Services	Individuals: 200 Families: 170	Individuals: 200 Families: 170	15
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals:200 Families: 170	Individuals: 8,200 Families: 3,470	

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

The Crisis and Referral (C&R) Project was designed in an inclusive planning process that included county and private providers of health, primary care, and mental health services. The programs in this project provide prevention and early intervention resources throughout Orange County. The following provides a brief description of how the C&R programs link individual participants who are perceived to need assessment or extended treatment for mental illness/emotional disturbance to County Mental Health and other providers.

- Crisis Prevention Hotline/Warm Line Network

The Orange County Crisis Prevention Hotline will provide 24-hour, toll-free suicide prevention service available to anyone in crisis or experiencing suicidal thoughts. Anyone who is assessed to be at imminent risk of danger to self will be linked to the County's 24-hour Centralized Assessment Team. The Team will immediately be dispatched to the location of the caller for a psychiatric crisis evaluation. Callers who are not experiencing an immediate need for intervention and are determined to be in need of further treatment may be linked with a County Behavioral Health Program or another service provider. This will be provided through a formal referral process that includes a contact sheet with pertinent information being faxed to the closest behavioral health clinic or services provider. Bilingual staff that speaks Spanish, Vietnamese, Korean and Farsi will be recruited. Deaf and hard of hearing persons will be able to access this resource utilizing a video relay system and/or TTY.

The Warm Line Network will consist of non-crisis, peer support telephone services for individuals and family members. Network providers will have access to up-to-date local resource list of services designed to provide emotional support for callers. Specific text and web-based resources will be provided in addition to community agencies that assist at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention, and other community-based resources. The Network providers will establish knowledge of these providers through ongoing collaboration that includes regularly scheduled meetings to provide program information and updates. Collaboration with the local 211 services will be explored. Again, linguistic competence will be essential to ensure access for all in need.

- Crisis Intervention Network

The Crisis Intervention Network will be available to respond to critical incidents in the community that may have psychological/traumatic effects on children, adults, and families. These regional resources will consist of professionals who can provide immediate crisis intervention services. The types of incidents include: suicide, disaster, either natural or man-made, multiple casualty incidents, and victims or witnesses of violence or crime within the County of Orange. Linkages to County Mental Health

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services will be made at point of first contact. The effectiveness of these resources will be enhanced by quick access to County Behavioral Health Programs. A standardized referral protocol will consist of establishing liaisons with regionally located Behavioral Health Programs to insure access to services as needed. As noted above, services will be coordinated with the existing Crisis Assessment Unit.

- Law Enforcement Partnership

The Orange County Psychiatric Emergency Response Team (PERT) is an MHSA/CSS-funded partnership with the Garden Grove, Orange, and Westminster Police Departments and South Orange County Sheriff's Department. The PEI/PERT partnerships will target Children/Youth who are identified to be in stressed families and/or at risk for mental illness. This population will be identified through law enforcement referrals. Children who are perceived to need assessment or extended treatment for mental illness will be provided linkages to County Mental Health Services. In addition, families will be provided with support services needed to care for loved ones. Law enforcement and mental health staff will develop liaisons with regionally located County Behavioral Health programs to ensure that every participant has access to prevention and early intervention resources. PEI/PERT staff will provide 24-hour follow up on all referrals to make sure that services are provided in a timely manner.

- Survivor Support Services

The priority goal identified by the PEI Stakeholder Meetings and Focus Groups was to address the reduction of suicide in Orange County. The Survivor Support Services Program will address this need by targeting the high-risk populations who have attempted suicide and the family members/loved ones of those who have committed suicide. This program is expected to reduce suicidal behavior and its impact on family, friends, and communities. The program will coordinate closely with County Behavioral Health programs that work with diverse high-risk populations. These include those individuals who have been impacted by suicide and need Survivor Support Services and/or improvement in family functioning.

6. Collaboration and System Enhancements

- Crisis Prevention Hotline/Warm Line Network

The Crisis Prevention Hotline/Warm Line Network will collaborate with community-based organizations and agencies such as schools, primary care providers, community clinics and health centers, mental health providers, cultural/ethnic providers and faith-based organizations. These collaborations will be developed through an extensive County-wide campaign to provide outreach and educate the community on prevention strategies for those experiencing suicidal thoughts and how to access the Hotline/Warm Line Network.

- Crisis Intervention Network

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The Crisis Intervention Network will be available to provide rapid response to critical incidents in the County of Orange. The partners necessary for this include schools, hospitals, emergency departments, law enforcement, public health, family centers, senior centers, homeless and domestic violence shelters, and additional healthcare settings. Collaboration will be established to synchronize levels of care by providing the communities with follow-up referrals and resources for additional services. The development of this network will enhance and strengthen the emergency crisis response system in Orange County.

- Law Enforcement Partnership

The Psychiatric Emergency Response Team (PERT) will have a direct relationship established with the Orange County law enforcement agencies. A clinician will be tasked with working with the juvenile and transitional age youth populations who come in contact with law enforcement. This population will consist of those who have been subject to family risk factors, including domestic violence, criminal activities in the home, and various types of abuse. The Juvenile-PERT team may be out stationed at the local police department. The clinician will receive referrals through the local law enforcement and regularly meet with the assigned officer and law enforcement team.

The active collaboration between law enforcement agencies and County Mental Health will be essential for the identification of Children/Youth who are at risk for continued mental health services. PERT clinicians will have the ability to provide Case Management/Mental Health services in the community that includes assessment services, mental health evaluation, linkage and consultation (i.e. inter-intra agency), communication, coordination and referral, and monitoring service delivery to ensure client's access to services. PERT will additionally reach out to providers of services in the community including: residential treatment programs, drug abuse services, multi-cultural community centers, and social service organizations to provide additional resources for the at risk population. PERT will be a visible community-based program that will unite law enforcement and mental health professionals in an effort to intervene early to assist individuals who are at future risk of developing severe, chronic mental health problems.

- Survivor Support Services

Survivor Support Services will be a collaborative program targeting community service providers that have direct experience with individuals suffering from mental illness and may be at risk for suicide. This peer support-led group will provide education to agencies serving high-risk individuals, such as school districts, law enforcement agencies, juvenile diversion programs, social service agencies, and faith-based groups with the specific goal of reducing suicidal behavior and its impact upon family, friends, and communities. Orange County will benefit from a culturally and linguistically competent program to provide bereavement services and support to the emotional needs of those who have their lives significantly affected by suicidal behavior.

7. Intended Outcomes

Mental Health Services Act Prevention and Early Intervention Plan

The outcomes listed below will apply to all of the programs within this Crisis and Referral Project:

Individual Outcomes

- Reduced number of completed suicides
- Increased appropriate help-seeking
- Increased knowledge of mental health resources, social, emotional, and behavioral issues

System/Program Outcomes

- Increased number of appropriate referrals to mental health system
- Increased number of individuals/families who participate in prevention programs and receive early intervention services

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

Individuals that are served by the programs within the Crisis and Referral Project can benefit from other MHSA programs. Protocols for referral from this project to other PEI and CSS programs will be developed. For example, program staff will coordinate with CSS resources such as the Children's and TAY Crisis Residential Programs and Full Service Partnerships, Older Adult Services, the Centralized Assessment Team (CAT), and the Program of Assertive Community Treatment (PACT) programs when services are indicated.

Individuals who are experiencing a crisis and can be served by this project will be referred for assistance. Contracted programs will be required to establish specific policies and procedures that clearly outline the process they will follow to refer clients in a timely manner.

The directors and staff from this program will meet regularly with the staff of other MHSA components. Coordinators and staff from partnering agencies will be invited to meet quarterly with the Orange County Behavioral Health provider staff to share program information updates, attend trainings, and provide networking opportunities.

9. Additional Comments (optional)

None

Mental Health Services Act Prevention and Early Intervention Plan

County: Orange PEI Project Name: Training

Date: 11/08

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

2. PEI Priority Population(s)* Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
G. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
* This chart reflects all priority populations. However, the primary target population for each program has been identified and may be found in Attachment 3 .				

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

The strategies and priority populations recommended for the **Training Program** were selected on the basis of the following stakeholder input and data analysis.

Focus Group Feedback:

During the local community program planning process, input was gathered from many individuals and partnering organizations with respect to their training needs regarding mental health prevention and early intervention issues. In fact, training was identified as a PEI priority need by 80% of the community focus groups and stakeholder meetings conducted. Specifically, these groups identified a need for culturally competent training and education for professionals (e.g., educators, health care providers, law enforcement personnel, religious leaders, social service providers, etc.) who often are the first to come into contact with individuals who are experiencing early signs of mental, behavioral and/or emotional problems.

Training and educational opportunities targeting the community and general public were also identified as a means to heighten public awareness about the prevention and identification of early signs of mental illness among all of the PEI priority populations. Educational and training opportunities for family members and caregivers of the mentally ill, developmentally disabled, and physically handicapped were also identified as needed to enhance their ability to provide appropriate care and to reduce the stress and the emotional toll associated with being a family member or caregiver.

Survey Data Review

A total of 1,564 Community Surveys and 390 Organizational Surveys were received during the local planning process. The quantitative and qualitative data indicate Orange County's interest in PEI training services. Training services provide a starting point for many of the PEI strategies survey respondents recommended. For example, 46% of community respondents selected training professionals such as educators, law enforcement, emergency responders, doctors, nurses, and nursing home staff on early recognition and response to mental illness as a priority strategy for addressing PEI in Orange County (OC). In addition, 38% selected training for the general public. The types of training include education and support services for parents, grandparents, and caregivers at community centers, churches, and other community settings.

The majority (61%) of organizational respondents thought that the most impact at the local level would come from offering services (e.g., training for professionals and the general public) where cultural, ethnic, and other underserved groups normally meet, and 58% saw the potential impact of working with local community leaders, pastors, doctors, teachers, and advocates (e.g., providing training regarding mental health problems and available resources). Providing resource and referral information (e.g., training materials) in multiple languages also was selected (by 42% of organizational and 40% of community respondents) as a high-impact strategy for delivering PEI services that respond to the needs of underserved groups in OC.

Approximately 27% of the combined written suggestions from community and organizational survey respondents were related to professional training services, and 26% had to do with training to increase public knowledge about mental health problems and available services. These suggestions mentioned priority populations that respondents think would especially benefit from PEI training services. These included medical staff and professionals in a variety of settings, emergency responders, law enforcement and probation officers, paraprofessionals and community volunteers, shelter workers, staff in faith/community based organizations, and social services staff.

The Training Services PEI Project and associated programs will enable a range of professionals and first responders to recognize the early warning signs of mental illness and know where to appropriately refer individuals and families for additional resources and interventions. With this training and technical assistance, OC will be able to address many of the community mental health issues prioritized by both community and organizational survey respondents.

3. PEI Project Description:

Training projects/programs target staff and volunteers working in schools and universities, primary care settings and emergency medical services, refugee and recent immigrant programs, law enforcement, teen programs, violence prevention programs, sexual assault crisis centers, homeless programs, disaster assistance/response programs, and grief support programs.

The major goal is to better understand, identify, and address the potential mental health needs of PEI priority populations and help these populations access/utilize local community mental health resources. An additional goal is to improve the way that both mental health clients and their caregivers take care of their physical health, nutrition, and ability to manage stress by providing education and training to them in these areas.

Training projects/programs may also target the general community and/or specific at-risk populations in an effort to increase the understanding and awareness of factors that contribute to the development of mental health problems; reduce the potential for stigma and discrimination against individuals with mental illness; and increase access to and awareness of local mental health resources.

The Training Project consists of five programs:

- Training and Technical Assistance
- Child Development Training
- Training in Physical Fitness and Nutrition
- Stress Management for Caregivers and Service Providers
- Community-Based Stigma Reduction Training

A brief description of each program is provided below.

(a.) Training and Technical Assistance

This program is designed to address those persons who are in contact with individuals experiencing their first onset of serious psychiatric illness. For all people involved in this program, outcome measures specific to the identification of serious mental illness will be collected in addition to other measures of system effectiveness.

This program would provide both training and a source where persons most likely to encounter individuals with warning signs of mental illness or undergoing a first psychotic break could learn about recognition, referral, community resources and, if appropriate, provide simple interventions for early developing mental illness.

- The program will provide community education on the warning signs of mental illness. The audience will include the community at large, as well as persons and organizations most likely to encounter individuals presenting early signs of mental disorders (e.g. faith-based organizations, medical providers, child care providers, etc.).The program will be provided in a culturally and linguistically appropriate manner to ensure that all communities are both able to hear the information and understand it.
- The audience for technical assistance will include pediatricians, family practice physicians, public health nurses, preschool teachers, providers of older adult services, caregivers for persons with developmental disabilities. The program will also address how mental illness is understood in other cultures.
- Physicians, high school and college staff, probation and juvenile justice staff, and mental health providers in the community will learn to recognize and refer persons experiencing a first psychotic break, including training on how to recognize and refer persons from diverse ethnic/cultural groups.
- For mild behavioral problems that could develop into more serious behavioral or mental disorders, a graduated system of interventions, such as the Triple-P model will be used so that minor problems can receive immediate, easily administered interventions (e.g. booklets, phone consultation, etc.)
- Technical assistance will be provided in multiple languages in an easily accessible format with wide distribution throughout the county (e.g. website, phone access, traveling training).

(b.) Child Development Training

This program is designed to address those persons who are in a decision making capacity regarding family unity and child placement. Although the program will be focus on resiliency and protective factors common to all families, there will be a special focus on how these are best supported in families from underserved cultural populations. For all people involved in this program, outcome measures specific to the understanding of cultural characteristics, and in particular, strengths will be collected in addition to other measures of system effectiveness.

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Child development, including attachment theory, resiliency, developmental milestones, and information about family risk and protective factors will be taught to 1) persons who make decisions with regard to family unity and child placement and 2) those who intervene with children and families to insure their health and safety. These two groups would include judges, attorneys, SSA social workers, public health nurses and visiting nurses.

A successful local early childhood program, the Orange County YMCA Model Community Court Project, may be used as the model for this program. This program combines the Zero-to-Three Court Community Team approach and the Best-for-Babies (B4B) approach from Yavapai County, Arizona into a local program. For preschool children through teens, the concepts from the “40 Developmental Assets” program will be used.

(c.) Training in Physical Fitness and Nutrition

This program is designed to serve those individuals experiencing their first onset of serious psychiatric illness. For all people involved in this program, outcome measures specific to recovery from serious mental illness will be collected in addition to other measures of individual well being and system effectiveness.

On average, people with schizophrenia die 25 years earlier than the general population. The most frequent single cause of death among people with schizophrenia is heart disease. Many factors contribute to the increased risk for heart disease, including obesity induced by some of the drugs used to treat the condition, combined with a tendency among people with schizophrenia to smoke more and exercise less than the general population.

Providing training on lifestyle modifications, risk factors, and early intervention in the lives of persons with newly developing serious mental illness may lessen the morbidity associated with these disorders. In addition, the research literature suggests that, for many variables, there is now ample evidence that a definite relationship exists between exercise and improved mental health. This is particularly evident in the case of a reduction of anxiety and depression. For these topics, there is now considerable evidence derived from hundreds of studies with thousands of subjects to support the claim that “exercise is related to a relief in symptoms of depression and anxiety.”

The training program will include:

- An individualized physical training program
- A system to measure outcomes of the training
- Information on nutrition
- Wellness strategies, including meditation, yoga, relaxation techniques and peer support
- Stop smoking programs

(d.) Stress Management for Caregivers and Service Providers

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This program will serve a broad range of caregivers from different backgrounds who, by the nature of their duties, are in contact with trauma-exposed individuals and who themselves are thus potentially vulnerable to mental health problems. Those caregivers regularly interacting with trauma-exposed individuals will receive priority access and interventions specific to their concerns. For all people involved in this program, outcome measures specific to the amelioration of the impact of vicarious traumatic experiences will be collected in addition to other measures of individual mental health status and system effectiveness.

Persons who provide care for others who have disabilities are at risk for developing mental disorders due to stress. Persons in high stress jobs providing service to others, such as police officers, are also at risk for mental disorders and have a suicide rate 25% higher than the general population. Training to manage stress in these groups, which are trauma-exposed by the nature of their jobs, will reduce mental disorders and suicide.

Types of training will include:

- Forming support groups or finding peer partners
- Internet sites that address caregiver issues
- Stress reduction techniques
- Methods for protecting caregiver's health
- Resources for spiritual support

(e.) Community-Based Stigma Reduction Training

This program will serve a broad range of people of different backgrounds and different ages. Of particular concern is the underserved cultural population where the stigma of mental illness is even greater than that of the general population. The training protocols and staffing patterns will be designed to address these issues. For all people involved in this program, outcome measures identifying their cultural and linguistic characteristics will be collected in addition to other measures of system effectiveness.

This program includes training to the general public to reduce stigma associated with mental illness. Such training is expected to increase the likelihood of persons and their families seeking help with mental illness; asking for help prior to illnesses becoming severe, and increasing the likelihood of supportive behavior toward persons with mental illness.

Training will include consumers who have been trained to tell their stories. It will use drama as a medium for reducing stigma, as well as other culturally and linguistically appropriate methods. Training will use consumers, family members, members from local immigrant groups, and others to identify ways of reaching isolated populations and to possibly conduct a social marketing campaign. The training will be provided in threshold and emerging languages, American Sign Language, and any other language in which a substantial number of community members would benefit from hearing the message.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Training and Technical Assistance	Individuals: 100 Families: 100	Individuals: 100 Families:100	15
Child Development Training	Individuals: Families: 75	Individuals: Families:	15
Training in Physical Fitness and Nutrition	Individuals: 100 Families:	Individuals: Families:	15
Stress Management for Caregivers and Service Providers	Individuals: 100 Families: 75	Individuals: Families:	15
Community-Based Stigma Reduction Training	Individuals: 100 Families: 100	Individuals: Families:	15
	Individuals: Families:	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 400 Families: 250	Individuals: 100 Families: 100	

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

Training programs funded under PEI will primarily address non-mental health professionals in the community (such as primary care physicians, child care staff, teachers, judges, lawyers and visiting nurses) or will address clients/families or the general community. When addressing clients or caregivers, training will be linked to the county and county-contracted mental health services. This will make the training programs available to the clients and their families. When providing technical assistance to non-mental health professionals in the community, it will be necessary to establish consultation and referral procedures with the county mental health system.

6. Collaboration and System Enhancements

To provide training and technical assistance to the non-mental health professional community, training and consultation staff will need to be made available to develop programs and procedures. Referral and assessment mechanisms will be enhanced through training and technical assistance as well as stigma reduction training efforts. As a result, more potential clients from underserved populations will be directed toward the system at the early stages of their illnesses. Likewise, these training programs, as well as other early intervention efforts within this PEI plan will contribute to the enhancement of services for persons experiencing their first episode of severe mental illness. In areas of training not normally addressed by the county mental health system, such as caregiver stress and physical fitness and nutrition, other county and non-county service providers will be enlisted. The efforts of the Stigma Reduction Program will be closely coordinated with the local Stigma Reduction Committee.

7. Intended Outcomes

Training and Technical Assistance

Individual-level outcomes

- Increased successful follow through on linkage/referrals
- Improved knowledge of the signs of a first break, as measured by pre-and post-test scores

Program-level outcomes

- Increased number of first breaks identified compared to the previous time period

System-level outcomes

- Increased number of organizations with a formal process for identifying individuals/families with social, emotional, and behavioral issues
- Increased number of organizations with capacity to ensure effective linkage to services

Child Development Training

Individual-level outcomes

- Improved knowledge of child development, as measured by pre- and post-test scores.

Program-level outcomes

- Decreased out-of-home placements

System-level outcomes

- Increased number of trainings presented to judges, attorneys and nurses

Training in Physical Fitness and Nutrition

Person-level outcomes

- Increased awareness of nutrition and physical fitness issues
- Increased level of exercise, weight reduction, and reduction in smoking

Program-level outcomes

- Increased number of people who quit smoking
- Increased number of people who improve their physical fitness as measured by a standardized fitness test

System-level outcomes

- Improved access to physical fitness, nutrition, and smoking cessation programs throughout the system

Stress Management for Caregivers and Service Providers

Person-level outcomes

- Increased knowledge of risk and resilience/protective factors as measured by the difference in pre- and post-test scores

Program-level outcomes

- Reduced number of participants reporting family stress/discord as self reported on a survey instrument
- Improved retention rates for caregivers and service provider staff

System-level outcomes

Increased number of individuals/families from underserved populations who receive prevention programs for caregivers and service providers

Community-Based Stigma Reduction Training

Person-level outcomes

- Increased knowledge of mental illness
- Increased contact with persons with mental illness

Program-level outcomes

- Increased number of people coming in for service

System-level outcomes

- Increased number of education programs designed specifically to address stigma/discrimination

Specific measures for the above outcomes will be established when County-operated and/or contracted PEI providers have been identified and related funding/resource levels are finalized.

8. Coordination with Other MHSA Components

The Stigma Reduction Training will closely coordinate with the statewide PEI Stigma Reduction Project. PEI training that addresses Community-based Stigma Reduction is related to some programs being pursued under MHSA Workforce Education and Training (WET). These include programs that use consumers and family members to present training to the community on mental illness. These programs will be coordinated. Consumers will be referred to MHSA CSS programs after they are identified as a result of participation in Training and Technical Assistance activities.

9. Additional Comments (optional)

None

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Early Intervention Services

Alcohol and Drug Specialist	Assess for alcohol and drug problems as well as provide individual and group treatment and linkage to on-going resources in the community to promote relapse prevention.
Clinic Office Manager	Manage office and supervise office support staff.
Clinical Director	Provides clinical direction and supervision
Clinical Psychologist	Provides clinical consultation to primary health care providers in the community to increase the primary care providers capacity to screen for and address first onset depression in older adults.
Director/Outreach	Provides outreach to the community. Trains, supervises, and coordinates life skills coaches.
Employment/Education Specialist	Assist consumer in identifying areas of interest or goals in employment and education and facilitate the linkage of the consumer to resources
Group Facilitator	Facilitates theme or topic-based discussions of the support group. Facilitator will have coped with the same issues and concerns as other members of the group. Will link group members to other resources in the community when needed.
Clinical Social Worker	Provide individual psychotherapy, group therapy, and case management.
Clinical Social Worker	Provides assessment and referral for psycho-therapeutic services for post-partum depression
Clinical Psychologist	Provide psychological testing, psychotherapy, and psycho-educational groups.
Life Skills Coach	Provides in-home visits to isolated adults and older transitioning them to outside activities,
Mentor Coordinator	Provides training and supervision to peer mentors.
Occupational Therapist	Assist program participants engage in positive activities, who have refrained from due to physical limitations or limitations imposed on them by their illness.
Office Support	Answer telephone and greet visitors (reception), enter data in billing system, filing, support management staff.
Program Coordinator	Provides overall direction to the program and supervises staff. Is major liaison with the County.
Psychiatrist	Provides assessment for and prescription of medication
Registered Nurse	Assess for medical conditions , facilitates the beginning of treatment and provides education for these conditions and medications, including medical tests.
Research Interviewer	Data collection and reporting including performance outcome data
Resource Coordinator	Identifies resources in the community for consumers enrolled in the program and links the consumer to these resources.
Supervisor	Provide training and supervision to group facilitators.
Supervisor/Administrator	Coordinates and performs administrative duties of the program as well as supervising the LCSWs.

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 4

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

County Name: Orange Date: _____
 PEI Project Name: School Based Services
 Provider Name (if known): TBD
 Intended Provider Category: TBD
 Proposed Total Number of Individuals to be served: FY 08-09 125827 FY 09-10 503307
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 125826.75 FY 09-10 503307
 Months of Operation: FY 08-09 3 FY 09-10 12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
24.0 FTE	Licensed Therapist	\$270,000	\$1,080,000	\$1,350,000
	Teachers/Certificated and Classided sta	\$158,313	\$633,250	\$791,563
1.0 FTE	Program Specialist	\$16,250	\$65,000	\$81,250
4.0 FTE	Program Coordinator	\$91,000	\$364,000	\$455,000
1.0 FTE	Administrative Support	\$12,500	\$50,001	\$62,501
1.0 FTE	Mental Health Outreach Worker	\$10,050	\$40,201	\$50,251
1.0 FTE	Technical Consultant	\$11,100	\$44,401	\$55,501
.5 FTE	Health Consultant	\$9,050	\$36,200	\$45,250
2.5 FTE	Behavioral Health Specialist	\$35,626	\$142,502	\$178,128
1.0 FTE	Project Assistant	\$6,725	\$26,901	\$33,626
1.0 FTE	Enrollment Coordinator	\$9,350	\$37,401	\$46,751
1.0 FTE	Social Skills Provider	\$10,663	\$42,651	\$53,314
1.0 FTE	Attention Training Provider	\$10,663	\$42,651	\$53,314
1.0 FTE	Facilitator	\$10,225	\$40,901	\$51,126
.5 FTE	Psychologist	\$9,050	\$36,200	\$45,250
1.0 FTE	Program Manager	\$18,100	\$72,401	\$90,501
.5 FTE	Coordination Assistant	\$6,425	\$25,700	\$32,125
b. Benefits and Taxes		\$224,413	\$897,653	\$1,122,066
c. Total Personnel Expenditures		\$919,504	\$3,678,014	\$4,597,518
2. Operating Expenditures				
a. Facility Cost				
		\$84,027	\$336,108	\$420,135
b. Other Operating Expenses				
		\$523,295	\$2,093,178	\$2,616,473
c. Total Operating Expenses		\$607,322	\$2,429,286	\$3,036,608
3. Subcontracts/Professional Services (list/itemize all subcontract)				
	Consultants/Speakers	\$8,500	\$34,000	\$42,500
	Indirect/Evaluation	\$76,500	\$306,000	\$382,500
	Translators 775 hours at \$16 per hour	\$3,100	\$12,400	\$15,500
	Subspecialties (Nurses, audiologist, visio	\$20,700	\$82,800	\$103,500
	Pediatrician	\$6,250	\$25,000	\$31,250
	Physican Liaison	\$13,750	\$55,000	\$68,750
	Training Modules	\$12,500	\$50,000	\$62,500
a. Total Subcontracts		\$141,300	\$565,200	\$706,500
4. Total Proposed PEI Project Budget		\$1,668,125	\$6,672,500	\$8,340,625
Revenues (list/itemize by fund source)				
1. Total Revenue				
5. Total Funding Requested for PEI Project		\$1,668,125	\$6,672,500	\$8,340,625
6. Total In-Kind Contributions				

Note: The Orange County Health Care Agency would like to request the \$ 8,340,625 for this program be taken from the FY 08/09 PEI Allocation.

Mental Health Services Act Prevention and Early Intervention Plan

PROJECT NARRATIVE

PROJECT: School-based Services

Admin Assistant	Provides administrative support to program, responsible for collection and analysis of process and outcome data.
Licensed Therapist	Provides screening, parent education, counseling, crisis intervention, case management, community linkages, referrals and educational groups
Licensed Therapist (School Readiness)	Provides developmental screening, case management, linkage, early intervention, in home visitation and parent consultation to preschool children and their families.
PBIS Coordinator	Provides coordination between the three levels of PBIS (Primary, Secondary and Tertiary), the geographic regions and Orange County Dept. Education. Responsible for technical assistance and training for school districts for the four units of VP: Safe from the Start, Gang Prevention, School Law Partnership and Hate Crime Prevention.
Program Coordinator	
Program Manager	Provides overall direction to the program, coordinates with other school based programs, supervises staff, is major liaison with County.
Program Specialist	Provides supervision to VP staff, coordinates services with other SBS, oversees collection and analysis of process and outcome data.
Program Specialists (PBIS)	Provides technical assistance and training on PBIS to schools in geographic area of responsibility

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 4

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

County Name: _____ Date: _____

PEI Project Name: Outreach and Engagement Services

Provider Name (if known): TBD

Intended Provider Category: TBD

Proposed Total Number of Individuals to be served: FY 08-09 _____ FY 09-10 _____

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

Total Number of Individuals to be served through PEI Expansion: FY 08-09 5100 FY 09-10 20400

Months of Operation: FY 08-09 3 FY 09-10 12

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
1.0 FTE	PEI Manager	\$16,496	\$65,985	\$82,481
3.0 FTE	PEI I&R Specialist	\$30,388	\$121,551	\$151,939
3.0 FTE	PEI Liasons/Resource Specialists	\$30,388	\$121,551	\$151,939
1.0 FTE	Administrative Assistance	\$9,551	\$38,202	\$47,753
1.0 FTE	Data Base Support	\$17,365	\$69,458	\$86,823
0.25 FTE	Call Center Manager	\$4,703	\$18,812	\$23,514
0.25 FTE	Operations Manager	\$5,643	\$22,574	\$28,217
1.10 FTE	Executive Director	\$2,981	\$11,924	\$14,904
3.0 FTE	Personal Service Coordinator	\$288,720	\$1,154,880	\$1,443,600
b. Benefits and Taxes @ 24.9%		\$103,718	\$414,871	\$518,589
c. Total Personnel Expenditures		\$509,952	\$2,039,807	\$2,549,759
2. Operating Expenditures				
a. Facility Cost		\$39,967	\$159,866	\$199,833
b. Other Operating Expenses		\$85,175	\$840,791	\$925,966
c. Total Operating Expenses		\$125,142	\$1,000,657	\$1,125,799
3. Subcontracts/Professional Services (list/itemize all subcontract)				
_____		\$0	\$0	\$0
_____		\$0	\$0	\$0
_____		\$0	\$0	\$0
a. Total Subcontracts		\$0	\$0	\$0
4. Total Proposed PEI Project Budget		\$635,093	\$3,040,464	\$3,675,557
B. Revenues (list/itemize by fund source)				0
_____		\$0	\$0	\$0
_____		\$0	\$0	\$0
_____		\$0	\$0	\$0
1. Total Revenue		\$0	\$0	\$0
5. Total Funding Requested for PEI Project		\$635,093	\$3,040,464	\$3,675,557
6. Total In-Kind Contributions		\$0	\$0	\$0

Note: The Orange County Health Care Agency would like to request the \$3,675,557 for this program be taken from the FY 08/09 PEI Allocation.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Outreach and Engagement

Call Center Manager/ Operations Manager	Plans, schedules, assigns, and directs staff of professionals and paraprofessionals; participates in hiring and training new staff; works closely with other agencies to coordinate and provide services
Data Base Support Executive Director	Responsible for developing and maintaining resource data base. Oversees, Plans, and directs staff of professionals and paraprofessionals; works closely with other agencies to coordinate and provide services.
Information and Referral , Resource Specialist	Provides brief psycho-education, referral and linkage services
Office Assistant	Provides support services to multidisciplinary team
Personal Services Coordinator	Plans, organizes and coordinates specialized mental health treatment services; educates individuals and the community in early intervention techniques. identifies existing services in the community for appropriate treatment sources

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Parent Education and Support Services

Asst. Program Manager	Responsible for overall direction of program, supervision of staff and liaison with other PEI Projects.
Case Managers	Conducts specialized Parent Empowerment or COPES training groups and interventions, case management and linkage as needed. BA level required.
Life Skills Coach	Provides Mental Health Education to groups and individuals within isolated communities, also provides case management and linkage as needed. No degree requirement, experience as a mental health consumer or family member strongly preferred.
Office Assistant	Provides administrative support to program, responsible for collection of process and outcome data.
Office Manager	Provides administrative support to program, establishes and supervises all office systems.
Peer Mentor	Facilitates connections between families entering the mental health system. No degree requirement, experience as a mental health consumer or family member strongly preferred.
PSC	Conducts specialized Triple P parent training groups and interventions, case management and linkage as needed. MA level or BA level plus experience required.
QI/Training Director	Provides technical assistance and training to PET staff and community partners on parent education and training models and best practices, supervises staff.
QI/Training Director	Develops quality standards, data collection systems and outcome assessment methods for all PET programs. Oversees collection and analysis of outcome data.

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 4

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

County Name: _____ Date: _____
 PEI Project Name: Prevention Services
 Provider Name (if known): _____
 Intended Provider Category: TBD
 served: FY 08-09 4900 FY 09-10 19600
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through
 PEI Expansion: FY 08-09 4900 FY 09-10 19600
 Months of Operation: FY 08-09 3 FY 09-10 12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages		\$0	\$0	\$0
2.0 FTE	Mental Health Specialist	\$17,760	\$71,040	\$88,800
3.0 FTE	Clinical Social Worker	\$35,621	\$142,482	\$178,103
1.0 FTE	Office Assistant	\$6,189	\$24,757	\$30,946
1.0 FTE	Licensed Clinical Supervisor	\$11,062	\$44,246	\$55,308
4.0 FTE	Mental Health Specialist	\$35,873	\$143,493	\$179,366
4.0 FTE	Clinical Social Worker	\$47,967	\$191,866	\$239,833
1.5 FTE	Office Assistant	\$9,376	\$37,505	\$46,881
1.0 FTE	Licensed Clinical Supervisor	\$14,365	\$57,459	\$71,824
2.0 FTE	Licensed Social Workers	\$21,105	\$84,421	\$105,526
1.0 FTE	Outreach Coordinator	\$7,478	\$29,911	\$37,389
.25 FTE	Licensed Clinical Supervisor	\$2,748	\$10,991	\$13,739
.25 FTE	Office Specialist	\$1,538	\$6,150	\$7,688
2.0 FTE	Training Officer	\$18,992	\$75,966	\$94,958
2.0 FTE	Outreach Coordinator	\$14,302	\$57,208	\$71,510
1.0 FTE	Office Assistant	\$5,881	\$23,525	\$29,406
2.0 FTE	Lead Case Manager	\$18,546	\$74,184	\$92,730
1.0 FTE	Outreach Coordinator	\$7,248	\$28,990	\$36,238
b. Benefits and Taxes		\$84,256	\$337,023	\$421,279
c. Total Personnel Expenditures		\$360,304	\$1,441,217	\$1,801,521
2. Operating Expenditures				
a. Facility Cost		\$17,656	\$70,624	\$88,280
b. Other Operating Expenses		\$45,401	\$181,604	\$227,005
c. Total Operating Expenses		\$63,057	\$252,228	\$315,285
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		\$423,361	\$1,693,445	\$2,116,806
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		\$423,361	\$1,693,445	\$2,116,806
6. Total In-Kind Contributions		\$0	\$0	\$0

Note: The Orange County Health Care Agency would like to request the \$2,062,019 is program be taken from the FY 08/09 PEI Allocation.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Prevention Services

Mental Health Consultants

Mental Health Specialists (2 FTEs): Position will organize and coordinate specialized mental health programs for specific segments of the population; to provide liaison, consultation and training services to staff and volunteers in specialized settings including schools and community-based clinics.

Clinical Social Workers (3 FTEs): Position will provide training and consultations services to professionals in schools and community clinic settings.

Licensed Clinical Supervisor (1 FTE): Position will supervise a multidisciplinary staff of professionals and paraprofessionals involved in providing specialized mental health prevention and early intervention services; perform administrative responsibilities.

Office Assistant (1 FTE): Position will provide support services to multidisciplinary team of professionals. Tasks include scheduling appointments and meetings, maintaining calendars, word processing, data entry and management; review documents to verify accuracy and completeness; gather and organize information from a variety of sources.

Children of Substance Users and Mentally Ill Parents

Licensed Clinical Social Worker (4 FTEs): Participates as a member of a multidisciplinary team to assist clients and relatives in understanding and recognizing the signs and symptoms of behavioral health problems and their reaction to them; help them work towards a solution for problems and stresses caused in part by the substance use and mental illness of the parents.

Mental Health Specialists (4 FTEs): Participates as a member of a multidisciplinary team to organize and coordinate specialized mental health prevention and early intervention services for at-risk children and their parents.

Licensed Clinical Supervisor (1 FTE): Position will supervise a multidisciplinary staff of professionals and paraprofessionals involved in providing specialized mental health prevention and early intervention services; perform administrative responsibilities.

Office Assistant (1 FTE): Position will provide support services to multidisciplinary team of professionals. Tasks include scheduling appointments and meetings, maintaining calendars. Word processing, data entry and management; review documents to verify accuracy and completeness; gather and organize information from a variety of sources.

PEI Services of Parents and Siblings in the Juvenile Justice System

Licensed Clinical Therapist/ Case Manager (2 FTEs): Position will provide individual assessment and group facilitation; case manage clients and assist them in understanding and recognizing the signs and symptoms of behavioral health problems and their reaction to them, work with clients towards solutions of problems caused in part by a variety of stressors in the family and link clients to appropriate resources.

Licensed Clinical Supervisor (.25 FTE): Position will supervise a multidisciplinary staff of professionals and paraprofessionals involved in providing specialized mental health prevention and early intervention services and perform administrative responsibilities.

Mental Health Services Act Prevention and Early Intervention Plan

Outreach Coordinator (1FTE): Position will recruit clients; assist with individual assessment and group facilitation; liaison with community programs and link clients to appropriate services.

Office Specialist (.25 FTE) Position will provide support services to multidisciplinary team of professionals. Tasks include scheduling appointments and meetings, maintaining calendars. Word processing, data entry and management; review documents to verify accuracy and completeness; gather and organize information from a variety of sources.

Youth Development and Resilience

Training Officer (2FTEs): Position will provide capacity building training at various school organizations to develop meaningful and relevant projects to enhance personal skills, leadership skills, and team skills. Position will also assist with goals and objectives development and evaluation of school organizations working within the community.

Outreach Coordinator (2FTEs): Position will provide support to school groups and guidance to adult coordinators to develop specific goals and objectives and evaluation for their activities and link youth to community programs and local government.

Office Assistant (1 FTE) Position will provide support services to multidisciplinary team of professionals. Tasks include scheduling appointments and meetings, maintaining calendars. Word processing, data entry and management; review documents to verify accuracy and completeness; gather and organize information from a variety of sources.

Transition Services

Case Manager (2 FTEs) : Position will liaison with schools, community based organizations (CBO), mentoring programs and the private business sector to coordinate linkages and referrals and will provide services to at-risk youth including conducting assessments develop action plans, mentoring, career counseling and providing referrals.

Outreach Coordinator (1FTE): Position will conduct outreach to schools and group homes and other settings populated with at-risk youth; provide direct assistance or linkages to tutoring, help with college financial aid applications and enrollment forms, application for scholarships, job information and career fairs.

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Screening and Assessment Services

Alcohol/Drug Specialist	Assesses and screens individuals for alcohol and drug problems using testing instruments
Clinical Psychologist	Oversees workload and directs staff assignments, responsible for selection of tools and instruments, establishes training curriculum
Clinical Psychologist (Program Coor.)	Oversees workload and directs staff assignments, responsible for selection of tools and instruments, coordinates assignments and referrals to the program
MH Specialist	Assesses and screens individuals using testing instruments, responsible for specialized referrals
MH Worker II	Responsible for training individuals in use of instruments
Social Worker	Assesses and screens individuals using testing instruments
Staff Specialist	Oversees workload and directs staff assignments
Staff Specialist	Responsible for training individuals in use of instruments
Substance Abuse Specialist	Assesses and screens individuals for alcohol and drug problems using testing instruments

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 4

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

County Name _____ Date: _____
 PEI Project Name: Crisis Crisis and Referral Services
 Provider Name (if known): _____
 Intended Provider Category: _____
 Proposed Total Number of Individuals to be served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 4589 FY 09-10 18355
 Months of Operation: FY 08-09 3 FY 09-10 12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages		\$0	\$0	\$0
1.0 FTE	Licensed Clinical Supervisor	\$11,694	\$46,777	\$58,471
1.0 FTE	Social Worker (MSW)	\$9,379	\$37,516	\$46,895
1.0 FTE	Registered Nurse	\$15,280	\$61,118	\$76,398
3.0 FTE	Personal Service Coordinator	\$24,541	\$98,165	\$122,706
3.0 FTE	Peer Mentor	\$18,406	\$73,624	\$92,030
1.0 FTE	Office Assistant	\$6,543	\$26,173	\$32,716
1.0 FTE	Service Chief I	\$11,464	\$45,854	\$57,318
3.0 FTE	Clinical Social Worker II	\$28,709	\$114,836	\$143,545
2.0 FTE	Mental Health Specialist	\$14,314	\$57,256	\$71,570
2.0 FTE	Mental Health Worker II	\$12,879	\$51,515	\$64,394
1.0 FTE	Behavioral Health Nurse	\$12,407	\$49,628	\$62,035
1.0 FTE	Office Specialist	\$6,032	\$24,126	\$30,158
1.0 FTE	Service Chief I	\$15,055	\$60,218	\$75,273
2.0 FTE	Clinical Social Worker II	\$25,136	\$100,545	\$125,681
1.0 FTE	Marriage Family Therapist II	\$12,568	\$50,270	\$62,838
1.0 FTE	Behavioral Health Nurse	\$16,294	\$65,175	\$81,469
1.0 FTE	Office Specialist	\$7,921	\$31,684	\$39,605
1.0 FTE	Licensed Clinical Supervisor	\$12,395	\$49,579	\$61,974
2.0 FTE	Personal Service Coordinator	\$16,361	\$65,443	\$81,804
2.0 FTE	Peer Mentor	\$12,271	\$49,082	\$61,353
b. Benefits and Taxes		\$92,229	\$368,915	\$461,144
c. Total Personnel Expenditures		\$381,875	\$1,527,499	\$1,909,374
2. Operating Expenditures				
a. Facility Cost		\$10,691	\$42,765	\$53,456
b. Other Operating Expenses		\$27,492	\$109,967	\$137,459
c. Total Operating Expenses		\$38,183	\$152,732	\$190,915
3. Subcontracts/Professional Services (list/itemize all subcontract				
_____		\$0	\$0	\$0
_____		\$0	\$0	\$0
_____		\$0	\$0	\$0
a. Total Subcontracts		\$0	\$0	\$0
4. Total Proposed PEI Project Budget		\$420,058	\$1,680,231	\$2,100,289
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		\$420,058	\$1,680,231	\$2,100,289
6. Total In-Kind Contributions		\$0	\$0	\$0

Note: The Orange County Health Care Agency would like to request the \$2,100,289 for this program be taken from the FY 08/09 PEI Allocation.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Crisis and Referral Services

Crisis Prevention Hot Line/Warm Line

Service Chief I

Plans, schedules, assigns, and directs a staff of professionals and paraprofessionals involved in providing mental health crisis/suicide prevention services to children, transitional youth, adults, older adults, and families via the telephone and Internet. Will be responsible for enhancing County mental health by providing immediate, confidential counseling and supportive services to individuals contacting the crisis lines. Participates in hiring and training new staff, evaluates performance of subordinates, reviews the work and service capacity of program. Works closely with other agencies and community based operations with regard to coordinating and providing services.

Clinical Social Worker

Under direction, to provide mental health crisis intervention services to children, transitional youth, adults, older adults, and families via the phone and Internet. Works on a multi-disciplinary team to deliver community-based services to intervene and assist at-risk individuals and/or families by providing needed resources, mental health counseling, referrals and follow-up contacts.

Behavioral Health Nurse

Under direction, to perform specialized behavioral health nursing for individuals needing crisis intervention supportive services. Will work closely with a multi-disciplinary mental health team to provide crisis intervention, assessment, and evaluations with children, transitional age youth, adults, older adults, and families who contact the suicide prevention/crisis hot line/warm line. Assists in providing needed resources, mental health counseling, medication information, referrals and follow up contacts.

Mental Health Specialist

Under general supervision, to plan, organize and coordinate specialized mental health treatment services to assist persons who are experiencing a mental health crisis and have contacted the hot line/warm lines. Assists licensed professional staff members in assessing the mental status of these individuals, and identify existing services in the community for appropriate treatment sources when needed.

Mental Health Worker

Under close supervision, assists in providing mental health treatment services to assist persons who are experiencing a mental health crisis and have contacted the hot line/warm lines. Learns to recognize service needs and to refer to appropriate treatment sources when needed.

Office Specialist

Under general supervision, to perform difficult and responsible office work in a specialized assignment; and to do other work as required. May compile a variety of narrative and statistical reports, perform a variety of keyboarding duties, and interact with the public or others in obtaining critical program data.

Crisis Intervention Network

Service Chief I

Plans, schedules, assigns, and directs a staff of professionals and paraprofessionals involved in providing services to children, adults, and families that may have experienced psychological/traumatic effects due to critical incidents in the community. Assists staff with difficult and complex treatment problems; coordination of treatment services. Participates in hiring and training new staff, evaluates performance of subordinates, reviews the work and service capacity of program. Works closely with other agencies and community based operations with regard to coordinating and providing services.

Clinical Social Worker

Under direction, to provide social casework services for persons who may be at risk of developing psychological/traumatic symptoms due to exposure of critical incidents in the community. Works on a multi-disciplinary team participating in assessment, diagnosis, treatment, care planning and case management of resources.

Mental Health Services Act Prevention and Early Intervention Plan

Mental Health Specialist

Under general supervision, to plan, organize and coordinate specialized mental health treatment services to assist persons who may be at risk of developing psychological/traumatic effects due to critical incidents in the community. Assists licensed professional staff members in assessing the mental status of individuals receiving treatment. Identifies existing services in the community for appropriate treatment sources when needed.

Mental Health Worker

Under close supervision, assists in providing services to persons who may have experienced psychological/traumatic effects due to critical incidents in the community. Learns to work with staff in conducting education programs in the community. Learns to interview prospective clients, to recognize service needs and to refer to appropriate treatment sources when needed.

Office Specialist

Under general supervision, to perform difficult and responsible office work in a specialized assignment; and to do other work as required.

Behavioral Health Nurse

Under direction, to perform specialized behavioral health nursing in a variety of settings. To make psychiatric nursing evaluations, provide crisis intervention and perform psychiatric casework as needed. Provide assessment and evaluation to persons who may be at risk of developing psychological/traumatic symptoms due to exposure of critical incidents in the community.

Law Enforcement Partnership

Service Chief I

Plans, schedules, assigns, and directs a staff of professionals and paraprofessionals involved in providing mental health prevention and early intervention services to children, transitional youth, adults, older adults, and families in partnership with local police departments. Will be responsible for enhancing County mental health to partner with law enforcement agencies to identify individuals at risk of developing severe mental health problems. Participates in hiring and training new staff, evaluates performance of subordinates, reviews the work and service capacity of program. Works closely with other agencies and community based operations with regard to coordinating and providing services.

Clinical Social Worker

Under direction, to provide mental health evaluations to children, transitional youth, adults, older adults, and families in partnership with law enforcement. Works on a multi-disciplinary team to deliver community-based services to intervene and assist at-risk individuals and/or families by providing needed resources, mental health counseling, referrals and follow-up contacts.

Marriage Family Therapist

Under direction, to provide mental health evaluations to children, transitional youth, adults, older adults, and families in partnership with law enforcement. Works on a multi-disciplinary team to deliver community-based services to intervene and assist at-risk individuals and/or families by providing needed resources, mental health counseling, referrals and follow-up contacts.

Behavioral Health Nurse

Under direction, to perform specialized behavioral health nursing in a variety of settings. Will work closely with law enforcement and a multi-disciplinary mental health team to provide crisis intervention, assessment, and evaluations with children, transitional age youth, adults, older adults, and families who are at identified to be at risk. Assists in providing needed resources, mental health counseling, referrals and follow up contacts.

Office Specialist

Under general supervision, to perform difficult and responsible office work in a specialized assignment; and to do other work as required. May compile a variety of narrative and statistical reports, perform a variety of keyboarding duties, and interact with the public or others in obtaining critical program data.

Mental Health Services Act Prevention and Early Intervention Plan

Survivor Support Services

Licensed Clinical Supervisor

Plans, schedules, assigns, and directs a staff of professionals and paraprofessionals involved in providing mental health prevention and early intervention services to children, transitional youth, adults, older adults, and families affected by suicide. Will be responsible for enhancing County mental health to identify individuals at high risk of developing mental health problems related to the suicide attempt/completion of a loved one. Participates in hiring and training new staff, evaluates performance of subordinates, reviews the work and service capacity of program. Works closely with other agencies and community based operations with regard to coordinating and providing services.

Personal Services Coordinator

Under general supervision, plans, organizes and coordinates specialized mental health treatment services to assist persons who have been directly affected by the suicide of a loved one. Educates these individuals and the community in early intervention techniques, warning signs, and available resources. Assists licensed professional staff members in assessing the mental status of these individuals, and identify existing services in the community for appropriate treatment sources when needed.

Peer Mentor

Under close supervision, assists in providing mental health treatment services to persons who may have experienced psychological/traumatic effects due to the suicide or attempted suicide of a loved one. Shares the experience of having been through a similar life event and offers support, hope, and encouragement to those in need. Learns to recognize service needs and to refer to appropriate treatment sources when needed.

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 4

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

County Name: Orange Date: _____
 PEI Project Name: Training
 Provider Name : TBD
 Intended Provider Category: TBD
 Proposed Total Number of Individuals to be served: FY 08-09 N/A FY 09-10 N/A
 Total Number of Individuals currently being served: FY 08-09 FY 09-10
 Total Number of Individuals to be served through PEI
 Expansion: FY 08-09 FY 09-10
 Months of Operation: FY 08-09 3 FY 09-10 12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages		\$0	\$0	\$0
1.0 FTE	Program Director	\$13,446	\$53,785	\$67,231
0.5 FTE	Psychiatrist/Trainer	\$24,304	\$97,214	\$121,518
1.0 FTE	Clinical Psychologist	\$13,446	\$53,785	\$67,231
1.0 FTE	Marriage Family Therapist	\$12,083	\$48,331	\$60,414
1.0 FTE	Office Manager	\$8,349	\$33,395	\$41,744
1.0 FTE	Data Specialist	\$7,043	\$28,172	\$35,215
1.0 FTE	Training Director	\$10,565	\$42,259	\$52,824
2.0 FTE	Case Managers	\$14,790	\$59,160	\$73,950
1.0 FTE	Office Assistant	\$6,543	\$26,173	\$32,716
1.0 FTE	Training Director	\$10,565	\$42,259	\$52,824
2.0 FTE	Life Skills Coach	\$13,882	\$55,529	\$69,411
1.0 FTE	Alcohol & Drug Specialist	\$9,157	\$36,628	\$45,785
1.0 FTE	Office Assistant	\$6,543	\$26,173	\$32,716
0.5 FTE	Data Specialist	\$3,522	\$14,086	\$17,608
1.0 FTE	Training Director	\$10,577	\$42,308	\$52,885
1.0 FTE	Life Skills Coach	\$6,949	\$27,797	\$34,746
2.0 FTE	Peer Mentors	\$12,273	\$49,090	\$61,363
0.5 FTE	Licensed Therapist	\$5,621	\$22,482	\$28,103
1.0 FTE	Training Director	\$10,565	\$42,259	\$52,824
1.0 FTE	Lead Peer Trainer	\$7,285	\$29,141	\$36,426
2.0 FTE	Peer Mentors	\$12,271	\$49,082	\$61,353
b. Benefits and Taxes @ % 		\$53,033	\$212,132	\$265,165
c. Total Personnel Expenditures		\$272,810	\$1,091,240	\$1,364,050
2. Operating Expenditures				
a. Facility Cost		\$28,126	\$112,503	\$140,629
b. Other Operating Expenses		\$72,333	\$289,332	\$361,665
c. Total Operating Expenses		\$100,459	\$401,835	\$502,294
3. Subcontracts/Professional Services (list/itemize all subcontract)				
0.4 FTE	Child Development Consultant	\$8,500	\$34,000	\$42,500
	Purchased Training 6 Events at \$15,000	\$19,125	\$76,500	\$95,625
	Dramatic Event-Consumers	\$4,250	\$17,000	\$21,250
	Dramatic Event-School Based	\$4,250	\$17,000	\$21,250
a. Total Subcontracts		\$36,125	\$144,500	\$180,625
4. Total Proposed PEI Project Budget		\$409,394	\$1,637,575	\$2,046,969
B. Revenues (list/itemize by fund source)				
1. Total Revenue				
5. Total Funding Requested for PEI Project		\$409,394	\$1,637,575	\$2,046,969
6. Total In-Kind Contributions		\$0	\$0	\$0

Note: The Orange County Health Care Agency would like to request the \$2,046,969 for this program be taken from the FY 09/10 supplemental PEI Allocation.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE

PROJECT: Training Services

Alcohol & Drug Specialist	Provides information to individuals and groups on alcohol and drug problems
Case Managers	Liaisons with schools, community based organizations (CBO), mentoring programs and the private business sector; coordinates linkages and referrals; provides direct services.
Clinical Psychologist	Provides oversight of assessment and data collection tools, processes and reports, serves as therapist as needed, provides clinical supervision to staff
Data Specialist	Collects, collates, reviews, analyzes and presents process and outcome data
Lead Peer Trainer	Provides training on daily life activities, shares relevant personal experiences, serves as mentor, provides supervision to life skill coaches. Provides mental health assessments, evaluations and crisis intervention services to children, transitional youth, adults, older adults, and families; delivers community-based services; provides needed resources, mental health counseling and referrals, follow up contacts, may provide clinical supervision to unlicensed staff and students
Licensed Therapist	
Life Skills Coach	Provides training on daily life activities, shares relevant personal experiences, serves as mentor.
Marriage Family Therapist	Provides mental health evaluations and crisis intervention services to children, transitional youth, adults, older adults, and families; delivers community-based services; provides needed resources, mental health counseling and referrals, follow up contacts, may provide clinical supervision to paraprofessional staff
Office Assistant	Provides support services to multidisciplinary team
Office Manager	Performs difficult and responsible office work in a specialized assignment; interacts with the public in obtaining critical program data, organizes office systems and may supervise office staff
Peer Mentors	Assists in providing mental health treatment services; shares experience with clients of having been through similar life events; offers support, hope, and encouragement
Program Director	Plans, schedules, assigns, and directs staff of professionals and paraprofessionals; works closely with other agencies to coordinate and provide services.
Psychiatrist/Trainer	Provides specialized training and consultation; assists with goals and objectives development
Training Director	Provides capacity building training; assists with goals and objectives development, oversees training curriculum for training project activities

In Kind Contributions: The implementation of the MHSA Community Services and Support (CSS) programs has shown that in kind contributions from the community include donated labor, facilities, office equipment usage, translation services, publicity, supplies and indirect costs. As the providers for these PEI programs have not yet been identified through a formal contracting process, it is not possible to detail the anticipated in kind donations for the programs but it is anticipated that it will be similar to those seen in CSS.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 5

County: Orange

Date: _____

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures					
1. Personnel Expenditures					
a. Administrative Manager III		1.75	\$57,340	\$229,361	\$286,701
b. Administrative Manager II		3.0	\$79,201	\$316,805	\$396,006
c. Administrative Manger I		3.0	\$55,177	\$220,709	\$275,886
d. Service Chief II		2.0	\$46,249	\$184,995	\$231,244
e. Service Chief I		1.0	\$20,738	\$82,950	\$103,688
f. Research Analyst IV		0.6	\$11,965	\$47,861	\$59,826
g. Program Evaluation Specialist		5.0	\$72,124	\$288,496	\$360,620
h. Psychologist		0.5	\$12,550	\$50,201	\$62,751
i. Program Supervisor		1.0	\$17,623	\$70,491	\$88,114
j. Secretary II		1.0	\$11,690	\$46,758	\$58,448
k. Staff Specialist		2.0	\$29,916	\$119,663	\$149,579
l. Office Specialist		1.0	\$10,951	\$43,805	\$54,756
m. Information Processing Technician		2.5	\$26,286	\$105,144	\$131,430
n. Employee Benefits			\$165,498	\$661,992	\$827,490
o. Total Personnel Expenditures			\$617,308	\$2,469,231	\$3,086,539
2. Operating Expenditures					
a. Facility Costs			\$41,915	\$167,658	\$209,573
b. Other Operating Expenditures			\$107,780	\$431,119	\$538,899
c. Total Operating Expenditures			\$149,694	\$598,777	\$748,471
3. County Allocated Administration					
a. Total County Administration Cost			\$91,748	\$366,992	\$458,740
4. Total PEI Funding Request for County Administration Budget			\$858,750	\$3,435,000	\$4,293,750
B. Revenue					
1 Total Revenue			\$0	\$0	\$0
C. Total Funding Requirements			\$858,750	\$3,435,000	\$4,293,750
D. Total In-Kind Contributions			\$0	\$0	\$0

Note: The Orange County Health Care Agency would like to request \$624,483 for this program be taken from the FY 08/09 PEI Allocation with the additional \$3,669,267 taken from the FY 09/10 allocation.

Mental Health Services Act Prevention and Early Intervention Plan

BUDGET NARRATIVE PEI ADMINISTRATION

Administrative Manager III	responsible for overall direction to PEI Division, coordinates with other divisions and HCA units.
Administrative Manager III	responsible for development and management of veterans and disaster response projects
Administrative Manager II	responsible for development and management of PEI contracted programs
Administrative Manager II	responsible for development and management of County Operated PEI programs, and Statewide projects and data coordination
Administrative Manager I	responsible for program evaluation and data coordination
Administrative Manager I	responsible for administrative management of provider contracts
Administrative Manager I	responsible for administrative management of provider contracts
Research Analyst IV	responsible for outcome research
PSC	assists with program evaluation and outcome research
Service Chief II	provides supervision of 2 or more projects supervises program evaluation specialists
Service Chief I	provides supervision of 1 project, supervises program evaluation specialists
Program Supervisor I	responsible for office support, supervises support staff
Program Eval Spec	monitors one or more programs
Secretary II	supports Administrative Managers III
Staff Specialist	supports Administrative Managers II
Office Specialist	supports Program Evaluation, Outcome and Research staff
Staff Specialist	supports contract administration staff
Information Process Spec	data input and reporting for programs
IPT	data input and reporting for programs

Indirect Costs Indirect costs are broken down into two categories, agency wide Administration and service area administration. Agency wide administration (\$238,545) includes Health Care Agency costs for the Agency Director and Assistant Director's offices, Compliance Office, Financial and Administrative Services, Human Resources and Quality Management. Service area administration (\$128,447) includes the offices of the Behavioral Health Deputy Agency Directors and Program Support staff providing direct support to behavioral health.

Mental Health Services Act Prevention and Early Intervention Plan

Form No. 6

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

County: Orange
Date:

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 08/09	FY 09/10	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
Early Intervention Services								
	Early Intervention Services for stressed Families	\$116,238	\$464,950	\$581,188	\$406,832	\$174,356		
	First Onset Services and Supports	\$571,827	\$2,287,308	\$2,859,135	\$1,561,087	\$669,038	\$257,322	\$371,688
	Socialization Program for Isolated Adults & Older Adults	\$85,000	\$340,000	\$425,000			\$51,000	\$374,000
	Peer Mentors for Youth	\$58,438	\$233,750	\$292,188	\$204,532	\$87,656		
	Peer Led Support Groups	\$21,250	\$85,000	\$106,250	\$18,593	\$7,969	\$37,188	\$42,500
School Based Services								
	School Based Mental Health Services	\$446,250	\$1,785,000	\$2,231,250	\$1,561,875	\$669,375		
	PBIS	\$603,500	\$2,414,000	\$3,017,500	\$2,112,250	\$905,250		
	Violence Prevention Program	\$212,500	\$850,000	\$1,062,500	\$743,750	\$318,750		
	School Readiness Program	\$405,875	\$1,623,500	\$2,029,375	\$2,029,375			
Outreach & Engagement Services								
	Information and Referral Services	\$199,750	\$799,000	\$998,750	\$83,895	\$35,955	\$499,375	\$379,525
	PEI Outreach & Engagement Services	\$435,344	\$2,241,464	\$2,676,808	\$361,133	\$654,771	\$337,405	\$1,323,499
Parent Education and Support Services								
	Triple P Continuum of Care Parenting Services	\$207,912	\$831,648	\$1,039,560	\$727,701	\$311,859		
	Parent Empowerment Program	\$122,659	\$490,634	\$613,293	\$429,305	\$183,988		
	Training Programs for Parents	\$153,321	\$613,284	\$766,605	\$536,624	\$229,981		
	Promotora Model-Community Health Educators	\$127,679	\$510,714	\$638,393	\$446,875	\$191,518		
	Family to Family Support	\$52,612	\$210,446	\$263,058	\$184,140	\$78,918		
Prevention Services								
	PEI Mental Health Consultants	\$108,645	\$434,578	\$543,223	\$155,905	\$66,816	\$108,645	\$211,857
	Children of Substance Abusers and/or Mentally Ill Parents	\$164,108	\$656,430	\$820,538	\$574,377	\$246,161		
	PEI Services for Parents and Siblings of Youth in the Juvenile Justice System	\$49,875	\$199,501	\$249,376	\$174,563	\$74,813		
	Youth Development and Resiliency	\$60,477	\$241,907	\$302,384	\$211,669	\$90,715		
	Transition Services	\$40,257	\$161,029	\$201,286	\$140,900	\$60,386		
Screening and Assessment Services								
	Screening Tools and Training	\$50,509	\$202,035	\$252,544	\$77,784	\$33,335	\$85,865	\$55,560
	Professional Assessors	\$93,241	\$372,964	\$466,205	\$130,537	\$55,945	\$107,227	\$172,496
	Mobile Assessment Team	\$53,765	\$215,058	\$268,823	\$75,270	\$32,259	\$123,659	\$37,635
Crisis & Referral Services								
	Crisis Prevention Hotline/Warm Line Network	\$124,149	\$496,597	\$620,746	\$260,712	\$111,734	\$93,113	\$155,187
	Crisis Intervention	\$125,380	\$501,519	\$626,899	\$219,415	\$94,035	\$156,724	\$156,725
	Law Enforcement Partnership	\$111,418	\$445,670	\$557,088	\$241,387	\$103,450	\$159,327	\$52,924
	Survivor Support Services	\$59,111	\$236,445	\$295,556	\$86,893	\$37,240	\$44,334	\$127,089
Training Services								
	Training and Technical Assistance	\$117,098	\$468,393	\$585,491	\$106,559	\$45,669	\$181,502	\$251,761
	Child Development Training	\$76,293	\$305,170	\$381,463	\$267,024	\$114,439		
	Training in Physical Fitness & Nutrition	\$66,376	\$265,502	\$331,878	\$78,987	\$33,851	\$82,970	\$136,070
	Stress Management Training for Caregivers & Service Providers	\$53,160	\$212,640	\$265,800	\$42,794	\$18,340	\$85,056	\$119,610
	Community based Stigma Reduction Training	\$96,467	\$385,869	\$482,336	\$168,817	\$72,351	\$120,584	\$120,584
	Administration	\$858,750	\$3,435,000	\$4,293,750				
	Total PEI Funds Requested:	\$6,129,229	\$25,017,005	\$31,146,234	\$14,421,560	\$5,810,923	\$2,531,296	\$4,088,710

County: **Orange**

Date: **December 19, 2008**

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

PEI Project Name: *School-Based Services*

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

The School-Based Services Project includes the following four programs:

- ***School-Based Mental Health Prevention and Early Intervention Services*** – school-based collaboratives providing parent education, individual/group counseling, crisis intervention, case management, community linkages, referrals, educational groups, screening and early intervention, and substance abuse prevention and intervention.
- ***Positive Behavioral Interventions and Supports (PBIS)*** – a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing mental illness, problem behavior and emotional distress. Implemented using a three-tiered, strategic approach to primary, secondary and tertiary prevention.
- ***School-Based Violence Prevention Education*** – including gang prevention education, safe and healthy lifestyles, character education, media literacy, and skills in conflict resolution.
- ***School Readiness Program Expansion*** – on-site comprehensive developmental and behavioral screenings, professional services, early care and education/ training, and consultation to identify children with developmental and behavioral concerns and refer for further assessment and intervention.

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

The School-Based Services Project was selected for evaluation based on input received during the planning process (e.g., stakeholder meetings and PEI surveys) which involved many individuals, partnering organizations and educators concerned about the needs and service gaps of at-risk school children. Two dedicated

Mental Health Services Act Prevention and Early Intervention Plan

stakeholder meetings provided exclusively for school district representatives in Orange County were also held as a means to build consensus among the 28 districts in Orange County and to assure full participation in school-based projects and programs proposed in this Plan. This full participation by all districts also provided an opportunity to design and propose prevention and early intervention programs that can be made available to every one of the estimated 500,000 school age children in Orange County regardless of where they live and attend school.

Many of the outcomes associated with the programs in the School-Based Services Project to be evaluated can be linked directly to measures already being carried out by school districts as a means to track and measure academic performance and conditions that influence learning and student behaviors. The availability of this data also minimizes the amount of new data tracking mechanisms that need to be created and maintained to measure the benefits of the School-Based Services Project.

In addition, this project targets children and youth, TAY, young adults, and new parents, with the aim of building resiliency, personal empowerment, and capacity to maintain healthy lifestyles while working to avoid and/or decrease the impacts of emotional, developmental, and behavioral concerns. The School-Based Services Project addresses a broad spectrum of community mental health concerns, including stress, violence, trauma, developmental/behavioral concerns, and/or onset of serious mental illness.

These programs will be implemented in a number of geographic areas with higher concentrations of poverty and underserved populations, and the project's use of schools as accessible, familiar, and comfortable settings may help reach consumers who might otherwise avoid seeking traditional mental health services. As a result, the programs in the School-Based Services Project have the potential to reach participation rates (estimating over 600,000 individuals served within the first 15 months of intervention) high enough to result in a measurable short-term impact.

Mental Health Services Act Prevention and Early Intervention Plan

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

Program	Person/Family-Level Outcomes	Program/System-Level Outcomes
School-Based Mental Health Prevention and Early Intervention Services	<ul style="list-style-type: none"> • Improved mental health status. • Improved school performance. • Improved resilience and protective factors. • Increased knowledge/awareness of mental illness and community resources. 	<ul style="list-style-type: none"> • Increased number of school districts reporting on-site mental health resources. • Increased ability of school districts to identify and assist/refer students in need of early intervention services
Positive Behavioral Interventions and Supports (PBIS)	<ul style="list-style-type: none"> • Improved resilience and protective factors. • Improved school performance. • Improved social behaviors. • Improved mental health status. 	<ul style="list-style-type: none"> • Increased number of school districts reporting on-site PBIS resources. • Increased ability of school districts to identify and assist/refer students in need of early intervention services. • Increased student attendance and retention rates
School-Based Violence Prevention Education	<ul style="list-style-type: none"> • Improved resilience and protective factors. • Increased appropriate help-seeking. 	<ul style="list-style-type: none"> • Increased ability of school districts to respond to critical incidents and acts of violence.
School Readiness Program Expansion	<ul style="list-style-type: none"> • Improved school readiness and performance. • Improved mental health status. • Improved resilience and protective factors. 	<ul style="list-style-type: none"> • Increased number of professional support services to parents, early childhood providers, administrators, teachers, directors and non-traditional community partners serving the early care and education population. • Increased ability of providers of early care and education to identify and assist/refer students in need of early intervention services and school readiness resources. • Increased number of referrals to other community resources.

Mental Health Services Act Prevention and Early Intervention Plan

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For “other”, provide numbers of individuals served for whom a category is not provided cultural Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION: *School-Based Mental Health Prevention and Early Intervention Services*

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
<u>ETHNICITY/ CULTURE</u>							
African American	15	15	45	10,695	60	15	30
Asian Pacific Islander	120	120	465	100,035	585	120	345
Latino	315	315	1,305	279,330	1,635	315	975
Native American			30	3,150	15		30
Caucasian	255	255	990	212,640	1,245	255	750
Other (Indicate if possible)	30	30	105	23,280	135	30	75
<u>AGE GROUPS</u>							
Children & Youth (0-17)	585	585	2,355	503,224	2,940	585	1,770
Transition Age Youth (16-25)	150	150	585	1,25,835	735	150	435
Adult (18-59)							
Older Adult (>60)							
TOTAL	735	735	2,940	629,059	3,675	735	2,205

Total PEI project estimated *unduplicated* count of individuals to be served* 629,059
 (note: 7,451 people will receive both prevention and early intervention school-based services)

*Estimated unduplicated count of individuals served (during 15-month period) by the School-Based Mental Health Prevention and Early Intervention Services Project.

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

All outcomes data, whether collected bi-annually or annually, will be compared to prior years' data each fiscal year.

School-Based Mental Health Prevention and Early Intervention Services

Individual Outcomes:

Students' mental health status, school performance, and resilience and protective factors will be measured using the California Healthy Kids Survey (CHKS) and the California School Climate Survey (both administered bi-annually), and student achievement data (measured annually). Student knowledge of mental health issues and community resources will be measured by pre- and post-test surveys completed by a random sample of students before PEI programs begin and annually thereafter.

System/Program Outcomes:

School districts' availability of on-site mental health resources and early intervention services and their ability to identify and assist/refer students in need of early intervention services will be measured by tracking of behavioral/mental health screenings, referrals to other community resources, participation in clinical sessions, and youth participation in groups. In addition, campus awareness of mental health issues and concerns will be measured by staff surveys at the conclusion of professional learning opportunities. Data will be collected annually.

Positive Behavioral Interventions and Supports (PBIS)

Individual Outcomes:

Students' resilience and protective factors, school performance, social behaviors, and mental health status will be measured using behavior outcomes based on PBIS benchmarks, behavior referral data using the School-Wide Information System (SWIS), and discipline data reports. Data will be collected annually.

System/Program Outcomes:

The number of school districts participating in PBIS will be tracked annually by the Orange County Department of Education. The depth of implementation for PBIS schools will be measured using the School-Wide Evaluation Tool (SET). The resulting data will measure a district's ability to identify and assist students in need of early intervention services.

School-Based Violence Prevention Education

Individual Outcomes:

Students' resilience and protective factors, risk factors, and appropriate help-seeking behaviors will be measured annually using student discipline reporting and the California Healthy Kids Survey (bi-annually), as well as an overall improvement in school climate as measured by the California School Climate Survey (bi-annually).

System/Program Outcomes:

A school district's ability to respond to critical incidents and acts of violence will be measured using the California Healthy Kids Survey (CHKS). Data will be compared to baseline levels bi-annually to assess students' perceptions of school safety and caring adults on campus.

School Readiness Program Expansion

Individual Outcomes:

Students' resilience and protective factors, school readiness and performance, and mental health status will be measured by monitoring indicators of Orange County children's well-being available through "Children Now" and the annual "Report on the Conditions of Children in Orange County." Data will be reviewed and reported annually.

System/Program Outcomes:

Professional development and support services to those serving early care and education population will be measured by the number of early childhood education providers and partners receiving training on screening, assessment, and interventions for health, safety, and behavioral services. The ability of early care and education providers to identify and assist/refer students in need of early intervention services and school readiness resources will be measured by: (a) the number/percent of children screened for developmental, behavioral, or mental health issues and were referred for follow-up services and (b) the number of parents screened for parental stress, depression, and/or anxiety and were referred for follow-up services. Data will be reported annually.

5. How will data be collected and analyzed?

The evaluation will leverage both existing evaluation strategies (California Healthy Kids Survey, California School Climate Survey, Positive Behavioral Interventions and Supports benchmarks and School-Wide Evaluation Tool, along with community indicator reports including Children Now and the Report on the Conditions of Children in Orange County, and other data available through the Orange County Department of Education and the Children and Families Commission of Orange County) and unique client specific service data, if appropriate for the service. All evaluation data collection activities will be carefully linked to program goals and objectives and may include protocols to be developed for conducting surveys, interviews, observations, and/or case studies.

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All Orange County school districts and community organizations participating in PEI School-Based Services will be responsible for collecting data to support the evaluation design. Parents of children who receive moderate to intensive services will be asked to sign an authorization/consent to provide information about their child and family for the evaluation, consistent with County policies to protect confidentiality in data sharing. Unique child data will be collected and reported monthly per contract requirements. Evaluation and indicators reports, as mentioned above, along with any unique child data, will be reviewed annually by a School-Based Services Evaluation Committee. The School-Based Services Evaluation Committee will consist minimally of the Health Care Agency/Children and Youth Services, Orange County Department of Education, the Children and Families Commission of Orange County, and a member of the Children's Services Coordination Committee to review accomplishments, trends, and community needs. The School-Based Services Evaluation Committee will also work with the service providers collectively and individually as needed to ensure that data are gathered accurately and on time.

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

Orange County educates the second largest 0-17 student population in California, with a public school enrollment of 503,224 students in 2007-08. English learners are approximately 28% of Orange County students. Nearly 40 % of Orange County students (39.9%) were eligible to receive free or reduced-price meals in 2007-08. In 2004, "Orange County became a majority-minority county, meaning no one ethnic group holds a majority of the population" (Baldassare, 2004). Orange County K-12 student demographics reflect their diverse language and educational needs: (44.4% Hispanic/Latino; 13.6% Asian; 0.6% Pacific Islander; 1.7% Filipino; 33.8% White; 1.7% African American; 0.5% American Indian/Alaska Native; and 3.7% Multiple/No Response). In 2007, Children Now estimated the Orange County preschool population (ages 3 and 4) at approximately 99,157 children (51.0% Hispanic/Latino; 11.4% Asian; 32.1% White; 1.6% African American; 3.9% Other).

To ensure that children from diverse backgrounds and diverse abilities have access to high-quality, culturally competent and developmentally appropriate opportunities, provided services will:

- Use culturally and linguistically relevant methods of communication and community outreach;
- Ensure that the evaluation approach incorporates a review of disaggregated data (ethnicity, language, age, socio-economic status) where available to further aid in program design;
- Provide information and support through culturally and linguistically responsive service providers who are also knowledgeable about children with special needs;
- Develop print, audio-visual, and electronic materials that are culturally and linguistically relevant for all communities served, are written at appropriate literacy levels, and are available for specialized populations;
- Schedule services according to family needs and situations;

Mental Health Services Act Prevention and Early Intervention Plan

- Support individualized programs that address the cultural and linguistic diversity, ability levels, behavioral issues, and learning styles representative of California's children and families;
- Ensure availability of adapted and specialized services and supports as needed to maximize full participation for all children and their families;
- Promote policies to assure availability of training and technical assistance to improve knowledge, skills, and attitudes and build capacity to work better within culturally and linguistically diverse communities.

A comprehensive evaluation approach will include a diverse team of stakeholders to conduct a culturally competent evaluation that is sensitive to and demonstrates an understanding of the cultural context of each program. For example, staff from Orange County Behavioral Health Services Cultural Competency and Multi Ethnic Services Program have been involved in the PEI planning process and will continue to be engaged during implementation and evaluation phases to help deliver MHSA services in a culturally and linguistically competent manner.

Evaluation tools and methods for the School-Based Services project will be culturally appropriate for use with all students and families. For example, the national Youth Risk Behavior Survey (YRBS) and the California Healthy Kids Survey (CHKS), which is a scientifically sound instrument with proven validity and reliability for use with students based on 17 years of survey research. The CHKS is available in Spanish, and information letters/consent forms are available to parents in 12 languages. The CHKS must be offered to all students in eligible grade levels at testing sites, and current district translation procedures are used as necessary. In addition, indicators of cultural competence can be measured via survey/interview feedback from consumers, providers and other key informants.

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

All staff participating in the implementation and evaluation of the School-Based Services Project will be trained in a consistent manner to maintain fidelity of implementation across school sites and districts. Measures will be developed at the practitioner performance level in order to evaluate adherence to the adopted models and to assist in improving performance. Ongoing training, monitoring, and coaching will provide for quality control in implementation of all programs.

Along with program process and outcome data, fidelity data (e.g., implementation tracking tools, quality monitoring tools, and other measures developed collaboratively by program managers and evaluation committee members) will be collected on an ongoing basis to assure that program and evaluation protocols are carried out according to original plans.

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

Sharing evaluation findings from the School-Based Services Project with various audiences will be important for communicating progress toward program goals and applying what is learned in order to improve access to and implementation of services.

A comprehensive annual evaluation report will be provided to the DMH and program managers/partners involved in the School-Based Services Project. The report on the evaluation of the School-Based Services Project and associated programs will be posted on the County’s MHSA PEI web page for review by all interested constituencies and the general public. This report will also be made available in hard copy upon request. Members of the local MHSA Steering Committee will be notified of this posting through email announcements, and provided with an opportunity to review the report during a scheduled monthly steering committee meeting.

In addition, executive summary reports could be disseminated more broadly to consumers and agency employees via articles in “Recovery Connections,” Orange County MHSA’s quarterly newsletter and “What’s Up”, the Orange County Health Care Agency’s monthly employee newsletter. Documents and web pages will be translated into Spanish, Vietnamese, and other threshold languages, as needed.

9. Additional comments (Optional)

None

ATTACHMENT 1

PREVENTION AND EARLY INTERVENTION TRAINING CURRICULUM

The Mental Health Services Act

**PREVENTION & EARLY
INTERVENTION**

Proposition 63

The Mental Health Services Act (MHSA) was passed in November 2004 as Proposition 63 on the ballot.

The MHSA will expand mental health care for children, youth, adults, and seniors using programs proven to be effective.

The MHSA also provides prevention services to help children, youth, adults and seniors get care before a mental illness becomes disabling.

MHSA:

- **Utilizes funding derived from a 1% tax on taxable personal income over \$1 million.**
- **Directs funding only to new or expanded programs that are based on models proven to be effective.**
- **Ensures that State and local governments can't redirect the funding.**

MHSA PLAN COMPONENTS

The State Department of Mental Health (DMH) has identified five MHSA components that are to be woven into an Integrated Plan at the local level and a comprehensive strategy at the state level. The components are:

1. Community Services and Supports
2. Capital Facilities and Information Technology
3. Education and Training Programs
4. Prevention and Early Intervention Programs
5. Innovative Programs

Through the **Community Services and Supports (CSS)** component, the MHSA provides treatment funding to develop recovery oriented services and supports for children, youth, adults and older adults living with a serious mental illness.

Through the **Prevention and Early Intervention (PEI)** component, the MHSA also provides funding to:

- develop universal and selective interventions and programs to help prevent the development of serious emotional or behavioral disorders and mental illness.
- provide “short–duration”, “low-intensity” interventions to avoid more extensive mental health services or to prevent a mental health problem from getting worse.

**DISTINCTION BETWEEN PEI AND
COMMUNITY SERVICES AND
SUPPORTS (cont.)**

- The intent of the PEI strategy is to engage persons prior to the development of SMI or SED.
- In the case of early interventions, the intent is to alleviate the need for additional mental health treatment and/or transition to extended mental health treatment.

**DISTINCTION BETWEEN PEI AND
COMMUNITY SERVICES AND
SUPPORTS**

- PEI interventions should be distinct from Community Services and Support services.
- PEI funding should be used to prevent mental health problems or to intervene early with relatively "short-duration" and "low-intensity".
- PEI funds should NOT be used to fill gaps in treatment and recovery services for individuals diagnosed with serious mental illness (SMI) or serious emotional disturbance (SED).

(cont.)

KEY TO TRANSFORMATION: HELP FIRST

“To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health, education, community organizations).”

(DMH PEI Guidelines Sept. 2007, page 2)

PRIORITY LONG TERM OUTCOMES OF PEI

Reduction of:

- **school failure**
- **prolonged suffering**
- **incarceration**
- **removal of children from homes**
- **homelessness**
- **unemployment**
- **suicide**

PRIORITY POPULATIONS

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

PEI PRIORITY AGE

- **PEI County Plans will address all age groups.**

however

- **A MINIMUM OF 51% of the overall County PEI budget must be dedicated to individuals who are between the ages of 0-25.**

“50% of all lifetime mental health disorders start by age 14 and 75% start by age 24” *

* Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, 2005
Ronald C. Kessler, PhD; Patricia Berglund, MBA; Olga Demler, MA, MS; Robert Jin, MA; Kathleen R. Merikangas, PhD; Ellen E. Walters, MS

RECOMMENDED PLANNING PARTNERS

- **Underserved Communities**
- **Education**
- **Client and Family Member Organizations**
- **Mental Health Providers**
- **Health**
- **Social Services**
- **Law Enforcement**

ORANGE COUNTY'S PEI PLANNING PROCESS STARTS NOW

Community Input:

- **Regional focus groups and stakeholder meetings**
- **Community and organizational on-line surveys:**

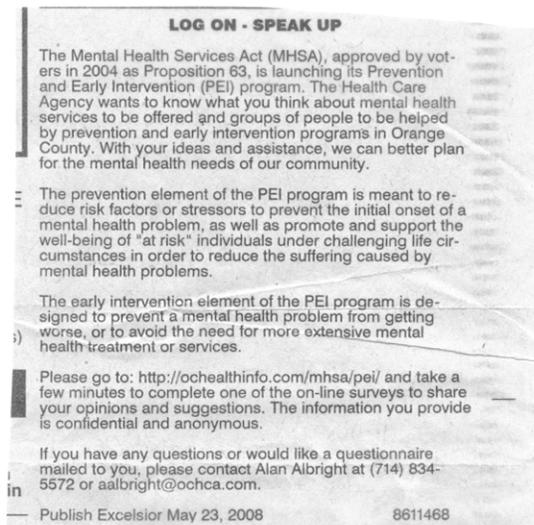
<http://www.ochealthinfo.com/mhsa/pei/>

For more information, or to arrange a focus group in your area, contact Alan Albright at: (714) 834-5572 or aalbright@ochca.com

ATTACHMENT 2

Advertisements Publicizing PEI Survey

Mental Health Services Act Prevention and Early Intervention Plan



Actual Size

Mental Health Services Act Prevention and Early Intervention Plan

- Goat - 54 Xem tiếp SỬA ĐỀ trang C10



VÀO MẠNG LƯỚI HOÀN CẦU – PHÁT BIỂU

Đạo Luật Dịch Vụ Sức Khỏe Tâm Thần (MHSA), được cử tri chấp thuận trong năm 2004 qua dự luật 63, đang bước vào giai đoạn bắt đầu của chương trình Phòng Bệnh và Sớm Chữa Bệnh (PEI). Cơ Quan Y Tế muốn biết quý vị nghĩ gì về những dịch vụ sức khỏe tâm thần sẽ được cung cấp và những nhóm thành viên sẽ được giúp đỡ bởi những chương trình Phòng Bệnh và Sớm Chữa Bệnh trong Hạt Cam. Với ý kiến và sự giúp đỡ của quý vị, chúng ta có thể hoạch định tốt đẹp hơn cho những nhu cầu về sức khỏe tâm thần của cộng đồng chúng ta.

Thành phần phòng bệnh của các chương trình PEI có mục đích để giảm bớt các nguy cơ hoặc yếu tố gây khủng hoảng để ngăn chặn sự khởi đầu các vấn nạn của sức khỏe tâm thần, cũng như để nâng đỡ và khích lệ sự lành mạnh cho những ai có "nguy cơ" bị bệnh trong khi trải qua những khó khăn của cuộc sống để giảm bớt nỗi đau buồn mất mát gây ra bởi các vấn nạn của sức khỏe tâm thần.

Thành phần sớm chữa bệnh của các chương trình PEI được thiết kế để ngăn chặn một vấn nạn của sức khỏe tâm thần bị nặng hơn, hoặc để tránh khỏi nhu cầu cần các dịch vụ và phải chữa trị một cách lâu dài và sâu rộng.

Xin ghé thăm mạng lưới hoàn cầu ở địa chỉ: <http://ochealthinfo.com/mhsa/pei/> và dùng chút ít thời gian để hoàn tất bản thăm dò ý kiến trên mạng để chia sẻ các ý kiến cũng như những đề nghị của quý vị. Tất cả các tin tức quý vị cung cấp đều được bảo mật và匿 danh (không có tên).

Nếu quý vị có gì thắc mắc hoặc muốn những câu hỏi của bản thăm dò ý kiến được gửi đến cho quý vị, xin liên lạc Alan Albright tại số (714) 834-5572 hoặc viết thư qua mạng tại aalbright@ochca.com.

CNSB # 1344532



Actual Size

Mental Health Services Act Prevention and Early Intervention Plan

đơn đi kiện cấp trên, vì công



VÀO MẠNG LƯỚI HOÀN CẦU – PHÁT BIỂU

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<http://ochealthinfo.com/mhsa/pei/> và dùng chút ít thời gian để hoàn tất bản thăm dò ý kiến trên mạng để chia sẻ các ý kiến cũng như những đề nghị của quý vị. Tất cả các tin tức quý vị cung cấp đều được bảo mật và nặc danh (không có tên).

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CNSB 1344522

Actual Size

ATTACHMENT 3

Primary Priority Target Populations by Program

Mental Health Services Act Prevention and Early Intervention Plan

Attachment 3

The six priority populations:

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

The eight project categories:

1. EI: Early Intervention
2. SBS: School-Based Services
3. O/E: Outreach and Engagement
4. PES: Parent Education Services
5. PS: Prevention Services
6. SAS: Screening and Assessment
7. CR: Crisis and Referral
8. Training Services

Primary Priority Target Populations By Program

Project	Program	Service Type	Age Group	Primary Priority Population
6	EI Mentors for Youth	peer mentors	5-26	Juvenile Justice Involvement
7	EI Peer Support Groups	peer mentors	all	Juvenile Justice Involvement
4	PS Youth Resiliency Clubs	train., consult.	youth	Juvenile Justice Involvement
	PS Services to Justice Involved Families	intervention	all	Juvenile Justice Involvement
5	PS Transition Services	mentoring	youth	Juvenile Justice Involvement
	EI 1st Onset Services	intervention	all	Onset of Serious Psychiatric Illness
3	CR Law Enforcement Partnership	intervention	0-21	Onset of Serious Psychiatric Illness
3	TS Fitness and Nutrition Education	training	18 +	Onset of Serious Psychiatric Illness
5	EI Socialization for Older Adults	friendly visitor	18+	Onset of Serious Psychiatric Illness
1	TS Training and Technical Assistance	train., consult.	all	Onset of Serious Psychiatric Illness
1	PS Mental Health Consultants	consultant	all	Onset of Serious Psychiatric Illness
2	SBS Positive Behavioral Supports	system change	5-18	Risk for School Failure
4	SBS School Readiness	consultation	5-18	Risk for School Failure
3	SBS Violence Prevention Education	multi MH service	5-18	Risk for School Failure
3	SBS School Mental Health Services	multi MH service	5-18	Risk for School Failure
5	PES COPE Model Parent Training	training	0-18	Stressed Families
2	PES Family to Family	peer support	0-18	Stressed Families
4	PES Parent Empowerment	training	0-18	Stressed Families
1	PES Promotoras	consultation	0-18	Stressed Families
1	PES Triple P	intervention	0-18	Stressed Families
1	EI EI for stressed families:	intervention	all	Stressed Families
1	SAS Tools and Training	train assessment	all	Trauma Exposed Individuals
3	SAS Mobile Assessment team	assessment	all	Trauma Exposed Individuals
2	SAS Professional Assessment	assessment	all	Trauma Exposed Individuals
2	PS Children of SMI and ADAS Parents	intervention	0-18	Trauma Exposed Individuals
4	TS Stress Management	train., consult.	all	Trauma Exposed Individuals
4	CR Survivor Support	peer led groups	all	Trauma Exposed Individuals
	CR Crisis Hotline/Warmline	phone tx	all	Underserved Cultural Populations
2	CR Crisis Intervention Network	intervention	all	Underserved Cultural Populations
2	TS Child Development Consultation	train., consult.	0-18	Underserved Cultural Populations
1	O/E Information and Referral	supported phone line	all	Underserved Cultural Populations
2	O/E Outreach and Engagement	outreach teams	all	Underserved Cultural Populations
5	TS Stigma Reduction	training	all	Underserved Cultural Populations

Attachment 4

Public Comments and Responses

Mental Health Services Act Prevention and Early Intervention Plan

Public Comment #1 on PEI Plan

As a family member who has been dealing with my adult daughter's mental illness for the past 12 years, I know we need more assistance for families who might like to bring their ill one home as they are 'recovering' - I need a support system to be able to keep working and still know that my ill family member is occupied and safe. Older or retired health workers, teachers, etc.. could be offered stipends or salaries to help work with these transition 'clients' so they would be busy and safe while family members are at work. I would especially like to see increased type of facilities where the mentally ill who are recovering have less restricted environments, housing in a village-type concept - where they can train for some type of volunteer work or employment - and still have daily monitoring for their medications and receive psychological support.

An increasing frustration every year is the conservatorship process which triggers my family member's relapse back into hospital stays - and the expense required if you are a private conservator who wants to try to minimize the impact of this process on your loved one. A new look needs to be given to ensure that the health and welfare of a sick individual comes first and foremost and if they are deemed to ill to go through the process any given year, then the doctors, family members, and county agencies should be able to reach agreement that this annual hearing should be put off until such time that the "client" is not in such fragile condition.

Thank you for listening to my concerns.

Response to Public Comment # 1

From: Qian, Yan Jenny

Sent: Thursday, January 22, 2009 6:21 PM

To: 'jdenenny@orangeusd.org'

Cc: Pavich, Kate; Perera, Anthony; Corral, Juan; Birnbaum, Bonnie

Subject: FW: Public comment on the PEI draft plan

Hi, Judy,

You have identified a critical area of need for many families. Your suggestions are excellent and are very much in line with the philosophy and principles of the Mental Health Services Act, to support the recovery of the individual and the efforts of their families to help them do so.

In the Mental Health Services Act, responsibility for implementing change for those persons with a mental illness and "in the system" is given to the "Community Services and Supports (CSS)" programs. For your daughter's recovery, we have referred your comments to the staff in charge the CSS sections of Adult Mental Health Services. The conservatorship is outside the scope of MHSa and PEI.

Mental Health Services Act Prevention and Early Intervention Plan

The Prevention and Early Intervention (PEI) section of MHSA has the responsibility of developing services for those people in the community who have not yet entered, or are just entering, the Mental Health system. One of our target groups for the PEI plan is the family or caretakers of the individuals who are mentally ill. We have several programs designed to provide information, support and assistance to families, including all of the programs in the Parent Education and Support project, the stress management program in the Training Project, the survivor support group in the Crisis and Referral Project and others. Your comments underline the need to make these services known and available to the parents of adult clients.

Thank you for bringing this to our attention. We appreciate your input and thoughts.

Jenny Qian
OC PEI Coordinator
714 834-2426
yqian@ochca.com

Public Comment # 2 on PEI Plan

My congratulations to the HCA, BHS and MHSA Office for a wide spread and comprehensive PEI Plan Draft.

Firstly, considering my role in the Mental Health System, I am very pleased and assured to see the component of Survivor Support Services under PEI – Crisis and Referral Projects and Programs. Thank you for that. My feed back includes the observation that this component needs to be more comprehensive to include not only the existing open ended bimonthly support group but also a time limited group for survivors based on the LA SOS Model, as well as other features from that existing program.

Secondly, the Crisis Hotline and Intervention Network is a major Intervention piece that has been missing in OC for way too long with over 200 to 300 of OC crisis calls being diverted to LA and beyond. Thank you for including this in this phase of the draft, this also being a component that needs to be further developed, of course.

Thirdly, however, there appears to be a void in the Suicide Prevention components which include a Public Awareness and Education piece that is not mentioned anywhere in the PEI Projects and Programs, including not under the Project and Program entitled Prevention Services, seemingly a logical place to include it.

To me this is the only thing that has been left out of the draft plan and must be included if it is to be truly a comprehensive for PEI plan. I would be happy to volunteer my time and experience to build this part of the plan when the time is appropriate.

Mental Health Services Act Prevention and Early Intervention Plan

Over all, the public health model of community Suicide Prevention is three pronged and must include 1.) Intervention, 2.) Prevention, and 3.) Post Vention (survivor support). As far as I can see, the existing PEI Draft Plan includes numbers 1. and 3., and to be effective and comprehensive must also include the missing Prevention piece.

Thank you again for all your work on this and I look forward to working with you in the future.

Response to Public Comment # 2 PEI Plan

From: Qian, Yan Jenny
Sent: Thursday, January 22, 2009 6:10 PM
To: 'Bordersls@aol.com'
Cc: Pavich, Kate; Corral, Juan; Birnbaum, Bonnie; Perera, Anthony
Subject: FW: Public Comment for OC's PEI Draft Plan

Hi, Linda,

It was very nice meeting you this morning at the public hearing. You have an excellent observation regarding the “missing piece.” There is an additional component to PEI, which is the “Statewide Projects” part. There are five statewide projects, headed by the state department of mental health, one of which will coordinate the Suicide Prevention Public Awareness and Education campaign. A description of the project can be read at the state DMH MHSA site (www.dmh.ca.gov/Prop_63/MHSA). We will be participating in this campaign.

With regard to enhancing the survivors group, the plan is designed to be flexible and also can be changed as needed with approval from the local steering committee and the state. With the survivor group and other programs, we know that some will be very effective and need to be increased – others may not be and will be reduced. We are committed to following the pattern of need and results, as we have in CSS programs that become apparent as the programs become operational.

Thank you for your comment and I look forward to working with you in the near future as we implement the PEI plan in Orange County.

Jenny Qian
OC PEI coordinator
714 834-2426
yqian@ochca.com

Attachment 5

**Mental Health Board
Public Hearing Minutes
January 22, 2009**

Mental Health Services Act Prevention and Early Intervention Plan



BOARD OF SUPERVISORS

Patricia C. Bates, Chair
Fifth District

Janet Nguyen, Vice-Chair
First District

John M.W. Moorlach, Chairman
Second District

Bill Campbell
Third District

Chris Norby
Fourth District

MHB MEMBERS

Cecile Dillon, Ph.D., Chair

Harvey Grody, Ph.D., Vice-Chair

Randy Beckx

Janice DeLoof

Pamela Kahn, RN, MPH

Jason Kellogg, M.D.

Kymerli Kercher Smith

Carol Langone, LCSW

Nomi Lonky

Janet Nguyen
First District Supervisor

Young Nguyen

Rachel Pedraza

Robert Reid

Frances M. Williams, Ed.D.

Gregory D. Wright

HEALTH CARE AGENCY

Mark Refowitz, Director
Behavioral Health Services

Mary Hale, Chief of Operations
Behavioral Health Services

Danielle Hopson, Staff Specialist
Behavioral Health Services

County of Orange Mental Health Board

405 W. 5th Street, Ste 501
Santa Ana, CA 92701
TEL: (714) 834-5481 / FAX: (714) 834-4586
Email: dhopson@ochca.com

Thursday, January 22, 2009
9:00 a.m. - 11:00 a.m.

**Hall of Administration
Board Hearing Room
10 Civic Center Plaza
(333 West Santa Ana Blvd.)
Santa Ana, CA 92701**

MINUTES

The regular meeting of the Orange County Mental Health Board was held on Thursday, January 22, 2009, at the Hall of Administration, 333 W. Santa Ana Blvd. Santa Ana, CA 92701.

During the regular meeting, a Public Hearing was held to consider the Mental Health Services Act Prevention and Early Intervention Plan & Request for Training, Technical Assistance and Capacity Building Funds. There were approximately 71 people in attendance with 4 guest speakers.

At the conclusion of the Public Hearing the Mental Health Board, with eleven members in attendance, voted unanimously by roll call in favor of approving the Mental Health Services Act Prevention and Early Intervention Plan & Request for Training, Technical Assistance and Capacity Building Funds as written.

Officially submitted by:

**Danielle Hopson, Mental Health Board Liaison
Reporting Secretary**

Next Meeting: The next Mental Health Board meeting will be held on February 11, 2009 from 7:30a.m. - 9:00a.m., 405 W. 5th Street, Conference Room 433, Santa Ana, CA 92701

ADDENDUM

Training, Technical Assistance and Capacity Building Funds Request Form

Mental Health Services Act Prevention and Early Intervention Plan



*Excellence
Integrity
Service*

COUNTY OF ORANGE HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES

JULIETTE A. POULSON, RN, MN
DIRECTOR

MARK A. REFOWITZ
DEPUTY AGENCY DIRECTOR
BEHAVIORAL HEALTH SERVICES

MAILING ADDRESS:
405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701

TELEPHONE: (714) 834-6032
FAX: (714) 834-5506
E-MAIL: mrefowitz@ochca.com

January 27, 2009

California Department of Mental Health
MHSA Prevention and Early Intervention Component
1600 9th Street
Sacramento, CA 95814

Dear Department of Mental Health:

Attached is the Training, Technical Assistance and Capacity Building funds request form for fiscal years 2008-2009 and 2009-2010, which is from the Prevention and Early Intervention Statewide Project. The funds are requested to provide training, technical assistance and capacity building for the eight projects proposed in our PEI Plan. We are submitting the funding request for the PEI Plan and the funding request for these funds simultaneously.

Sincerely,

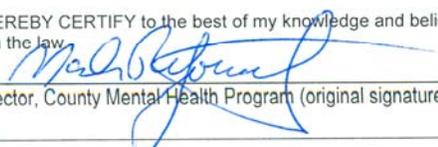
Mark A. Refowitz
Behavioral Health Director

Attachment

Mental Health Services Act Prevention and Early Intervention Plan

Enclosure 2

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

Date: 12/22/08	County Name: Orange
Amount Requested for FY 2008/09: \$493,300	Amount Requested for FY 2009/10: \$493,300
<p>Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).</p> <p>In order to improve the capacity of local partners outside the mental health system, such as, education, primary health care, law enforcement, etc, as well as County staff and partners who will be working on the development, implementation and evaluation of prevention and early intervention work plans and programs that will be funded through the County's Plan, we will implement training and technical assistance, including educational presentations, development and dissemination of training materials, development of Web and online resources and train-the-trainer approaches in areas such as: models of early intervention, models of prevention, school-based approaches to prevention and early intervention, outreach to underserved communities, parent education and support, screening and assessment and crisis approaches.</p> <p>In order to develop the capacity of local organizations outside of county behavioral health to implement PEI projects we will provide multi-disciplinary conferences and trainings to enhance the capability of community providers and community partners as well as collaborative opportunities in which staff of such organizations can learn through interactive trainings and experiences from county behavioral health staff. Enhancement of communication across systems (education, law enforcement, primary health care, community providers, faith-based organizations) will be addressed by developing cross-system networks that can be utilized by the various partners who will be implementing the PEI plan.</p>	
<p>The County and its contractor(s) for these services agree to comply with the following criteria:</p> <ol style="list-style-type: none"> 1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County's Three-Year Program and Expenditure Plan. 2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services. 3) These funds shall only be used to pay for the programs authorized in WIC Section 5892. 4) These funds may not be used to pay for any other program. 5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC Section 5892. 6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities. 7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines. 	
<p>Certification</p> <p>I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.</p> <div style="text-align: center;">  _____ Director, County Mental Health Program (original signature) </div>	